From: patrick@pmauselaw.com
Sent: Sunday, December 10, 2017 11:22 AM
To: EBSA, E-ORI - EBSA
Cc: patrick@pmauselaw.com
Subject: 1210 - AB39 -- Opposition to Delay or Changes to Previously-Adopted ERISA Rules

Dear Deputy Assistant Secretary Hauser –

I have previously written in support of the DOL's initial proposed ERISA disability rule changes, many of which were adopted, and then more recently in opposition to the DOL's proposed delay of those rules. Briefly, I am an attorney who handles plaintiffs' ERISA disability claims, as well as non-ERISA bad faith claims. The first six years I was a lawyer I did ERISA defense work for a large Arizona and southwest law firm. For the past 6-1/2 years, I have been representing ERISA disability claimants in administrative appeals and litigation against disability carriers. I write to oppose the industry-requested delays and any changes they may propose to the final rules, which are now scheduled to take effect April 18, 2018.

Initially I note that, in violation of the Administrative Procedures Act (APA), the industry representatives appear to be rearguing the final rules which the DOL properly considered and issued. I have seen nothing from industry that should permit them to avoid the requirements of the APA. And as discussed below, industry's arguments are largely hollow, incorrect, or backwards.

Industry's Claim Costs Will Increase Is Dubious, Unlikely, And Ultimately Insufficient:

I have a difficult time believing industry claims that the final rules will increase costs. Not only is this an argument industry should have (and I believe did) raise during the initial public comment period, and which was properly weighed by the DOL in the final rulemaking, but it is largely preposterous. I have been told repeatedly by experts and in-house disability insurer personnel that only about 10% of disability claimants appeal a claim denial or termination. Because nearly all of the adopted rules affect claim denials and administrative appeals, the portion of claims actually affected by the rule changes is quite small.

Additionally, the industry argument is completely speculative. To my knowledge, industry has not provided any actual, credible data supporting

its position. And undercutting industry's claims, after the previous rule changes in 2002 participation of private industry workers in short- and long-term disability insurance *increased*; as Bureau of Labor Statistics data shows. https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm In fact, from 2003, shortly after the rules' adoption, to 2014, participation in employer-sponsored long-term disability plans increased from 28% to 33%. Industry's new claims that the additional, properly-considered, properly-adopted, APA-compliant rule changes will decrease enrollment is fanciful conjecture. The BLS statistics speak volumes about the fallacy of industry's claims.

The previously-adopted rule changes will lead to more fair claims procedures and help reduce (if slightly) industry malfeasance. Thus, if there is any increase in premiums (and I remain highly dubious because the BLS data shows an increase in participation), that is not necessarily a bad thing. In business, it can be more expensive to be honest and fair rather than dishonest and fraudulent. It would be cheaper to sell untested pacemakers that are actually just parts from a Fisher Price toy rather than selling pacemakers that have been properly designed, tested, manufactured, and ensured to work properly. That doesn't mean we should allow *Bob's Discount, Untested Fisher Price Pacemakers* to enter the market simply because it's so much cheaper. A more fair ERISA process (or, more accurately, a slightly less industry-favoring process) is an absolute public good. If it costs industry slightly more to handle claims fairly, that is far better than having industry sell the public an illusory promise that purports to, but does not, protect them from financial calamity in the event they suffer a debilitating injury or sickness. I can't tell you the number of clients I've had who are shocked when they learn how highly ERISA is stacked against them and say "But I paid for this benefit. How can they do this?"

The properly considered and adopted rules will effect a slight shift toward fairness. That is a good thing and any alleged cost increases are dubious and undermined by the BLS statistics discussed above. Moreover, as also discussed above, because most of the properly-adopted rules pertain to claim denials and administrative appeal issues, and because only about 10% of claimants appeal an improper benefits denial or termination any alleged costs will be negligible at best. I note that when considering industry's objections to the previously-adopted rules, I would encourage the DOL to consider industry's failure to submit information about the

percentage of disability appeals or denials that are actually appealed to be a significant omission.

Plans Should Discuss The Basis For Rejecting A Social Security Disability Award:

Industry's complaints about having to give a real explanation for rejecting a Social Security Disability Insurance (SSDI) award are likewise hard to accept. First, I note that two insurers – Unum and Cigna – are already required to do so by Regulatory Settlement Agreements they entered into to resolve unfair claims practices. Thus, if Unum and Cigna are complaining about the previously-adopted rule, the DOL should reject such complaints. In fact, if they want a more level playing field, they should be jumping for joy that other insurers will now have to abide by this common sense rule.

As the DOL is likely aware, most or all ERISA disability carriers *require* claimants whose LTD benefits are approved to apply for SSDI benefits in nearly every case. They even assist claimants with the SSDI process by, for example, explaining the benefits of an SSDI award and hiring an attorney or advocate to assist them with the process. Then, they reap the benefit of the SSDI award by reducing the claimant's monthly LTD benefit by the amount of the claimant's initial gross SSDI award. Then, however, carriers—including Unum and Cigna, which are supposed to give an SSDI award significant weight due to their RSAs—turn around and terminate benefits without giving any appreciable weight to the Social Security Administration's recognition that the claimant is unable to perform any gainful work at any level in the national economy; a far stricter standard than any LTD plan's "any-occupation" standard I am aware of.

I have had multiple Unum cases in which my claimants have received SSDI awards and Unum concocts threadbare reasons for rejecting that award. The most popular is that Unum's in-house physicians (it's OSPs or "on-site physicians" and DMOs or "designated medical officers," who are eligible for bonuses of up to 25% of their pay (*see Warner v. Unum*, 2014 WL 7497233 (N.D.Ill. 2014)) disagreed with the SSDI award. In cases in which those doctors have been deposed, however, they have been unable to identify any specific reasons to reject the SSDI award. The same is true for Unum's QCCs (quality compliance personnel mandated by the RSA who, according to the testimony of one such person, is supposed to act as a "watchdog" on

behalf of the claimant) The Unum personnel simply reject the award with no reasoning, collect their bonuses, and move on to the next claim.

Cigna actually seems to be worse. I believe Cigna has an internal policy or practice of terminating a claimants LTD benefits almost immediately after he or she receives an SSDI award. In probably 80% of my Cigna LTD cases in which my client is receiving benefits, Cigna has terminated my client's LTD benefits within a few months of their SSDI award being approved. Cigna's process appears to be: 1) LTD claim is approved, often only after the claimant files an appeal protesting an absurd denial; 2) Cigna demands the claimant file for SSDI; 3) the claimant files for SSDI and begins lengthy appeals process; 4) Cigna wrongfully terminates benefits at the own-occupation to any-occupation disability transition, probably hoping the claimant will be one of the 90% who do not appeal that decision; 5) Cigna reinstates LTD benefits following another appeal; 6) the claimant's SSDI claim is finally approved by an ALJ after a hearing; 7) Cigna immediately demands the claimant reimburse the overpayment that occurred due to the receipt of retroactive SSDI benefits; 8) within usually one to five months of being notified of the SSDI award and demanding reimbursement of the overpayment, Cigna terminates the claimant's LTD benefits; 9) in the benefits termination letter, Cigna includes a standard, copy-and-paste paragraph saying it considered the SSDI award but had "more recent" evidence, such as a 1-month post-SSDI-approval review from one of its "medical directors" saying the claimant was not disabled; 10) a review of the claim file shows either the "medical director" never considered the SSDI award or just included the same copy-and-paste language in his or her review as appears in other reviews. This is essentially what happened in a case I recently filed in the District of Arizona, *Smith v. Life Insurance Company of North America*, Case. No. 4:17-cv-00488-RCC, filed October 3, 2017. Another variant of that scenario, again quite common, is that the claimants SSDI claim is approved following the any-occupation termination, that approval is included with the appeal, Cigna demands reimbursement of the overpayment, but Cigna then denies the appeal with the same copy-and-paste-type language dismissing the significant of the claimant's SSDI claim having been recently approved by an ALJ.

Sure, it will take a little more time for insurers to actually consider an SSDI award. And if they do so fairly (which does not appear to be the case, even for carriers subject to an RSA like Unum and Cigna), it might lead to fewer

improper claim denials. But how is that a bad thing? Again, selling an illusory promise can be cheap. But that doesn't afford claimants, many of whom actually pay premiums for their benefits, the protection promised to them by the disability plans they purchased. Moreover, if carriers actually do give more real, and not illusory or copy-and-paste-fraudulent weight to an SSDI award, it could actually reduce costs significantly by reducing the incidence of litigation relating to improperly denied claims; as discussed further below.

Claimants Should Be Entitled To Review And Comment On New Evidence The Insurer Relies Upon For Denying An Appeal And Doing So Should Reduce—Not Increase—Costs:

Again, because only 10% of disability claimants appeal benefits denials or terminations, the actual pool of claims affected by this rule is quite small. Any effort by industry to magnify this alleged issue by discussing the total number of claims they manage should be rejected; and the industry's failure to provide meaningful details regarding the number of claims that are actually appealed and would potentially be affected by this rule should be viewed as a significant omission.

I again ask how promoting fairness is a bad thing? Industry has a long and bad habit of sandbagging claimants with new evidence or rationales on appeal and then refusing to look at evidence contradicting their conclusions.

Beyond that though, and contrary to industry's assertions, rather than increasing costs this rule should ***reduce costs*** to insurers and the public because it should lead to fewer lawsuits. To give one example, I had a client where the insurer denied the STD claim and we: a) appealed that denial and, b) simultaneously filed his claim for LTD benefits. On appeal for the STD claim, the carrier sent my client to an "independent medical examination" with a physician with an unfortunate history. *See e.g. Ritchie v. Krasner*, 221 Ariz. 288, 211 P.3d 1272 (Ct. App. 2009). Based on Dr. Krasner's conclusions, the insurer upheld the denial of the STD claim, which represented a final decision under ERISA. The insurer then used the same IME to deny the application for LTD benefits. We then appealed the LTD denial based on the inadequacy of the IME and the insurer approved those benefits.

We then asked the insurer to reinstate STD benefits because the approval of LTD benefits necessarily meant the claimant was disabled through the plan's "elimination period," which overlapped with the period during which he was eligible for STD benefits. The insurer agreed and reinstated STD benefits based on the same information that had been used to challenge the LTD denial. Thus, by being able to submit additional information responding to new evidence raised during the appeal—the IME—the parties were able to avoid having the case submitted to a judge to decide. This reduced the costs for the insurer, the public, and my client; whose claim was resolved within months and not years. In short, industry's argument that permitting claimants to respond to new information raised during appeal is backwards. The rule should lower costs by enabling claimants to challenge flawed information quickly and more efficiently.

Deemed Exhausted Is Already The Rule And Is Not Costly:

Under the existing rules, and under *Jebian* and *Spinedex* in the Ninth Circuit, a claimant may already file suit if an insurer fails to make a decision within 45 or 90 days of submitting his or her appeal. I understand this is also the rule in several other circuits, including the Second Circuit under *Halo*. Industry's objection to this rule is hollow. This rule would not increase costs. And to the extent there may be a few circuits where this might not be the rule, the previously-adopted rule would promote uniformity, which industry has traditionally argued is a cost-reducing benefit. Again, only about 10% of people whose claims are denied or terminated appeal that decision. I suspect a lot of those are claimants who follow the recommendation of the carrier to submit a letter explaining why they disagree with the decision (I believe this apparently common practice is absolutely evil because industry, knowing ERISA cases are evaluated based on a closed administrative record, fail to disclose that issue and entice claimants to sandbag themselves with inadequate information on appeal). Thus, the number of untimely-decided appeals in circuits where exhaustion is not already the rule will be quite small.

Experts Should Be Impartial:

This provision is a no-brainer. If an insurer repeatedly uses biased medical, vocational, or other experts, it deprives the claimants of the full and fair review to which they are entitled. I cannot conceive of a rational way for industry to challenge this rule. I can understand why they are doing so,

though, because like Unum's paying in-house physicians up to 25% of their annual pay in bonuses or relying on unfair IME or other physicians, having a stable of physicians it can rely upon to terminate ERISA claims would be quite profitable indeed. *See e.g. Merrick v. Paul Revere Life Ins. Co.*, 500 F.3d 1007, 1012 (9th Cir. 2007) (Unum's "practices included pressuring claimants to settle for a fraction of total benefits, insisting upon 'objective medical evidence' of a disability even when the policy did not require such evidence, building a stable of biased Independent Medical Examiners who would support claim denials, and holding regular 'round table' meetings with lawyers, doctors, and claims handlers designed to 'tri-age' the most expensive claims. Merrick introduced a substantial number of internal Unum Provident memos showing the evolution of this scheme during the early 1990s, and Prater testified regarding the tremendous financial gains Unum Provident posted by adopting these 'best practices.'"); *see also Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 867 (9th Cir. 2008) ("This nationwide vote of no confidence seems to have been precipitated by the cupidity of one particular insurer, Unum–Provident Corp., which boosted its profits by repeatedly denying benefits claims it knew to be valid. Unum–Provident's internal memos revealed that the company's senior officers relied on ERISA's deferential standard of review to avoid detection and liability. See John H. Langbein, Trust Law As Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA, 101 Nw. U.L.Rev. 1315, 1317–21 (2007) (describing Unum–Provident's behavior).").

There is no rational basis to challenge a rule requiring fairness under a statute that guarantees claimants a "full and fair" review of their claims. 29 U.S.C. § 1133. Any objections to this rule should be rejected.

The Rule Requiring Disclosure Of Contractual Limitations Periods Should Be Upheld:

I struggle to understand how this rule would increase costs for insurers. Disability carriers typically calendar most important dates early on, including the effective date of the disability claim, the date for the own-occupation to any-occupation transition, the date maximum periods for "mental/nervous" benefits end, and the date the claimant's eligibility for benefits end. When insurers terminate or deny benefits, it will not be difficult for them to calculate and disclose one more date—the date(s) any internal limitations expire. Moreover, the benefits of this rule far outweigh

any alleged costs. Disclosing the limitations date will lead to less uncertainty by claimants and insurers (and their lawyers) and reduce attorneys' and court time and expense challenging and defending the date on which a lawsuit was filed (*Heimeschoff* went all the way to the U.S. Supreme Court on this issue). Uncertainty in administrative or legal cases leads to expense. This rule should reduce costs, not increase them.

Internal Guidelines Should Be Disclosed:

Again, this rule falls into the no-brainer category. Disability claimants should be entitled to know, and challenge, any internal policies or procedures relied upon or related to his or her claim. Otherwise, the claimant will not receive the full and fair claim review ERISA guarantees.

To give one example, Cigna frequently relies on "Reed Group Disability Guidelines" to support a claim decision. Cigna, however, always refuses to disclose these guidelines. In one case, Cigna twice denied benefits for a client of mine who had suffered a ruptured subarachnoid hemorrhage (and miraculously survived—the hospital had read her last rights and told her family to say their goodbyes). One of my client's symptoms from the hemorrhage was severe, unrelenting headaches; in addition to severe cognitive dysfunction and other problems. After paying my client for two years for her "own occupation" benefits (after initially denying her claim, of course), Cigna denied her claim for "any occupation" benefits citing the Reed Group Guideline for "headache" which had a maximum disability period of either 3 or 7 days. I fought with Cigna for months to try to get these guidelines, and other potentially relevant guidelines, to determine whether Cigna had ignored or mischaracterized them. Finally, without providing the actual guidelines, Cigna informed me in a letter that there was another Reed Group guideline for stroke with a maximum possible benefit period of "lifetime." Cigna, of course, had ignored this guideline when terminating my client's benefits and instead relied on the obviously-inapplicable guideline for "headache." (My client, unfortunately, died not long after her claim was denied and I believe Cigna's decision was a large, contributing factor to her death).

I have had other cases with Cigna in which they have applied Reed Group Guidelines that, like that case, were obviously inaccurate and woodenly applied. Cigna, however, refuses to provide any information regarding the guidelines or its use of the guidelines. This is obviously abusive, a violation

of Cigna's fiduciary obligations under ERISA, and denies disability claimants the full and fair review to which they are entitled.

To give another example, in a bad faith case with another insurer we obtained the insurer's complete claims manual. Because the claims manual is subject to a protective order, I cannot specifically say what was in it. Generally speaking, however, I believe much of the information and procedures documented in that claims manual is relevant to almost all the ERISA cases I have had with that insurer. I also believe that same information would undermine a large portion of the decisions by that insurer to deny or terminate benefits. Thus, requiring the disclosure of that information would lead to more fair claim adjudications and would therefore likely reduce costs by reducing litigation related to improperly denied or terminated benefits.

Insurers should be required to disclose any internal policies and procedures they rely upon—including claims manuals and "external" guidelines like the Reed Group Guidelines—to enable ERISA claimants to challenge an improper benefits denial or termination. Disclosing such information will enable the claimant to investigate and challenge whether the insurer's decision is substantively or procedurally flawed because, for example, it ignored or violated other policies or guidelines that support the claim. That is only fair, and doing so should not increase insurer costs at all. In fact, I suspect it would reduce costs for them to do so—Unum voluntarily produces its claims manual upon request and therefore does not have to spend time and money challenging that issue in court. They simply burn it to a CD and send it out, which probably costs them a total of $0.25 when they include it with other correspondence.

The Benefits Of The Previously-Adopted Rules Far Outweigh Any Alleged Costs:

ERISA claims have been rife with abuse for decades. When I did defense work, the easiest cases to defend were those brought by an attorney (or a pro se litigant) in which the claimant had done his or her own appeal. Given the severe evidentiary and proof hurdles they faced—such as a closed administrative record, abuse of discretion review, and limited discovery—defending such claims was a piece of cake and the insurers were largely insulated from a meaningful challenge.

The previously-adopted rules fully complied with the APA. They considered the benefits of those changes, as well as the costs (which, at best, are illusory and speculative as discussed above). The previously-adopted rules will help level the ERISA playing field even if it is only a slight leveling.

I oppose any delay or modification of the previously-adopted rules. The DOL should reject industry's untimely, improper requests to do so.

If you have any questions or would like to discuss this issue further, please feel free to contact me.

Sincerely,

Law Office of Patrick Mause, PLLC
290 North Meyer Avenue
Tucson, AZ 85701
520-342-0000 (phone)
520-342-0001 (fax)
www.PMauseLaw.com