From: Mala Rafik
Sent: Monday, December 11, 2017 4:01 PM
To: EBSA, E-ORI - EBSA
Cc: Mala Rafik; Sarah E. Burns; Socorra DeCelle; Mala Rafik
Subject: 1210-AB39

By Mail: 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: 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)), which are currently scheduled to go into effect on April 1, 2018.

Our firm has been representing ERISA disability claimants for almost 22 years. We have represented individuals suffering from chronic illnesses and disabilities during both the internal appeals process and in litigation. We have litigated many of the issues addressed by the proposed regulations, which only serve to even an unfair playing field of individuals suffering from disability under employer-based plans.

While I appreciate the opportunity to comment on the Department's re-examination of the costs of the final rules governing disability claims, the concerns raised by the industry have already been addressed by the extensive process that preceded the final rules. It appears that the industry is merely attempting to reargue issues considered by the Department of Labor. The final rules are based on policy determinations that have been made by Congress, by the Department of Labor, and by the federal courts interpreting ERISA. Accordingly, another argument about the merits is unnecessary.

However, given the significance of the issues posed, I am grateful for the opportunity to address the objections that have been raised, focusing my attention on those issues most in need of a response.

I. Increase in Costs of Disability Insurance.

The primary objection raised (again) by the industry is that the final rules will result in an increase in costs that will be transferred to employees through a premium increase, which will eventually result in reduced access to these benefits. This claim lacks merit, and was already contemplated by the Department before issuing the final rules.

In particular, the Department concluded that costs associated with the final rules would not outweigh the obvious benefits to both claimants and plans. An agency is not required to "conduct a formal cost-benefit analysis in which each advantage and disadvantage is assigned a monetary value." *Michigan v. Environmental Protection Agency*, 135 S. Ct. 1699, 2711 (2015). Nevertheless, the Department has asked for data addressing whether costs increased in response to the last set of rules applying to ERISA disability plans that became effective in 2002. This information is readily available by the Department's Bureau of Labor Statistics. https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm.The data shows that access and participation in employer-based disability insurance *increased*, not decreased, between 1999 and 2014, after the 2002 rules were implemented. The final rules at issue here are not dissimilar to those passed in 2002, which again, sought to ensure that the full and fair review contemplated by ERISA occurred during the internal appeals process. It is relevant to note that the BLS document demonstrates the cost of disability insurance is extremely modest. Thus, even if costs did increase, the increase would be so trivial that it is unlikely to make any difference.

The Department has also requested information on whether disability premiums increased in response to the adoption of statutory bans on discretionary language clauses in disability policies by some states. Notably, during the time period of the BLS study, many states enacted discretionary clause bans. This includes but is not limited to Arkansas Admin. Code 054.00.101-4 (2013); Cal. Ins. Code §10110.6 (2012); Colo. Rev. Stat. §16-3-1116 (2008); 50 Ill. Admin. Codes 2001.3 (2005); Md. Code ann. Ins. §12-211; Mich. Admin. Codes. R. 500.2201-2202 (2007); R.I. Gen. Law §§ 27-18-79; Tex. Admin. Code §3.1202-1203; Tex. Ins. Code §1701.062, §1701.002 (2011); WAC §284-96-012 (2009). Notwithstanding these statutory developments, access and participation in disability plans increased according to the BLS data.

Given the information already in the possession of the Department, the overall increase in plan participation despite the passage of the 2002 regulations, the implementation of statutory bans on discretionary language clauses in disability policies, and two market conduct studies conducted on both Cigna Group Insurance and Unum Group, the purchase of disability insurance by employees has only increased. As a result, I strongly urge the Department to reject any claim by the industry that the cost of the final rules will result in decreased access to insurance by employees.

II. Consideration of the Social Security Administration's Determination regarding Disability.

The industry has expressed considerable distress regarding the rules' requirement that it articulate the basis for its adverse benefit decision, including in its explanation a discussion as to why it disagreed with a favorable Social Security determination of disability. As a preliminary matter, many jurisdictions require such an explanation. The regulatory settlement agreements of which Unum and Cigna are required to abide also both require such an explanation, implying that both the Department and departments of insurance nationally find such an explanation a necessary part of an adverse decision. ERISA benefit plans have the advantage of an offset for Social Security Disability Insurance ("SSDI") benefits, and accordingly, require ERISA claimants to file for SSDI benefits. They are also required to conduct a full and fair review of an employee's claim and to articulate why, if they reach an adverse determination, the employee is not disabled. Adding an explanation as to why the SSDI decision does not provide evidence of disability does not require additional cost. In fact, if benefits are awarded, many ERISA claimants' benefits are reduced the minimum benefit, or a significantly reduced benefit amount, particularly when dependent offsets are taken into consideration.

If the industry is arguing that increasing the cost of disability insurance will burden the government, and more specifically the SSA, the Bureau of Labor Statistics publication specifically addresses this:

> It is important to note that expanding access to employer-provided disability insurance would not necessarily relieve the burden on SSDI. The ability to access disability insurance does not affect a worker's eligibility for SSDI. People can receive SSDI benefits and long-term disability payments, but the private disability insurance payment is usually reduced by the amount of the SSDI payment.

https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm.

The final rules only increase uniformity among insurance companies and jurisdictions. It is a minimal requirement to impose on insurance companies. It is also generally associated with cost savings and not cost increases.

III. Disclosure of any Internal Limitations Period

The final rule requires claims administrators to provide the claimant with the date when any internal time limit for filing suit will expire. Again, several jurisdictions have already imposed such a requirement on insurers. *See 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). Moreover, it is difficult to ascertain exactly the basis of the commentators' dispute with this requirement. It imposes clarity in an otherwise unclear world. It will reduce litigation around this issue. The limitations period is an essential plan term, which, like every other relevant plan term that impacts a claimant's receipt of benefits, should be disclosed to unwary plan participants. There is simply no need to hide the ball in this regard. And, again, the final rule creates uniformity among jurisdictions.

IV. Disclosure of Internal Guidelines.

Commentators have objected to the proposed rule requiring claims administrator to disclose internal guidelines or certify that none exist. The objections appear to imply that the guidelines are irrelevant as they address procedural rather than substantive matters. However, as the case law has repeatedly demonstrated, an insurer's procedural requirements directly impact the substance of a claim. For example, internal guidelines often dictate how plan provisions are interpreted, thereby clarifying for courts the relevant contractual standard under which claims should be adjudicated. *See Glista v. Unum Life Ins. Co. Of Am*., 378 F.3d 113, 123-125 (1st Cir. 2004). Moreover, requiring the disclosure of these guidelines should reduce the cost of litigation, since the parties often dispute the discovery of this information.

V. The Benefits Outweigh the Costs

While the costs of the final rules are likely minimal, the benefits of the final rules far outweigh the costs. The Department has already articulated its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. Please do not abandon these

purposes. The final rules simply seek to ensure that disabled claimants receive the full and fair review to which they are entitled.

Thank you. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

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