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General Comment

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

For over twenty years, my law practice has focused exclusively on the representation

of insurance policyholders, including disability benefit claimants in pre-litigation administrative appeals and ERISA litigation.

I understand that a number of insurers and plans oppose the new regulations, claiming they will increase costs. In particular, they have argued that providing an insured the right to review and respond to new evidence or rationales during the appeal process will be prohibitively expensive. This argument is contradicted by what typically occurs in practice.

In reality, by the time a denied disability claim ends up in federal court, the reviewing court will usually reject an insurer's claim denial where the insurer relied on new evidence without giving the participant a chance to respond. In that instance, a court will be forced to review the new evidence itself, and generally, reject the insurer's decision based on the new evidence or remand the matter to the plan for further findings. Each of these alternatives is incredibly more expensive to the plan than would be allowing the participant to respond to the evidence in the first instance, during the appeal stage of the claim.

Not only is it more judicially efficient to allow insureds to respond to "new evidence" at the appeal stage, but also it is fundamental to a full and fair review.

It is important to note what this rule actually does. It allows a claimant to respond to a disability claims administrator's (often an insurance company) assertions in a way that will make the response a part of the record if the claimant has to go to court to vindicate his/her rights. This is because most ERISA cases are decided on a closed record. Without this rule, the claims administrator's new evidence or rationale will be included in the record that the court reviews, but the claimant's rebuttal will not. This explains why many judges will "remand" a case with "new evidence" back to the insurer: to allow the claimant to build up his/her side of the administrative record before appearing before the judge again. Obviously, not allowing an insured to respond to new evidence during an appeal is incredibly inefficient for all parties including the court.

After years of experience representing ERISA claimants, there is no question in my mind that the insurer's ability to sandbag disabled claimants with a "new" medical opinion that he/she cannot refute, or a new plan provision to rely upon that he/she cannot counter, is a common denial technique in the disability claims industry. In order to prevent administrators from attempting to suppress meritorious disability claims, the final rule needs to be kept as is in the regulations.

If the industry's true concern is that their claims handlers will need to do more work in

the same amount of time, this could be addressed by modifying the rule instead of eliminating the rule altogether. Commenters from both sides have suggested this as a compromise.

I dispute the industry's comments to the effect that a second appeal, which is offered with some plans, serves the same purpose as the right to respond to new evidence or rationales before a final decision. In my experience, this is absolutely false because a second appeal permits the claims administrators the same sandbagging opportunity as the first appeal. Second appeals are not necessarily a useful device to plan participants. Moreover, second appeals are not universal and are not required by most disability plans. The second appeals that the industry touts are a matter of plan design, and can be changed at any time by plan sponsors. In fact, it is possible that "second appeals" will become obsolete where the claimant has a true right to respond to new evidence, resulting in cost savings for the industry.

The procedural protections provided by the disability claims regulations are important in light of the few substantive rights and protections afforded plan participants and beneficiaries. However, the benefit of allowing insureds an opportunity to respond to new evidence is not limited to participants. Allowing an opportunity to respond allows a claimant to address the accuracy and reliability of that evidence to ensure "a meaningful dialogue" between the parties. Booton v. Lockheed Medical Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997).

Thank you for the opportunity to comment upon these important proposed regulations.

Very truly yours,

Terrence J. Coleman