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December 11, 2017

Via email at e-ORI@dol.gov
Office of Regulations and Interpretations,
Employee Benefits Security Administration
Room M-5655
U.S. Dept. of Labor
200 Constitution Avenue NW
Washington, D.C., 20210

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 you with a simple request. Please avoid any modification of the final version of 29 C.F.R. § 2560.503, which is now scheduled to go into effect on April 1, 2018.

My name is Joseph P. McDonald and I am the President of McDonald & McDonald Co., L.P.A., an employee benefits law practice in Ohio. My wife and I exclusively focus on representing individuals participating in long-term disability plans that are governed by ERISA. We practice in multiple states and make appearances in several Federal Courts. I am admitted to the practice of law in Ohio and New York.

As a practitioner who works exclusively in this area of the law, I believe that I have gained a perspective which will be valuable to the choices that are made concerning the final regulation which was published on December 19, 2016. That final regulation represents a necessary enhancement to the existing regulatory structure at 29 C.F.R. § 2560.503.

This will be the third time that I have voiced my concerns relative to the new regulation. I submitted my original comments on January 18, 2017, when the Department of Labor was considering changes to 29 C.F.R. § 2560.503. I also resisted the industries' attempt to delay the enhancements to 29 C.F.R. § 2560.503 when I wrote to the Department of Labor on October 24, 2017. I understand that the effective date of the regulatory change is now delayed until April 1, 2018.

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I write to you today because I am concerned that many of the observations and arguments offered by the insurance industry are insufficient to modify the regulation *after* the public comment period expired.

It is my understanding that the delay in regulation was largely prompted by concerns of the insurance industry after the public comment period was completed. Based upon concerns of insurers and plan administrators, the Department was asked to consider the impact of the enhanced regulation, and whether it is contrary to Executive Order 13777.

At this point, it is incumbent upon me to remind anyone who would like to listen, that the current regulations have been in place for nearly 20 years. Thus, the industry has had the same regulatory guidance on the administration of welfare benefit claims for some time. When the 2000 regulations were under consideration, the Department of Labor received over 800 comments and felt compelled to take two days of live testimony before enacting the regulation! In comparison, the current enhancements to 29 C.F.R. § 2560.503 generated less than 200 comments and very little input from the insurance industry. Now those same insurers are avoiding scrutiny by rewriting the rule making process. The lack of timely objection by the insurance industry makes their new argument against the enhanced regulations hard to hear.

The larger question that we have to consider is: what is really new about the regulation enhancements that will go into effect on April 1, 2018? The fundamental thrust of this regulation has been to generate an environment which ensures that a disabled American worker will receive a "full and fair review" of their appeal after an adverse benefit decision. The enhancements, which are scheduled to go into effect on April 1, 2018, don't change the fundamentals in any material way. It is not as if these regulations require insurance companies to engage in new behaviors or mandate new actions. The regulatory enhancements are directed to subtle components such as timing, language, information, disclosure and the submission of proof in a disability claim. None of these enhancements will add to the existing cost structure of any plan administrator.

The insurance industry has always fought any regulation of disability claims and they routinely cite increased cost and wave the threat that these benefits will go away if expenses increase. In contrast, I am pleased to report that the insurance industry has thrived under the current set of regulations! If you were to conduct a survey of insurers who participate in the administration of disability plans, you would not find any of them teetering on the edge of bankruptcy. In a recent Motion for Attorney Fees, I was forced to look at Liberty Mutual's profit for a calendar year. The number was staggering. It is beyond any reasonable argument that costs will increase in a material way to affect the already substantial profitability of the participating insurance companies. Complaints of increased costs, even if true, would not harm the already immense profit margins that these participating insurers enjoy. As I wrote to you in October 2017, I do not think these regulations in any way, would impact jobs or job creation or somehow restrict

the ability to employ any American worker. Therefore, I urge you to not change the final rule because the industry's claim of increased costs seems illusory at best.

THE BENEFITS IN ENACTING THE ENHANCED RULE ON APRIL 1, 2018, WITHOUT MODIFICATION, OUTWEIGH ANY POTENTIAL COSTS.

The comments which drove the formulation of the enhanced regulation were meaningful because they updated the administration of welfare benefit claims. We must keep in mind that the goal of these regulations is to ensure a "full and fair review." The goal of these regulations is the protection of the plan participants. ERISA, fundamentally, operates under a fiduciary construct. That is to say, the insurance company which administers a long -term disability plan has a fiduciary obligation to ensure that the claimants are treated fairly and that plan assets are not wasted. By enhancing the regulation at 29 C.F.R. § 2560.503, American workers are guaranteed that the benefit plans they participate in can be clearly understood.

The Department of Labor, in its notice seeking public comment, shared an idea that abuse was occurring in benefit administration. Indeed, many commenters provided specific examples where the insurance industry was not following the existing regulatory guidelines.

Without the enhancements to 29 C.F.R. § 2560.503, we are putting American workers at risk. No one in the United States Senate or the House of Representatives or the White House is against American workers. Therefore, it remains a matter of mystery to me how enhancing regulations which protect working Americans is something that violates Executive Order 13777. The enhanced protections within 29 C.F.R. § 2560.503 are reasonable and continue to remind the industry that they serve the disabled workers in a non adversarial environment. The more protection that we can provide to those workers, the better off we will all be. The benefits of the enhanced regulatory protection outweigh any alleged but dubiously non-specific increases in costs argued by the insurance industry.

As an ERISA professional, I keep track of how many cases I do not take. The number of working Americans who exhaust their administrative appeals without doing anything is significant. Not even the best lawyers can undo the damage done by a plan participant who does not understand that they are not going to get a trial or testify or call their doctor to supply testimony at the courthouse. ERISA's procedural paradigm is unique in American law. In ERISA, you will not be able to obtain a bench trial or a jury trial in a long-term disability case. Most potential clients of my firm are absolutely stunned to know that they will not be able to modify any of the information in their claim file after suit is filed. The enhancements to 29 C.F.R. § 2560.503 help to eliminate the "surprise" that ERISA's unique procedural rules create.

FORCING THE INDUSTRY TO OFFER A REASONABLE EXPLANATION OF HOW THE SOCIAL SECURITY ADMINISTRATION CAN PAY DISABILITY BENEFITS BUT THE PLAN CANNOT.

The Social Security Disability program is legislative in its delivery of benefits and benefits are only paid by completing the five step process at 20 C.F.R. §404.1520(a), which examines the ability to perform any full time job in our national economy. In contrast, long-term disability is a non-specific contractual program which can be based on "own occupation" or occupations with a specific level of income. The Social Security Act has more specifics regarding disabling conditions than any long-term disability policy. Many people do not understand this subtle point. In the Code of Federal Regulations at Appendix 1, Subpart P of Part 404, specific medical guidance on proving disability can be found. Also, several Social Security Rulings (SSRs) provide advice and guidance on pain and the evaluation of opinion evidence. You will not find any guidance in a long-term disability policy whatsoever on how bad a medical condition has to be before a benefit can be paid. This lack of specifics gives the insurance industry's medical cohorts an ability to opine recklessly that an individual's severity would be good enough to obtain a benefit.

Thus, the specifics of the Social Security Act when compared to the generalization offered by the long-term disability policy create an ironic inconsistency. I believe that this inconsistency requires the long-term disability insurer to explain in a detailed way why its decision is contrary to any Social Security ruling in favor of disability. Many people do not realize that the standards in any long-term disability policy and the standards of any claimant under the age of 50 are identical under both the long-term disability and under the Social Security Act. The government uses no special rule that would disable an individual if they are under the age of 50. This is yet another reason why it is absolutely necessary for plans to discuss their basis for disagreement with a Social Security finding in favor of disability.

In addition, there are several parts of the insurance industry's complaints that make little sense but above all, I want to address the rule requiring disclosure of a statute of limitation. Presently, I have cases in my office for plans that require the filing of suit within 1 year of the date of the original denial of the claim. I have other plans that are 2 years from the day that "proof was due." Finally, I have others that are 3 years from the day the final denial is issued.

Considering the loss of continued long-term disability can be catastrophic to American workers, what could our motivation possibly be for hiding the statute of limitations from the worker and/or his lawyer? If an adverse benefit decision that says that the claimant's appeals are exhausted, it should contain the day that the disabled worker must file his or her lawsuit. Nothing the industry says will discourage me from the view point that the statute of limitations is important information that should not be left to guess work or interpretation. Making the insurer tell the worker when a lawsuit must be filed by is a burden on no one and protects everyone.

Also, I continue to believe that the rules regarding the disclosure of internal guidelines are a valid request to any insurance company administering a benefit plan. The insurance policies issued to many American workers as "plan documents" or "summary plan descriptions" offer little guidance as to how the insurance company is evaluating evidence. Workers should still have the ability to insist on receiving any specific guidelines used by an insurer to evaluate disability. Internal guidelines used by insurance companies are valuable in understanding how the insurance company perceives a specific problem and also it gives the disabled worker an opportunity to be able to prove their case.

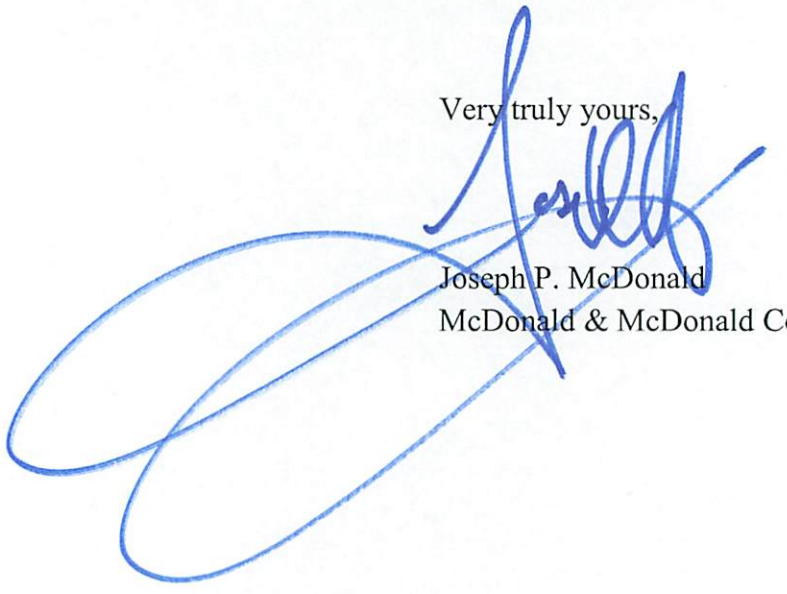
My final comment to you is relative to the claimant's ability to respond to evidence obtained in its final appeal review. It is not uncommon to see the following scenario: A claimant is denied long-term disability benefits and the denial was based upon the opinion of a nurse employed by the insurance company administering the plan. After the claimant consults their doctor and submits an appeal, the insurance company will hire 4 cardiologists to each explain why the claimant's doctor couldn't possibly be right. Upon receiving a final denial letter which has 4 cardiology opinions referenced in it, the claimant has no ability to respond. This practice, which we refer to as "sand-bagging", regrettably puts the claimant at an extreme disadvantage. With a new ability to have the "final word", the claimant may be able to clarify his or her medical condition, medical symptoms or medical treatment or expose a misunderstanding of doctors hired by insurers. Indeed, I can easily see a scenario where the claimant's response might reduce unnecessary litigation. I can see a scenario where the information supplied in response to medical rationale used to deny the claim, could cause the insurance company to reverse the denial and pay the benefit. I believe that this practice of giving the claimant the last word has the likelihood of decreasing litigation!

I encourage you to not modify any of the regulations scheduled to go into effect on April 1, 2018. I ask you to leave the regulation intact because frankly I can see no reason to do what the industry requests.

As a final note, I feel compelled to point out that the insurance industry is not adhering to the regulations in place presently. You do not have to look farther than the frustration that Judge Katzmann had in *Halo v Yale Health Plan*, 819 F 3d 42 (2nd Cir., 2016). Likewise, I completed a case in the Western District of New York where Aetna was hiding evidence that its own peer reviewers requested when they communicated with the claimant. See *Standish v. Federal Express Corp. Long Term Disability Plan, et al.*, Case No. 6:15-cv-6226, (WDNY, Nov. 17, 2016, Judge Michael Telesca), (...the standards imposed by ERISA requires that a plan administrator's notice letter be written in a manner calculated to be understood by the participant). As you can see, the enhancements to 29 C.F.R. § 2560.503 are necessary.

Protecting the rights of American workers is and always will be the most important thing in ERISA. Therefore, I strongly urge you to leave the regulation presently due to be effective April 1, 2018 intact.

Very truly yours,



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