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December 11, 2017

Office of Regulations and Interpretations,
Employee Benefits Security Administration
U.S. Dept. of Labor
200 Constitution Avenue NW, Room M-5655
Washington D.C. 20210

Re: Re-Examination of Claims Procedure Regulations
for Plans Providing Disability Benefits
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503

Dear Deputy Assistant Secretary Hauser:

I am writing to discourage the Department from modifying or further delaying the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) that are now scheduled to go into effect on April 1, 2018.

For 22 years I have represented claimants in ERISA long term disability (LTD) benefit claims, both in the claims appeal process and in litigation. I testified before the Department of Labor in Washington, D.C., when it was considering adoption of proposed ERISA claim rules in Y2K. On behalf of my clients since then, we thank you and have appreciated the procedural protections you made possible. You now have another such opportunity to assist disabled workers in obtaining reasonable and fair procedural protections in pursuing claims.

(1) Assuming that the final regulations have some impact on cost, the costs will not outweigh the benefits. The Department has already articulated its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The Department should ignore the industry's invitation to abandon these purposes. Moreover, these benefits cannot be outweighed by costs where ERISA claimants are at such a procedural disadvantage. ERISA disability claimants who are denied their benefits face a process that is far below the standard for regular civil disputes. These procedural hurdles include: (1) there are no jury trials; (2) there is a closed record from the claims process that can rarely be supplemented in litigation; (3) courts often apply an unfavorable standard of

judicial review, that is, it's not a preponderance of the evidence wins, but the claimant can't win unless proving that the adverse determination was an abuse of discretion; and finally (4) there are no remedies to discourage self-serving behavior on the part of plans (most of which are insurance companies). Even with the final rules in place, plan participants will not have achieved the "higher-than-marketplace standards" that the Supreme Court insists are required of plan administrators who are supposed to serve as fiduciaries in processing ERISA claims. *MetLife v. Glenn*, 554 U.S. 105, 115 (2008). Thus it cannot be the case that any increase in costs justifies denying ERISA claimants the limited protections that the final rules provide.

It is only at the point of becoming disabled that most LTD claimants discover the procedural hurdles that are unique to ERISA claims. Attorneys often have to turn down representation of ERISA disability cases that are otherwise meritorious because, *e.g.,* the record is closed or the claimant had not understood that a contractual limitations period had passed. To the extent that increased protections bring disability claims administration in line with the reasonable expectations of the employee-participants, the costs are outweighed by the benefits. This is what is meant by higher-than-marketplace standards.

(2) A claimant is entitled to a well-articulated explanation for the adverse benefits decision, so that the participant may fairly dispute it. The 2000 regulations require no less. As the Department has already noted, it is doubtful that there are costs associated with the requirement of discussing the reasons for disagreeing with a favorable Social Security Disability (SSD) decision. ERISA disability benefits have always been intertwined with SSD and typically supplement SSD benefits. For many employees a Social Security award will offset their entire ERISA benefit or reduce it to a mere $100 per month (a typical "minimum benefit"). Most LTD insurance plans require claimants to apply for SSD so they can limit their liability under offset provisions of the plan. In order to decide which claimants qualify for this representation, disability insurance claims handlers need to know the standard that the SSA uses. Comment #114, p.8 (ACLI). As such, their claims manuals tend to include pages of instructions related to SSD and its standards. Both the UNUM and CIGNA Regulatory Settlement Agreements required the insurers to give greater weight to the Social Security awards. Thus, insurers are no strangers to the SSA process or its standards. Additionally, courts in many jurisdictions require an explanation of a favorable Social Security award. *Montour v. Hartford Life & Acc.Ins Co.*, 588 F.3d 623, 635-637 (9th Cir. 2009); *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011); *Bennett v. Kemper Nat. Services* Inc., 514 F.3d 547, 553-554 (6th Cir. 2008); *Brown v. Hartford Life Ins. C*o., 301 F. App'x 777, 776 (10th Cir. 2008). As a matter of Supreme Court precedent, it is arbitrary and capricious for the claims administrator to advocate for Social Security benefits, reap the benefit of the Social Security award by means of an offset, and then ignore the SSA's determination. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008). Requiring an explanation of the reasons for disagreeing with the SSD decision and other contrary evidence tracks the existing procedural standard. Logically, it should not increase costs to simply codify it.

(3) The industry's concern about the "deemed denial" rule seems to be that plaintiffs and their attorneys will race into court, increasing the volume of ERISA litigation and hence the overall costs of administering disability claims. This is incorrect. Plaintiff's attorneys are ever mindful of building a record on which the court will make its decision and therefore would rather engage in the appeal process and exhaust internal remedies. This rule serves the dual purpose of possibly resolving the dispute or otherwise creating a record for the court to review in case the claims dispute cannot be resolved.

Additionally, as with most of the other final rules, this rule is mostly a codification of existing judge-made law. Claimants are already able to get into court when the claims process has failed them in a meaningful way. *See e.g. Brown v. J.B. Hunt Transp. Servs.*, 586 F.3d 1079, 1085-86 (8th Cir. 2009) (failure to respond to request for documents excused claims from exhaustion requirement because there was no full and fair review). It is not likely that additional costs will result from this regulation. *Hall v. National Gypsum Co.*, 105 F.3d 225, 231-32 (5th Cir. 1997); *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010); *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98 (2d Cir. 2005); *Jebian v. Hewlett-Packard Co. Employee. Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003); *Dunnigan v. Metropolitan Life Ins. Co.*, 277 F.3d 223, 231 n.5 (2d Cir. 2002).

(4) Providing the right to review and respond to new evidence or rationale from the plan during the appeal review is not costly. This rule is fundamental to full and fair review. The Department has already acknowledged the importance of this rule and that it is already the standard in some jurisdictions. The industry complains that providing the claimant with new evidence or rationales before making a final decision is costly. The industry's claim to cost impact is suspect for several reasons. First, several disability plans or insurers already provide for the right to review and respond. They do so on a voluntary basis, as their comments to the proposed rules admit. Second, courts require plans or insurers to do this in many cases. Lastly, whether they provide this information to the claimant during the ERISA appeal process, they will have to provide it eventually in one form or another. New reasons or evidence will need to be included in the claim file and likely again in 26(a)(1) disclosures. Thus, the industry's portrayal of the chaos that might ensue if they were required to locate and supply these documents is not credible. If the issue is the cost of mailing, such a concern should not be permitted to interfere with such a basic procedural due process right.

It is important to note what this rule does. It permits a claimant to respond to a disability claims administrator's assertions in a way that will make the response a part of the record, if the claimant has to go to court to vindicate his or her rights. This is because most ERISA cases are decided on a closed record. Without this rule, the claims administrator's new evidence or rationale will be included in the record that the court reviews, but the claimant's rebuttal will not. Perhaps what the industry is really chafing about is the loss of its ability to strategically withhold

information that would help the claimant achieve reversal or win the case in court.

I strongly disagree with industry comments to the effect that a second appeal, which is offered with some plans, serves the same purpose as the right to respond to new evidence or rationales before a final decision. This is absurd, as a second appeal permits the claims administrators the same "sandbagging" opportunity as the first appeal – the claimant is robbed of an opportunity to comment on the plan's new evidence, while the plan obtains a trump card to reinforce its prior denial – where is the fundamental fairness? Allowing claimants to respond to new evidence produced by the plan still gives the plan the final say in its final claims decision.

(5) The credibility of medical experts who are opining on whether a claimant qualifies for benefits should be subject to *some* sort of scrutiny. If a claimant wants to conduct discovery into whether a physician hired by the plan administrator, or its corporate vendor (*e.g.,* "Defense Medical Examiners"), is well known to support denials, the cost of conducting this discovery cannot possibly outweigh the benefits because ERISA claimants are entitled to a process that does not have a predetermined outcome based on which reviewing physician is hired by the plan.

(6) As with most of the final rules, information respecting the period of limitations is required to be disclosed in several jurisdictions, so it is unlikely to incur additional costs to create uniformity. *Santana-Diaz v. Metro. Life Ins. Co.*, 816 F.3d 172, 179 (1st Cir. 2016); *Moyer v. Metro. Life Ins. Co*., 762 F. 3 503, 505 (6th Cir. 2014); *Mirza v. Ins. Adm'r of America, Inc*., 800 F. 3d 129, 134 (3d Cir. 2015). For the plan administrator, it'll be a stock paragraph with some blanks to fill in the dates. For the participant, it is notice of a deadline on claiming benefits that might otherwise, without that vital information, relinquish benefits lost to the participant's ignorance. It helps to remember that plans are often written in language that may be confusing to participants. For example, rather than just saying the deadline for commencing litigation is three years from the date of disability, the plans might say it's three years from when proof of loss is due. Then you look under proof of loss and it may say that's 90 days from the period for which we are liable for payment. Then you have to look at when they're liable for payment, etc., etc. Please, make them put the date in the notice.

Yours,

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