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VIA ELECTRONIC SUBMISSION TO www.regulations.gov

Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Attention: Claims Procedure for Plans Providing Disability Benefits Examination

Re: Claims Procedure for Plans Providing Disability Benefits; 90 Day Delay of Applicability Date (RIN 1210-AB39)

To Whom It May Concern:

Thank you for the opportunity to submit comments on the Claims Procedure for Plans Providing Disability Benefits Examination.

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as Cigna), is a global health services organization dedicated to helping people improve their health, well-being and sense of security. Our subsidiaries are major providers of medical, dental, disability, life and accident insurance, and related products and services. Worldwide, we offer peace of mind and a sense of security to our customers seeking protection for themselves and their families at critical points in their lives.

Cigna appreciates the work of the Department of Labor (Department) stemming from Executive Order 13777 entitled Enforcing the Regulatory Reform Agenda, and reconsidering the recent regulations impacting individuals who might become disabled. Cigna thanks the Department for its decision to delay the applicability of the December 19, 2016 Final Rule for 90 days, and to carefully consider additional comments and data while examining alternatives to minimize unnecessary costs and adverse consequences. As we indicated in our prior comment letter, the Department's actions are an important recognition of the far-reaching impact the Final Rule will have on the affordability and availability of disability coverage, the burdens upon the federal courts, and the time and resources required to conclude the administrative process and resolve claims for benefits.

In response to the Department's request for data and information demonstrating those impacts, we join in support of the data submitted by the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP). We believe AHIP and ACLI provide the Department the

reasonably convincing factual evidence it seeks to appropriately revise the Final Rule. We set out below both our support for and concerns with the Final Rule. We understand the Department's focus is on costs, benefits, and impacts, so we placed our emphasis accordingly. We outline first our support for those portions of the Final Rule we deem economical consumer protections and conclude with those parts of the Final Rule we deem unduly expensive and objectionable.

I. Provisions Cigna Supports

Coverage Rescissions

We support the adoption of this consumer-oriented provision without change.

Conflicts of Interest

We support the adoption of this consumer-oriented provision without change.

Our support is based on our agreement with the Department's commentary in the Preamble adopting the Final Rule which clarified that the conflict of interest "requirements in the rule do not modify the scope of 'relevant documents' subject to the disclosure requirements in paragraphs (g)(1)(vii)(C) and (h)(2)(iii) of the section 503 Regulation, as amended by this rule."

II. Provisions Cigna Supports with Clarification and/or Modification

Communication Requirements in Non-English Languages

We support the adoption of these consumer-oriented requirements to provide a statement informing certain claimants of the availability of oral language services and, upon request, their claim "notice" in a culturally and linguistically appropriate manner.

Contractual Limitations Disclosure

We support the adoption of this consumer-oriented provision, with one modification.

Requested Modification: The Final Rule requires plans determine and disclose "the calendar date on which the contractual limitations period expires for the claim." Because the Final Rule is asking a plan to determine a legal question, the answer to which a court may or may not agree with, we suggest the Department recognize that and revise the rule to require the plan to determine the "calendar date on which the contractual limitations period **for the claim is expected to expire**" (emphasis added).

Enhanced Disclosure Requirements and Claim File and Internal Protocols

We support these consumer-oriented standards and requirements in the Final Rule, with one modification.

Requested Modification: The Final Rule requires plans to disclose certain information "relied upon" by the plan in making an adverse benefit determination "or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist." The requirement for a negative response if no such information is required to be disclosed is illogical. The Final Rule only requires plans to affirmatively disclose the information if it is, in fact, relied upon in making an adverse benefit determination. For example, it will be possible for a guideline to "exist" at the plan but not be disclosed because it was not actually used and "relied upon" in making any given claim determination. A rule that forces a binary choice between disclosure and representing that such a guideline does not exist would put such a plan in an impossible position; a position where it cannot provide a fully accurate response. And because plans have to "strictly adhere" to the Final Rule, they are at risk for costly court intervention for a rule violation they could not avoid. We, therefore, request the Department eliminate the language that says "Either ... or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist."

III. Provisions of Concern to Cigna

Before we set out our concerns, we emphasize that much of the Final Rule's actual burden and impact to which we object is directly proportional to the frequency of use of the behaviors encouraged by the Final Rule. Therefore, we ask the Department to consider the expected impacts contained in the AHIP and ACLI submissions in light of the expected behavior the commenters who support immediate unchanged implementation of the Final Rule are likely to exhibit. The large majority of those commenters are plaintiff disability lawyers. Recognizing the comments of that constituency, the Department concluded those commenters "firmly believe[s] that disability claimants are *in need* of the *increased procedural* protections provided by the Final Rule"[1] (emphasis added). If that is so, then we believe it reasonable for the Department to take them at their word and assume claimants and their representatives will routinely and frequently utilize the procedural aspects of the Final Rule they believe they need. Those very costly procedures include the deemed exhaustion/strict adherence mechanism that encourages new, premature, and more numerous federal court interventions, and the "review and respond" procedure that adds unnecessary, additional layers of procedure and cost without commensurate material consumer benefit while endangering full and fair adjudication. We believe these two parts of the Final Rule cause virtually all of the objectionable, additional, and unproductive costs identified in the ACLI data.[2]

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[1] 82 FR 56562 (Nov. 29, 2017)

[2] ACLI Comment Letter, regarding "Claims Procedure for Plans Providing Disability Benefits", dated December 11, 2017.

New Deemed Exhaustion Mechanisms **Will** Unnecessarily Increase Plan Costs and Expenses, Produce Underdeveloped Administrative Records, and Increased Burdens Upon the Federal Court Dockets and **Will Not** Improve Plan Decision-Making Quality or Accuracy, nor Accelerate Benefit Delivery of Payable Claims.

This section of the Final Rule is a short-cut to expensive litigation at the claimant's/plaintiff's lawyer's sole option. Claimants, and more specifically their lawyers, who believe these procedural elements of the Final Rule are necessary, should be expected to use them. We urge the Department to recognize use increases costs as supported by data provided by the industry. Unfortunately, these procedural mechanisms will not provide consumer benefits that outweigh the costs and burdens.

This portion of the Final Rule provides, in part, the following:

1) A requirement to "strictly adhere" to "all" requirements of the Final Rule (strict adherence);
2) Deemed exhaustion with the right to proceed to court (deemed exhaustion);
3) A claimant may allege "any" violation of the Final Rule and require the plan provide a written explanation within 10 days that the alleged violation is *de minimis* and should not trigger deemed exhaustion (10 day letter);
4) When courts reject a claimant request for immediate deemed exhaustion review, a requirement that the claim be "refiled" with the plan "on appeal" (refiling on appeal).

The strict adherence standard permits claimants and their lawyers, at their option, to inappropriately circumvent the administrative process and waste judicial resources. A violation allegation of any kind can trigger expensive court proceedings at any time for minor violations, no matter how small, immaterial or inconsequential the alleged violation's impact is on quality of the claim process or benefit decision-making, if any at all. And, even if the court ultimately rejects the claimant's complaint, the time, effort, and costs to respond to a federal complaint will be substantial, all while the claimant endures delayed decision-making on the merits of their claim. The anticipated delay to claimants is likely substantial. According to the recent Federal Court Management Statistics, as of March 2017, the median time from court filing to disposition for a civil matter is 9.9 months, and, the amount of federal judicial vacancies has increased from 641.7 "vacant judgeship months" in 2016 to 1,032.3 vacant judgeship months in 2017.[3]

The strict adherence standard inappropriately and inefficiently captures minor, inconsequential plan errors. The Final Rule requires claim adjudicators to "strictly adhere" to "all" the provisions of the Final Rule. However, for many, many years a number of federal circuits have employed the "substantial compliance" standard.[4] And, in fact, the Department itself rejected strict adherence

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[3] *Federal Court Management Statistics, June 2017* available at http://www.uscourts.gov/sites/default/files/data_tables/fcms_na_distprofile0331.2017.pdf (as visited December 8, 2017).

[4] *Lafleur v. La. Health Serv. & Indemnity Co.*, 563 F.3d 148 (5th Cir. 2009)(explaining that substantial compliance with ERISA claim regulations requires a "meaningful review" by the plan and a "meaningful dialogue" with ERISA plan

when it last considered changes to the disability claim regulations in 2000.[5] Substantial compliance wisely allows the much less expensive and more efficient[6] administrative claim process to continue to resolve disputed claims containing only minor regulatory errors. Substantial compliance also reserves judicial authority to revoke plan deference, but typically only in cases where the violation(s) impact the decision or process in some substantial, prejudicial, and/or material way. Because the substantial compliance standard more effectively addresses only material and consequential plan errors and strikes a fair balance in conjunction with the other changes made by the Final Rule, the strict adherence standard should be rejected.

While absolute procedural adherence to the Final Rule may be a laudable policy goal, the practical effect of this Final Rule is to encourage inappropriate incentives to waste plan resources. Claimants may use the Final Rule to allege against the plan any regulatory failure whatsoever, no matter how small or inconsequential to the claim decision quality or process. Allegations may be made at *any time* during a claim (e.g., during the initial and appellate levels) and *without limit* as to the number and type of allegations made. *Each time* an allegation is received, the Final Rule *requires* the plan to field, review, investigate, and write a response in the form of a 10 day letter; a letter which, once received by the claimant or claimant's lawyer, requires no further action by the claimant. The plan nevertheless has expense associated with that activity. That expense is real, whatever the amount, and the Final Rule provides absolutely no disincentive for abuse. We fail to see how the benefits of unfettered use of a strict adherence violation tactic, coupled with the 10 day letter requirement, outweigh its costs. In contrast, the "substantial compliance" standard has served all ERISA constituencies well by balancing the competing interests of encouraging completion of the less expensive and efficient administrative process and preserving an incentive for plans to strive to comply with the claim regulations, while minimizing plan and claimant costs and litigation.

Furthermore, if claimants take advantage of these new strict adherence and deemed exhaustion mechanisms and file early in federal court, judicial resources will be further strained or wasted. Overuse will clog the federal dockets. Claims cut short from the administrative process will result in less developed and incomplete administrative records to the courts. This leaves federal courts to either become substitute claim examiners who must further develop the record through the very expensive and typically slow discovery and litigation process, or, simply remand the matter back to the claim administrator. In either case, the costs to resolve the claim increase. If the claim

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beneficiaries); *Lacy v. Fulbright & Jaworski, LLP Long Term Disability Plan*, 405 F.3rd 254 (5th Cir. 2005)(adopting substantial compliance and recognizing its use by a variety of federal courts); *Moore v. LaFayette Life Ins. Co.*, 458 F.3rd 416 (6th Cir. 2006); *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3rd 621 (7th Cir. 2005)(finding a failure to substantially comply with the claim regulations and ordering retroactive reinstatement of benefits); *Perry v. Metro. Life Ins. Co.*, 2016 Lexis 116610 (M. D. GA Aug. 30, 2016)(applying substantial compliance to ERISA claim deadlines).

[5] Benefit Claims Procedure Regulation FAQs, Q/A-F2, available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation (as visited on December 5, 2017).

[6] Based on U.S. Department of Labor studies and data and public court filing statistics, 99.3% of all long-term disability claims are *resolved* through the current ERISA administrative process. America's Health Insurance Plans, Public Comment Letter regarding "Claims Procedure Amendment for Plans Providing Disability Benefits", dated January 19, 2017.

is kept by the court, additional costs are likely significant. If remanded, then the claimant is back before the same claim adjudicator, but only after incurring the costs required to go to court and back. In either case, we see no evidence that the result to claimants, self-funded plan sponsors, and/or insurers will be any different than if the claimant went through the administrative process as it is currently configured.

Finally, should the Department retain this section of the rule, we ask the Department to eliminate the requirement of refiling on appeal and, instead, allow the claim to be refiled as an initial claim (not on appeal).

Review and Respond

In addition, the Rule's new requirement mandating a claimants' right to review and respond to new information on appeal before a decision is made is flawed and should be eliminated, revised, or replaced. The Final Rule, at section (h)(4)(i) and (ii), requires:

1) Before the plan can make an adverse benefit determination on appeal, it must provide the claimant with "any new or additional evidence" it "considered, relied upon, or generated", in connection with the determination, "as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided" so that the claimant has a "reasonable opportunity" to respond "prior to" the date the decision is required to be provided; and

2) Before the plan can make an adverse benefit determination on appeal "based on a new or additional rationale", it must provide "the rationale" to the claimant "as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided" so that the claimant has a "reasonable opportunity" to respond "prior to" the date the decision is required to be provided.

The requirement should be eliminated because it adds administrative costs while creating a process that may negatively impact the quality of benefit decisions made. Under current regulations, before a final determination is made, claimants already have the right to submit, and adjudicators are required to consider, whatever comments, arguments, and information they desire during both the initial claim stage and the required mandatory appeal. Furthermore, the Final Rule fails to adequately address situations the Department acknowledged in the Preamble to the Final Rule may occur; the endless loop of back and forth. *See*, 80 Fed. Reg. 72017. Without an explicit tolling mechanism, plans may simply run out of time even though they are continuously engaged in good faith in the exchange of information. In that event, the plan will be rushed to decision (and be forced to do so without securing the additional, necessary expert opinion) simply because it has to meet the impending decision deadline required by the Final Rule. This is not merely theoretical given the plan is to be held to strictly adhere with the Final Rule requirements, including time deadlines. More troubling still is the regulation simultaneously requires that plans "shall consult with a health care professional who has the appropriate training and experience in

the field of medicine involved in the medical judgment" before making its final appeal determination. Therefore, in some situations, plans will be forced to choose between violating the regulations by missing the time deadline or by forgoing medical opinions they are required to obtain. We fail to see how this promotes full and fair treatment and/or better decision quality.

If this portion of the Final Rule is not eliminated, then, at a minimum, the Department should consider revising the Final Rule in at least three ways. First, there should be an explicit "tolling" mechanism stopping decision-making timeframes from running from the date the new or additional information or rationale is provided and the date the claimant responds. Second, even if the rule provides for tolling, the residual time left upon the plan's receipt of a claimant response may still be inadequate for appropriate decision-making. The Final Rule should therefore include an explicit, but reasonable, period of time within which the plan must make its decision (for example, 30 days). Third, the Department should consider adding a timeframe within which claimants are required to "respond" (for example, 30 days). And, further, if claimants fail to timely respond, this communication loop should be considered closed, freeing the plan to decide the claim within the remaining timeframe.

Alternatively, the Department could consider a different approach. A familiar and economical approach would be to add a requirement that plans offer a voluntary appeal at the option of the claimant and, further, that the voluntary appeal must consider whatever information and arguments the claimant seeks to submit. Therefore, a claimant who believes the adjudicator has changed rationales or introduced new information during the *mandatory* appeal that they wish to address, would now have two options to address those concerns (court or further appeal) instead of one (court). If claimants are ready for court, they may pursue redress in that forum because mandatory appeals have been exhausted, but if they desire to address those concerns further in the administrative process they may demand the voluntary appeal. Another alternative could be adoption of a rule which requires plans that do not offer voluntary appeals to remain subject to sections (h)(4)(i) and (ii), while those plans who do offer a voluntary appeal are exempted from those requirements.

This optional appeal should be expected to resolve a material amount of claims. Further, voluntary appeals come with certain claimant protections such as, that plans waive the right to claim voluntary appeals are required for exhaustion, the statute of limitations is tolled during voluntary appeals, no fees or costs to appeal are allowed, and the right to receive claim information such that the claimant can make an informed decision about whether to submit to a voluntary appeal.[7]

This alternative would also address an additional concern with the Final Rule as currently written, which is, the very real risk that plans will eliminate offering voluntary appeals to claimants in response to the rising administrative costs imposed by the Final Rule as currently written. Leaving the Final Rule unchanged puts at risk additional appeal mechanisms which, according to

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[7] 2560.503-1(d) and 1(c)(3).

the data submitted by the ACLI, are currently used by approximately 42% of STD plans and 51% of LTD plans.[8]

Thank you for considering these comments and for your efforts to strengthen the disability income insurance market through enhanced consumer protections and reasonable modifications to allow more individuals to enjoy the peace of mind afforded by this important coverage.

Respectfully,

David Schwartz

[8] ACLI Comment Letter, regarding "Claims Procedure for Plans Providing Disability Benefits", dated December 11, 2017.