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By E-Mail (e-ORI@dol.gov) & U.S. Mail

Office of Regulations and Interpretations
Employee Benefits Security Administration, Room N-5655
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

Attention: Claims Procedure Regulation for Plans Providing Disability Benefits
RIN 1210-AB39

Dear Sir or Madam:

The NFL Player Disability & Neurocognitive Benefit Plan ("NFL Player Disability Plan") greatly appreciates this opportunity to provide further comments on the Final Rule amending disability claims procedures (81 Fed. Reg. 92316 (Dec. 16, 2016), the "Regulation") under ERISA. We attach a copy of our prior letter, dated January 19, 2016. In that letter we described why the Department's economic benefit analysis was inadequate, why the Regulation would greatly increase the cost and complexity of administering disability benefits, and why the Regulation would cause wasteful and expensive litigation.

In this letter we focus on collectively-bargained multiemployer plans, like the NFL Player Disability Plan, and estimate the added costs. Nowhere are the costs and burdens created by the Regulation more apparent than for multiemployer plans. According to ALM's American Directory of Group Insurance, 1,062 multiemployer plans provide disability benefits, and those plans have a total of 3,661,426 participants.[1] As described below, we estimate the Regulation could easily add **$45 million or more** in annual administration and legal costs for multiemployer plans. That is $450 million over 10 years. Many, if not most, of these plans are defined benefit plans, and, because added costs reduce plan funding, a portion of this burden would ultimately be placed on the PBGC.

Multiemployer plans often contain rules for disability appropriate for that industry, whether it be construction, manufacturing, trucking, or professional football. With 1,000 multiemployer claims processing centers working with different rules, economies of scale generally do not exist. Multiemployer disability claims processing is significantly more expensive, per claim received, than claims processing by insurance companies.

[1] Data retrieved from ALM's American Directory of Group Insurance on November 29, 2017.

I. The Disclosure and Rebuttal Rule is Unworkable, and Could Easily Add About $5 Million in Annual Administrative Costs.

In paragraph (h)(4), the Regulation proposes to require *all* disability plans to provide claimants with any new evidence or rationale considered prior to issuing an adverse decision on review. According to the Regulation, *all* plans must produce this new evidence or rationale to claimants "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… to give the claimant a reasonable opportunity to respond prior to that date."

This disclosure and rebuttal process is unworkable for multiemployer plans. The NFL Player Disability Plan's administrator—like the administrators of many collectively-bargained, multiemployer plans—is a board of trustees that meets on a quarterly basis. Because the board meets quarterly, and its decisions are due five days following each quarterly meeting, it will be **impossible** for the administrator of the NFL Player Disability Plan to ascertain the existence of any new evidence or rationale; assess its (adverse) impact on a claimant's appeal; and then provide the evidence or rationale and an explanation of the adverse impact to the claimant at any point prior to the applicable decision deadline, much less "sufficiently in advance" of the deadline "to give the claimant a reasonable opportunity to respond prior to that date." With its broad, one-size-fits-all approach lifted from the ACA, the Regulation does not take into account how multiemployer plans are administered.[2]

The most recent Gen Re Disability Fact Book (7th Ed. 2013-2014) indicates that 0.53% of covered participants file long term disability claims each year. Multiemployer plans frequently cover workers who perform physical labor, and the percentage of claims in those industries is higher. Even at 0.53%, when multiplied by the over 3.6 million participants covered by multiemployer disability plans, that's more than 19,000 new claims filed each year. We estimate the additional administrative burden of *attempting* to comply with the disclosure and rebuttal process at $250 per claim filed, partly because of the vagueness of determining what is new evidence or a new rationale, partly because of the delays and confusion in *attempting* to comply with the rule where the deciding fiduciary meets quarterly, and partly because 1,000 separate

[2] Prior comments received by the Department described how a plan might "have to send claimants new or additional evidence before the plan may have determined whether and how the evidence may contribute to an adverse appeal decision, claimants would receive new or additional evidence piecemeal as the appeals process continues[,] and claimants could be required to provide comments back without necessarily knowing how that information may, if at all, affect the decision." 81 Fed. Reg. at 92326. The Department flatly rejected this notion, explaining that a plan's obligation to provide new or additional evidence or rationales arises only "when the plan has decided that it is going to deny the claim on appeal." *Id.* This response shows the Department did not contemplate the Regulations' impact on multiemployer plans, because any multiemployer plan trying to comply with the Regulation would be forced to do precisely what the Department says the Regulation does not require: provide additional evidence to claimants before a board meeting occurred, and without knowing whether and how it would ultimately affect a decision.

claims processing units will have to adjust to the new rules. In many cases legal advice will be required.

We therefore estimate the total added administrative costs at $5 million each year. This does not take into account start-up costs. Again, it also does not take into account that multiemployer plans often cover workers who perform manual labor, and that such workers apply for disability at a higher rate. Unfortunately, we do not have data to quantify this disproportionate claim rate.

II. Added Litigation Costs Could Easily Add $40 Million a Year.

The above $5 million estimate is only the tip of the iceberg. Not only is the disclosure and rebuttal rule unworkable, but, combined with the proposed "strict compliance" standard, it will lead to and exacerbate litigation expenses. If a plan "fails to strictly adhere" to the disclosure and rebuttal rule and many other provisions, paragraph (l) of the Regulation states that "the claimant [will be] deemed to have exhausted the administrative remedies available under the plan," and he or she will be "entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." The Regulation also provides that, "[i]f a claimant chooses to pursue remedies under section 502(a) of the Act under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary." The Department has acknowledged that the "legal effect" of this provision "may be that a court would conclude that de novo review is appropriate" in any action brought under section 502(a)(1)(B) of the Act. 81 Fed. Reg. at 92328.

In plain English, this means multiemployer plans will be forced to litigate the appropriate standard of judicial review in many cases. Where they lose, the court will review the claim de novo, which generally means a full-blown trial with discovery, depositions, and witnesses. The added legal costs will be enormous.

It is reasonable to assume that litigation over alleged regulatory violations, and the appropriate standard of judicial review, would consume 100 hours of attorney time. At an average hourly rate of $400 per hour (a relatively low rate), multiemployer plans can be expected to expend $40,000 in attorneys' fees every time a claimant chooses to litigate the standard of review. If 1,000 multiemployer disability plans face just *one* such legal issue *every other year*, $20,000,000 in plan funds would be spent on legal fees—not benefits. Of course, this estimate says nothing about the disruption that such litigation would have on the day-to-day administration of a plan and the attendant costs of that disruption. It also does not speak to the added burdens that this ancillary litigation would impose on an already overburdened court system.

Obviously, if a plan loses on the standard of review, that plan will likely have to endure a full-blown trial, with discovery, depositions, and witnesses. Trials are *very* expensive. We estimate an equal amount – another $20 million a year – in the added legal costs of full-blown trials over disability claims. Plans will win some of the motions on standard of review and regulatory compliance but, where they lose, the legal costs of a full-blown trial will be greater than the legal costs of arguing over the standard of review.

These costs were not intended by Congress. The Supreme Court has recognized the balance contemplated by ERISA, *i.e.*, "Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

For years, litigants and commentators alike have lamented the increasing burdens and costs of litigation-related discovery.[3] Under existing precedent, discovery in ERISA disability benefits litigation is typically very limited. That will no longer be the case, however, because the Regulation invites wide-ranging discovery about the cause of alleged regulatory violations, the effect of those violations, and whether the violations are "part of a pattern or practice" by the plan. Written discovery, document productions, depositions, and mini-trials over the nature and extent of a plan's alleged regulatory violations will soon become the norm in benefits cases. Whether claimants pursue these allegations prior to a final benefits decision or after (the Regulation permits either scenario), they will surely pursue them.[4] Plans will have to defend against the allegations, and courts will be forced to resolve them, before ever reaching the merits of any given benefits decision.

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[3] *See, e.g.*, Lawyers for Civil Justice, *Litigation Cost Survey of Major Companies* (2010) at 2 ("The survey confirms empirically what corporate counsel have long known anecdotally – the transaction costs of litigation against large companies, especially discovery, are so high that the mandate of Rule 1 ('the just, speedy, and inexpensive determination of every action and proceeding') is simply not being met.") (*available at* http://www.uscourts.gov/sites/default/files/litigation_cost_survey_of_major_companies_0.pdf); *id.* at 4 ("Litigation transaction costs, independent of judgments awarded in disputes or settlements reached between parties, constitute a significant economic cost of doing business in the United States.... There is no doubt that a significant driver of the higher U.S. costs is the procedural and discovery costs associated with our justice system."); ABA, *ABA Section of Litigation Member Survey on Civil Practice: Full Report* (Dec. 11, 2009) at 2 ("Discovery is the reason most often picked by [survey] respondents as the primary cause of delay [in civil litigation]. 48% picked that reason, while the next most popular reason (delayed rulings on motions) garnered only 25%.") (*available at* https://www.americanbar.org/content/dam/aba/migrated/litigation/survey/docs/report_aba_report.authcheckdam.pdf); *id.* ("82% agree that discovery is too expensive, but within that group only 61% of plaintiffs' lawyers think it so.").

[4] The Department has said that it "does not believe that the typical participant pursuing a disability benefit claim in the context of a fair and timely review process will... seek remedies in court in the case of insignificant missteps in claims management processes that have no impact on the ultimate decision on the claim." 81 Fed. Reg. at 92328. However, a claimant has every reason to try to capitalize on procedural missteps because, if successful, it would lead to de novo review of the participant's claim for benefits, a key objective of any claimant in disability litigation today. If unsuccessful, the participant loses nothing.

III. Some Multiemployer Plans Will Reduce or Completely Eliminate Disability Benefits.

The Department asked for data "on the price elasticity of demand for disability insurance coverage." Unfortunately, we do not have precise data on the extent to which, in collective bargaining, unions and employers may reduce or eliminate disability benefits because of added costs. Nevertheless, as the Department is well aware, many multiemployer plans and their industries are under substantial financial pressure. Added costs of $45 million per year will further stress the system. The Department should not ignore the obvious reduction in multiemployer plan disability benefit coverage that the Regulation will cause.

* * *

In closing, we appreciate the Department's willingness to review these issues. We ask the Department to withdraw the regulation altogether, rewrite it to account for the realities of multiemployer plan administration, or completely exempt multiemployer plans. Our attached letter of January 19, 2016 further describes how workers covered by multiemployer plans are protected better in collective bargaining than through one-size-fits-all regulation.

Thank you for your time and attention to this very important matter. We will be following up to request a meeting with the Department to discuss this important topic.

Sincerely,

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Enclosure

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January 19, 2016

VIA EMAIL (e-ORI@dol.gov) & U.S. MAIL

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

Attention: Claims Procedure Regulation
Amendment for Plans Providing Disability Benefits

Dear Sir or Madam:

The NFL Player Disability & Neurocognitive Benefit Plan ("NFL Player Disability Plan" or "Plan") greatly appreciates this opportunity to comment on the proposed changes to the claims procedures for plans providing disability benefits, as published at 80 Fed. Reg. 72014 (Nov. 18, 2015) ("Proposed Rule").

As described below, the Proposed Rule will inhibit, not improve, the administration of complex, industry-specific plans such as the NFL Player Disability Plan. Accordingly, we ask the Department to consider withdrawing the Proposed Rule, or exempting multiemployer plans, such as the NFL Player Disability Plan, which are the most likely to contain complex, industry-specific rules. We also comment on three parts of the Proposed Rule that are particularly troublesome.

Because of the substantial complexities and dangers of the Proposed Rule, and the special concerns of multiemployer plans, we ask the Department to hold a public hearing, and we respectfully request the opportunity to present oral testimony.

THE NFL PLAYER DISABILITY PLAN

The NFL Player Disability Plan was forged through decades of collective bargaining between the NFL and the NFL Players Association. It may provide the most generous disability benefits in the world, and its procedures have been developed to evaluate claims comprehensively and fairly. The Plan currently pays about $10 million a month to former NFL Players.

Players have access to three types of disability benefits. They may apply for any one, any two, or all three at a time. If a Player applies for all three, the Plan must still comply with all

requirements of the claims regulation, including the need to make three timely decisions while juggling three different claims for different benefits under different standards.

The first type of disability benefit is awarded where a Player is deemed totally and permanently disabled. In most plans of this type, the sole decision to be made is whether the claimant can work, and that decision follows fairly quickly after the claimant's working career ends. Frequently, such decisions may be based completely or in large part on treating physician reports. In contrast, the NFL Player Disability Plan generously allows Players to qualify for total and permanent disability benefits if they become unable to work, for any reason, before they elect to receive their pension, normally at age 55. Thus, these decisions are typically made many years, and in some cases decades, after the Player's NFL career has ended. These decisions may also follow a lengthy period of time during which a retired NFL Player chooses not to engage in work, or works only occasionally.

If a Player is ultimately deemed to be currently unable to work, the decision-making process has only begun. The Plan's fiduciaries must next allocate each successful claimant to one of four categories of total and permanent disability, and establish an effective date for the total and permanent disability. Because of collectively-bargained rules, the decisions required may include: the cause of disability, whether the claimant was physically or mentally incapacitated from filing an application sooner, whether the condition has lasted or is expected to last for at least one year, and whether there are substance abuse or psychological issues involved. Social Security disability awards are binding on the Plan, but only with respect to whether the claimant currently is totally and permanently disabled. Social Security onset dates and findings as to causation are not binding on the Plan.

These unusual, industry-specific factors make it difficult to determine whether a Player is entitled to total and permanent disability benefits, and, if so, what category. The bottom line is that these decisions require careful analysis.

The second type of disability benefit is awarded where the Player is deemed to be partially disabled. This unusual benefit, called a "line-of-duty" disability benefit, has been designed specifically for professional football players. A Player who applies for line-of-duty disability benefits is simultaneously rated for dozens of potential impairments and disabilities, and is awarded "points" according to a complex custom system developed by some of our country's top orthopedic surgeons. This industry-specific rating system was developed through collective bargaining.

The third type of disability benefit is a one-of-a-kind "neurocognitive" disability benefit. This benefit is the most recent product of collective bargaining. Evaluations require two days of medical examinations, the first day by a neurologist and the second by a neuropsychologist, each using examination protocols developed specifically for the benefit. Like the total and permanent disability benefit, this benefit contains special rules for substance abuse and psychiatric conditions. It requires a sophisticated screen for validity testing conducted under normed neuropsychological exams.

The decision-making fiduciaries of the Plan must not only carefully apply all of these rules, they must do so while reviewing voluminous records. It is typical for a claimant to submit hundreds or thousands of pages of documents, including their entire college and NFL medical records.

The Plan has special procedures to review claims carefully and objectively. It has enlisted some of the most distinguished specialists in the nation, in fields such as orthopedics, cardiology, neurology, psychiatry, and so on. Each of these doctors is a renowned specialist in his or her field, and each is still actively practicing. Each of these doctors has also been reviewed and approved by both union and management sides of the Board. Specialist meetings are regularly held, and it is always emphasized that each physician must evaluate claims fairly, with no bias for or against the Player.

In some cases the medical evidence is extremely difficult to evaluate, such as if there is a difference of opinion among doctors. In such cases, or where there is a deadlock, the Plan refers cases to a "Medical Advisory Physician," or MAP. MAP medical decisions are final and binding on the Board. All MAPs are distinguished specialists approved by both sides of the Board.

THE PROPOSED RULE

The Proposed Rule imports the recent changes to the claims procedure rules for group health plans, enacted in the Patient Protection and Affordable Care Act, into the context of disability benefits. The Proposed Rule does so even though Congress declined to do so, and there is no statutory basis for the changes.

The following three provisions are particularly troublesome:

1. Strict Compliance: The Proposed Rule would revise the deemed exhaustion provision of the existing rule and established case law. If a plan fails to strictly adhere to all rules for processing disability claims, a claimant is deemed to have exhausted the plan's administrative procedures and may sue at any time under a *de novo* standard of judicial review, unless a "minor errors exception" applies. In other words, any slight error or delay could eliminate the plan's right to deference, and a court could decide the case *de novo*, substituting its judgment for that of the plan's fiduciaries, and even hold a hearing.

2. Expanded Disclosure Requirements: The Proposed Rule would require a discussion of why the plan disagrees with the views of a treating physician or with any disability determination by the Social Security Administration, treating physician, or other third party disability payor.

3. Right to Review and Respond to New Information Before Final Decision: The Proposed Rule would require a disability plan to provide, prior to a plan's decision on appeal, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim. This information must be provided as soon as possible and in advance of the plan's decision on appeal to give the claimant a reasonable opportunity to respond to such new or additional evidence.

ANALYSIS

I. Because the Proposed Rule is defective in three ways, the Department should consider withdrawing it.

A. The Department should take great care not to impose undue costs and burdens on voluntary disability plans.

Private sector disability benefits are provided voluntarily. They are not vested, and can be reduced or eliminated at any time. There are no minimum standards or coverage rules.

When ERISA was enacted, Congress explicitly sought to avoid overburdening voluntary plans. Congress acknowledged what has been called the "ERISA bargain": participants receive certain federal protections in exchange for foregoing certain potential remedies. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 n.17 (1985) (*citing* H.R.Rep. No. 93-533, 1, 9 (1973), 2 Leg.Hist. 2348, 2356; 120 Cong.Rec. 29949 (1974), 3 Leg.Hist. 4791; 120 Cong.Rec. 29210-29211 (1974), 3 Leg.Hist. 4706-4707) (noting that "Congress was concerned lest the cost of federal standards discourage the growth of private pension plans").

Great care is appropriate before imposing extra administrative costs and litigation expenses. As the Supreme Court noted:

> [C]ourts may have to take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.

Varity Corp. v. Howe, 516 US 489, 497 (1996).

The Proposed Rule is intended to enhance protections for participants, but it creates risks for participants. As plan sponsors experience the substantial extra costs and increased litigation risks described below, they may ask themselves whether providing disability benefits is worth the expense. They may note that their workers are covered for disability by Social Security, and that very few new hires focus on disability benefits. The Department should not lightly impose additional costs and burdens on plans providing voluntary disability benefits.

B. Disability benefits and health benefits are fundamentally different, and different rules should apply.

In the Patient Protection and Affordable Care Act ("Affordable Care Act"), Congress undertook a major overhaul of the marketplace for health coverage. Among other changes, it subjected disparate health markets to a unified set of rules for processing claims. These markets include employer sponsored plans covered by ERISA and individual plans not subject to ERISA. Congress did not, in any way, state that the claims procedure changes would or should have any effect beyond health claims. If Congress intended to include plans providing disability benefits

within the sweep of the Affordable Care Act's claims rules, it would have done so explicitly. *See, e.g., Central Bank of Denver v. First Interstate Bank*, 511 U.S. 164, 176-77 (1994) (although "Congress knew how to impose aiding and abetting liability when it chose to do so," it did not use the words "aid" and "abet" in the Securities Exchange Act of 1934, and so did not impose aiding and abetting liability in that statute). The Affordable Care Act uses the word "disability" 38 times in other contexts.

The Department nevertheless proposes "to uplift the current standards applicable to the processing of claims and appeals for disability benefits so that they better align with the requirements regarding internal claims and appeals for group health plans under the regulations implementing the requirements of the Affordable Care Act." The sole rationale given is that because some plans that pay disability benefits also pay health benefits, the Affordable Care Act rules are already familiar.

We believe the Department's conclusion is flawed. Many if not most disability plans, including the NFL Player Disability Plan, have no familiarity with the rules of the Affordable Care Act. Moreover, disability benefits are fundamentally more like pension benefits than health benefits. Disability benefits are intended to replace income, and generally involve a monthly stream of payments over a period of time, extending as long as the recipient's life span. Health benefits generally involve payment for a product or service; invoices are created for each product or service. There are other important differences. Disability claims decisions require a sensitive, often much more complex holistic analysis of the claimant's physical and mental condition. Health claims decisions typically look only at whether the product or service sought to be covered is appropriate for the stated diagnosis. Disability benefits require manual processing. Health benefits are typically susceptible to automated processes.

The government's own programs recognize these distinctions. There are differences between how the Social Security Administration and the Veterans Administration process disability claims, and how Medicare processes health claims. For example, a decision on an initial application for Social Security disability claims takes an average time of over 100 days (https://www.ssa.gov/open/data/Combined-Disability-Processing-Time.html). The Medicare Claims Processing Payment Manual, by contrast, states that health claims normally should be paid within 30 days (https://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/ Downloads/clm104c01.pdf).

Because of these differences between health and disability benefits, Congress did not extend the Affordable Care Act claims rules to plans providing disability benefits. The Department should not go further than Congress.

C. The Department's economic impact analysis grossly underestimates the added costs.

Executive Orders 12866 and 13563 direct the Department to "assess **all** costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits." Executive Order 12866 requires the Department to estimate costs

and consequences using the best reasonably obtainable scientific, technical, economic, and other information.

The Proposed Rule grossly understates some costs and does not take into account others.

- Plans will have to "staff up" to meet the requirements of the Proposed Rule. For example, staff will have to scour voluminous medical records that are typically submitted by claimants to find those notes or sentences that may be viewed as favorable to a claim, and to describe in decision letters why the plan has not followed those notes or sentences. New staff will also be required to respond to requests for information and to track the status of appeals.

- Litigation will increase. The Proposed Rule creates an incentive to game the system, to "foot fault" a plan into making a minor procedural error, so that claimants can go directly to court and obtain *de novo* review.

- Plans that do not currently provide non-English language services will have to do so. The Department incorrectly assumes that disability plans already provide such services because they also provide health benefits. That is not true.

- In connection with the new step that the Department proposes for all appeal cases, the Department only considers the cost of sending the new evidence or rationale to the claimant. The Department does not consider the additional costs involved in assessing what the claimant then submits, which may be substantial. The claimant's submission may require substantial new review by medical specialists, which will then trigger another round of comments by the claimant, and so on. None of those additional costs are included in the Department's estimate.

- With respect to the concept of hiring truly independent and impartial decision-makers and medical experts, the conduct the Department proposes to eliminate is already prohibited by law. Adding a duplicative regulatory obligation will impose additional costs that the Department has not considered. For example, litigation costs will rise as counsel depose decision-makers about their compensation and hiring practices.

- The Department appears to be contemplating a change in disclosure of applicable statutes of limitations, but assesses no cost in connection with this regulatory change. Plans and third party administrators will have to revise their communications accordingly, and there are costs to that.

- The Department justifies the Proposed Rule by stating that its procedural protections will increase the accuracy of decision-making, causing fewer incorrect benefit denials. The Department fails to establish the critical predicate for their assumption: that many incorrect benefit denials occur. Absent that predicate, the costs associated with the Proposed Rule would be far greater than the benefits the Department claims.

We ask the Department to consider withdrawing the Proposed Rule so it can conduct a more complete economic analysis.

II. If the Department does not withdraw the Proposed Rule, the Department should consider exempting multiemployer plans because collective bargaining more effectively protects claimants.

Plans forged through collective bargaining, where decisions are made by committees and boards comprised of equal numbers of employer and union representatives, should be exempt from the Proposed Rule. Collective bargaining parties know the needs of their constituencies, and will bargain for the procedural protections that are appropriate for their population.

In multiemployer plans, there can be no bias against claimants, and the Department need not be concerned about the independence and impartiality of the decision makers. The emphasis is solely on administering the plan according to its terms, which requires careful consideration of all cases, under the existing legal standard of a "full and fair review." In the multiemployer context, it is established law that there is no conflict of interest among its fiduciaries because of the equal representation requirement.

Collective bargaining protects workers better, and in a more cost-effective way, than regulation. For example, the Proposed Rule requires that non-English language services be made available if a participant happens to live in certain counties. Here that requirement is unnecessary. The Plan is aware of no Players who lack fluency in English, yet will have to spend money on meeting the Department's requirements. The bottom line is that the bargaining parties know better than the Department what the participants need.

We note again that collectively bargained plans, like the NFL Player Disability Plan, typically have complex, industry-specific rules and standards, and have procedures in place for fair and impartial review. If the Department makes multiemployer plans more costly to administer, those additional costs must ultimately reduce wages. There is no free lunch. Again, the bargaining parties are in a better position to allocate scarce resources.

III. Three features of the Proposed Rule are particularly troubling, and should be excluded from any revision of the existing claims regulation.

A. The strict compliance standard is antithetical to decades of established case law, encourages claimants to game the system, and unconstitutionally involves the Department in the business of the federal judiciary.

Under the Proposed Rule, "if the plan fails to strictly adhere to all the requirements of this section . . . the claimant is deemed to have exhausted the administrative remedies." If such a claim is litigated, "the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary." In other words, even the slightest misstep by a plan will allow a claimant to skip the administrative process and go directly to federal court. There, the judge would decide the case *de novo*; he or she might even hold a hearing and allow testimony.

The proffered *de minimis* rule will not provide any relief. A plan would have to perfectly meet five conditions, including that the violation is not "part of a pattern or practice of violations by the plan." Of course, every claimant will argue exactly that.

The Department is well aware of the rich case law following the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch,* 489 US 101 (1989). In those cases, the federal courts studiously fleshed out the standard of judicial review for cases involving disputes over benefit claims. This case law is at the very core of ERISA, and accurately reflects the voluntary nature of the employee benefits system and the common law of trusts that underlies ERISA.

Courts have overwhelmingly determined that "substantial compliance" by a plan with the claims procedure prescribed by the Department does not disrupt the standard of judicial review. Substantial compliance exists where there has been "an ongoing productive evidence-gathering process in which the claimant is kept reasonably well-informed as to the status of the claim and the kinds of information that will satisfy the administrator." *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 634 (10th Cir. 2003) (*citing Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 691 (7th Cir. 1992)). The rationale for the substantial compliance doctrine is clear:

> [Requiring strict compliance] could inhibit collection of useful evidence and create perverse incentives for the parties. Even in cases where additional medical information is clearly necessary for a proper decision, administrators would have an incentive to issue a final denial on the inadequate record in order to preserve their right to deferential review, rather than to wait for the information and risk losing deference. On the other side, claimants might be encouraged to delay a final decision by suggesting that they intend to produce additional information, only to pull the plug and demand *de novo* review in federal court on the 121st day. This result would be antithetical to the aims of ERISA. ERISA's procedural regulations are meant to promote accurate, cooperative, and reasonably speedy decision-making, not to generate an endless stream of business for employment lawyers. Thus, in the context of an ongoing, good faith exchange of information between the administrator and the claimant, inconsequential violations of the deadlines or other procedural irregularities [should not pose litigation consequences].

Id. at 635. The Department would undo this substantial body of law.

The Department's rationale boils down to the following:

> The Department's intentions in including this provision in the proposal are to clarify that the procedural minimums of the Section 503 Regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference.

The Department does not say, however, why each and every rule contained in the claims regulation is so "essential to procedural fairness" that "a decision made in the absence" of any one of them, where there otherwise has been substantial compliance, should forfeit the normally applicable standard of judicial review.

Under the Proposed Rule, litigants will fight over the standard of judicial review in every case, and efforts to game the system may be rewarded. For instance, undeserving claimants (or their lawyers) can seek to win an award of disability benefits by overlooking a minor error by the Plan at the initial stage, continuing through the claims process to completion, and, if dissatisfied by the final decision, go to court for *de novo* review. Such gamesmanship makes a mockery of the administrative review process. As another example, undeserving claimants (or their lawyers) can try to "trip up" plans by taking actions to complicate the processing of their claims. The Proposed Rule would allow such claimants or their lawyers to submit multiple medical reports, and argue that the plan did not adequately explain "the basis for disagreeing" with some "view or decision" of those physicians, thereby forfeiting the deferential standard of review that the plan is entitled to receive. Such claimants or their lawyers may submit confusing arguments and evidence, or delay and confuse deadlines, all in an effort to induce an error by the plan.

It appears that the Department wishes to tilt the litigation odds in favor of claimants and against plans. We ask the Department to reconsider that intent.

B. The expanded disclosure requirement is vague, and will create burdens.

The preamble to the Proposed Rule states that is would require disability plans, in each adverse benefit determination, to describe "the basis for disagreeing with any disability determination by the Social Security Administration (SSA), a treating physician, or other third party disability payor presented by the claimant, to the extent that the plan did not follow those determinations." The proposed regulation would also require a discussion of any disagreement with the "views" of any medical professional whose report is submitted to the plan.

This expanded disclosure requirement is vague, and will not advance the statutory standard required by ERISA for claims procedures (plans must "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1)).

The following questions illustrate the problem:

- How is the Plan to determine, exactly, what must be discussed, when a claimant submits hundreds or thousands of pages of medical records? For example, if the claim involves total and permanent disability, is it enough to describe those determinations that explicitly address total and permanent disability, or must medical descriptions of impairments that may render a claimant totally and permanently disabled, individually or in combination, also be discussed in every adverse benefit determination?

- What if the standards of the Plan vary from the standards applied by the SSA, the treating physician, or the third party disability payor? How is the Plan to know the standards applied by a third party disability payor, and whether those standards differ from the standards of the Plan?

- When the SSA makes a disability determination, what part of the determination must be discussed? For example, SSA decides first whether a claimant is totally and permanently disabled, but it also sets an onset date of total and permanent disability. Are all SSA determinations as to onset dates subject to the Proposed Rule, even though they may be unreliable when the SSA onset date precedes (as is does sometimes by many months) the date as of which SSA benefits may actually be payable? Similarly, in some cases SSA may identify the totally and permanently disabling impairments; is that determination subject to the Proposed Rule? SSA also takes into account factors that a plan may be prohibited from recognizing, such as age and education at the time of application. How are such factors to be addressed, if the complete SSA file is not provided to the Plan by the claimant?

- What is a treating physician? How many visits does it take before a physician becomes a treating physician? Is more discussion required when there is a long history between a claimant and a physician than when there is a short history? We note that treating physician reports are not entitled to deference. As Justice Ginsburg noted in *Black and Decker Disability Plan v. Nord*, 538 US 822, 832 (2003), "the assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks. And if a consultant engaged by a plan may have an 'incentive' to make a finding of 'not disabled,' so a treating physician, in a close case, may favor a finding of 'disabled.'"

- What is a "view" of a medical professional? Does every statement in a medical report constitute a "view"?

- What level of discussion will satisfy the Proposed Rule? Is it enough to say that the fiduciary weighed the evidence and found a treating physician or third party disability payor unpersuasive? Is some greater level of discussion contemplated by the Proposed Rule?

Because of the vagueness in the Proposed Rule, to be safe, plans will be forced to undertake extraordinary steps in all cases to parse voluminous medical records, determine what is worthy of discussion in an adverse benefit determination, and create a legalistic discussion that exceeds what is necessary to fairly and clearly apprise the claimant of the decision and why it was made. Plans will have to "staff up" to comply, which will greatly increase administrative costs. The economic analysis in the Proposed Rule does not take into account this increased cost.

C. The right to review and respond to new information before final decision adds a substantial, time-consuming step to the appeal process, but the Proposed Rule does not give additional time for final decisions.

The Proposed Rule obligates plans providing disability benefits to add an entirely new step to all appeals. In this step, the plan must provide any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the appeal to the claimant. The plan must also provide any new rationale for denial of the appeal. The plan must do so as soon as possible, and sufficiently in advance of the appeal decision to provide the claimant with a reasonable opportunity to respond to such new or additional evidence or rationale. The Proposed Rule explains how this new step would work:

> [A]ssume the plan denies a claim at the initial stage based on a medical report generated by the plan administrator. Also assume the claimant appeals the adverse benefit determination and, during the 45-day period the plan has to make its decision on appeal, the plan administrator causes a new medical report to be generated by a medical specialist who was not involved with developing the first medical report. The proposal would require the plan to automatically furnish to the claimant any new evidence in the second report. The plan would have to furnish the new evidence to the claimant before the expiration of the 45-day period. The evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline (including an extension if available) in order to give the claimant a reasonable opportunity to respond to the new evidence. The plan would be required to consider any response from the claimant. If the claimant's response happened to cause the plan to generate a third medical report containing new evidence, the plan would have to automatically furnish to the claimant any new evidence in the third report. The new evidence would have to be furnished as soon as possible and sufficiently in advance of the applicable deadline to allow the claimant a reasonable opportunity to respond to the new evidence in the third report.

There are three major flaws in this proposal, as it is described by the Department.

First, as the Department recognizes in the preamble, courts have identified sound policy reasons to exclude this step at the administrative appeal stage:

> Permitting a claimant to receive and rebut medical opinion reports generated in the course of an administrative appeal—even when those reports contain no new factual information and deny benefits on the same basis as the initial decision—would set up an unnecessary cycle of submission, review, re-submission, and re-review. This would undoubtedly prolong the appeal process, which, under the regulations, should normally be completed within 45 days. 29 C.F.R. § 2560.503–1(i)(3)(i).

Metzger v. UNUM Life Ins. Co., 476 F.3d 1161, 1166-67 (10th Cir. 2007).

Moreover, such repeating cycles of review within a single appeal would unnecessarily increase cost of appeals. *See* ***Sandoval*** *v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 382 (10th Cir. 1992) (noting that Congress intended to minimize the costs of claims settlement by passing ERISA).

The Proposed Rule does not address these sound policy reasons. Instead, the Proposed Rule justifies itself in the following words:

> It is the view of the Department that claimants are deprived of a full and fair review, as required by section 503 of ERISA, when they are prevented from responding at the administrative stage level to evidence and rationales. Accordingly, adding these provisions to the Section 503 Regulation would explicitly address this problem and redress the procedural wrongs evidenced in the litigation under the current regulation.

The cryptic reference to "procedural wrongs evidenced in the litigation" (citing *Metzger*) is nowhere explained by the Department. The Proposed Rule fails to give a justification for this major change.

Second, this new step raises unanswered questions: What is the fiduciary to make of a claimant who does not respond to such new evidence or rationale? What is required to give the claimant a "reasonable opportunity" to respond—one week, thirty days, more, or less? What happens if the claimant desires to submit materials, but cannot do so in the time provided?

Third, the Department describes this new step as an "overlay" to the existing timetable for appeals. It is conceivable that in some cases the new step may be complete in a short time period, but in other cases each turn around may require a substantial amount of time. For example, if a claimant would like to rebut a new medical report with his own medical report, the claimant may need weeks, or more, to obtain the rebuttal report from a busy doctor. It is not administratively workable for plans to meet the existing timetables while also providing this new step in every case.

For the three reasons described above, the Department should drop this change altogether. If the Department insists on this new step, the only way to make it workable is to reset the clock to zero each time the claimant begins a new cycle by submitting a response to new evidence or rationale forwarded by the plan. That is the only way to achieve the meaningful dialogue that the Department wishes to foster, while also providing plans the ability to make well-considered decisions on the merits of the appeal and provide the final decision letters that claimants deserve.[1]

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[1] The Proposed Rule could create the disability claims equivalent of the famous tennis match of John Isner versus Nicolas Mahut, in which Isner defeated Mahut after 11 hours, 5 minutes of play over three days. Because the players exchanged game after game in much the same cyclical manner as proposed by the Department, it took Isner 138 games to win the final set (by a score of 70–68). Normally a set requires no more than 10 to 12 games to finish. The Department should not impose such burdens on claimants and plans.

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Again, the NFL Player Disability Plan appreciates the opportunity to comment on the Proposed Rule. The Plan respectfully asks the Department to hold a public hearing on the Proposed Rule, and requests the opportunity to present oral testimony at that hearing.

Sincerely,

Douglas W. Ell

Alvaro I. Anillo

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