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Sent: Monday, December 11, 2017 7:12 PM
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Subject: RIN: 1210-AB39

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)) that are now scheduled to go into effect on April 1, 2018.

For 20 years I have represented claimants in ERISA benefit matters both in the internal appeal process and in litigation. The vast majority of my clients were seeking to reverse denials of short-term or long-term disability claims.

The objections that have been raised are no without merit.

The Objection That The Rules Will Increase Costs Which Will Then Reduce Employee's Access to Disability Plans Is Without Merit

The industry's logic - that the rules will increase administration costs, which in turn will cause premium increases, which in turn will reduce employees' access to disability plans - has no basis. Please do not would not allow an industry that profits from denied claims to prescribe what is good for ERISA disability plan participants. As my experience has taught me, and as the Department has already acknowledged, the disability claims industry is needlessly adversarial toward ERISA disability plan participants. The industry's argument that the final rules are bad for participants – despite all evidence to the contrary - does not pass the smell test and cannot be taken seriously.

Please note that available data shows that this industry argument is specious. The Bureau of Labor Statistics' February 2015 publication, *Beyond the Numbers, Disability Insurance Plans; Trends in Employee Access and Employer Costs,* addresses these concerns.

https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm. There was an increase in participation between the years of 1999 and 2014, a period of time that obviously covers the promulgation of the 2000 claims regulations. This increase occurred despite the fact that employment in the service industry has increased, an industry in which employees are less likely to have access to employer-based disability coverage. This increase also occurred despite a number of court decisions that continued to heighten the plans' obligations. The final rules simply will not cause employers to abandon disability coverage. This BLS document also demonstrates that the cost of disability insurance is low, a possible explanation for why modest increases don't seem to lead to less participation.

The Department has also asked for data about whether disability premiums increased in response to the adoption of state statutory bans on discretionary language clauses in disability policies. Notably, during the time period covered by the BLS publication, many states enacted discretionary clause bans. A list of these states 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). These state regulations have not affected access or participation.

Also, during the period covered by the BLS publication, two major insurers with significant market share, UNUM and CIGNA, were examined by the states for poor claims handling practices. As a result they became subject to fines and Regulatory Settlement Agreements that raised the bar for their disability claims administration. http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2004/unum_multistate/unum_multistate.html. Nonetheless, during this period access and participation increased.

An additional reason that employers are not likely to stop providing disability benefits is that these benefits play a role in recruitment and retention. MetLife, one of the industry's large disability insurers, urges employers to consider how benefits, including disability benefits, increase loyalty and productivity and reduce the apparently rampant worries of financial insecurity. https://benefittrends.metlife.com/us-perspectives/work-redefined-a-new-age-of-benefits/; https://benefittrends.metlife.com/media/1168/2016_ebts_opportunityknocks_insights.pdf.

To the extent that the industry also argues that increased costs will lead to employers requiring employees to pay their own disability premiums, this is not necessarily an unwelcome thing. Where the disability claimant pays his own premiums with after-tax dollars, his disability benefits are tax-free. This is an enormous benefit to many disability claimants.

The Department should not change the final rules in response to the industry's cost argument. Nor should the industry's cost argument cause the Department to extend the effective date further.

The Industry Argument that the Benefits Will Outweigh the Costs Is Without Merit -- Benefit Claimants Very Much Need A More Equitable System Where the Cards Are Not Stacked In Favor of the Industry

Regulations are not improper just because they affect the market. *Mkt. Synergy Grp. v. United States Dep't of Labor*, 2016 U.S. Dist. LEXIS 163663, 2016 WL 6948061 (D. Kan. 11/28/2016).

But assuming that the final regulations have some impact on cost, the costs will not outweigh the benefits. The Department has already articulated its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The Department should ignore the industry's invitation to abandon these purposes. Moreover, these benefits cannot be outweighed by costs where ERISA claimants are at such a procedural disadvantage.

ERISA disability claimants who are denied their benefits face a process that is far below the standard for regular civil disputes. These procedural hurdles include: (1) there are no jury trials; (2) there is a closed record from the claims process that can rarely be supplemented in litigation; (3) courts often apply an unfavorable standard of review, and (4) there are no remedies to discourage unfair and self-serving behavior on the part of plans. This will never be a level playing field much less one that favors plan participants. *United States v. Aegerion Pharmaceuticals, Inc*., 2017 WL 5586728, at *7 (D.Mass. 11/20, 2017)("The insurance industry found it could largely immunize itself from suit due to the Employee Retirement Income Security Act ("ERISA").) Even with the final rules in place, plan participants will not have achieved the "higher-than-marketplace standards" that the Supreme Court insists are required in processing ERISA claims. *MetLife v. Glenn*, 554 U.S. 105, 115 (2008). Any consideration the Department makes about the benefits of the final rules relative to costs should take these "higher-than-marketplace" standards into account. It cannot be the case that any minor increase in costs justifies denying ERISA claimants the limited protections that the final rules provide.

Furthermore, from the perspective of plan participants, an inexpensive but illusory disability plan is worse than no plan at all. It is important to note that when a disability claimant is unfairly denied benefits that she thought were promised through an employer's plan, it is too late for her to purchase private individual insurance to cover the risk of becoming destitute. It is only at the point of becoming disabled that claimants discover the procedural hurdles that are unique to ERISA claims. Attorneys often have to turn down representation of ERISA disability cases that are otherwise meritorious because the record is closed or the claimant had not realized that a contractual limitations period had passed. To the extent that increased protections bring disability claims administration in line with the reasonable expectations of the employee-participants, the costs are outweighed by the benefits. This is what is meant by higher-than-marketplace standards.

In sum, if there are costs associated with the final regulations, these costs could and should be tolerated in the name of supplying a modicum of protection for plan participants.

Requiring the Plan to Discuss the Basis for Disagreement with Social Security Decisions or Other Contrary Opinions is NOT Costly.

This rule merely requires disability plans to observe a fundamental due process principle that is imbedded in ERISA—namely the principle that a claimant is entitled to a well-articulated explanation for the adverse benefits decision so that the participant may fairly dispute it. The 2000 regulations require no less.

As the Department has already noted, it is doubtful that there are costs associated with the requirement of discussing the reasons for disagreeing with a favorable Social Security decision. ERISA disability benefits have always been deeply intertwined with the Social Security system and mostly are simply supplemental to Social Security benefits. For some employees a Social Security award will wipe out their entire ERISA benefit or reduce it to a mere $100 per month. Most disability plans require claimants to apply for the SSA benefit, and the plans usually provide representation for claimants. This is done so that the plan may take advantage of the plan term that the SSDI benefit will offset the LTD benefit. In order to decide which claimants qualify for this representation, claims handlers need to know the standard that the SSA uses. Comment #114, p.8 (ACLI). As such, their claims manuals tend to include pages of instructions related to Social Security disability and its standards. Both the Unum and Cigna Regulatory Settlement Agreements required the insurers to give greater weight to the Social Security awards. The insurers are no strangers to the SSA process or its standards.

To the extent that the industry argues that increasing the cost of disability insurance will burden the government, and more specifically the SSA, the Bureau of Labor Statistics publication speaks to 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.

Additionally, courts in many jurisdictions require an explanation of a favorable Social Security award. *Montour v. Hartford Life & Acc.Ins Co.*, 588 F.3d 623, 635-637 (9th Cir. 2009); *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011); *Bennett v. Kemper Nat. Services* Inc., 514 F.3d 547, 553-554 (6th Cir. 2008); *Brown v. Hartford Life Ins. Co*., 301 F. App'x 777, 776 (10th Cir. 2008). As a matter of Supreme Court precedent, it is arbitrary and capricious for the claims administrator to advocate for Social Security benefits, reap the benefit of the Social Security award by means of an offset, and then ignore the SSA's determination. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008). As the industry comments often acknowledged, requiring an explanation of the reasons for disagreeing with the Social Security decision and other contrary evidence tracks the existing standard. Logically, it should not increase costs to simply codify this standard.

A rule clarifying that an explanation of the basis for disagreeing with a Social Security decision is a requirement will increase uniformity and predictability in the process, which is generally associated with costs savings and not cost increases.

The Deemed Exhausted Rule is Not Costly

The industry's concern about this rule seems to be that plaintiffs and their attorneys will race into court, increasing the volume of ERISA litigation and hence the overall costs of administering disability claims. This is incorrect. Plaintiff's attorneys are ever mindful of building a record on which the court will make its decision and therefore would rather engage in the appeal process and exhaust internal remedies. This serves the dual purpose of possibly resolving the dispute and creating a record for the court to review in case the dispute cannot be resolved internally. Under the final rule, the plaintiff will mostly obtain a remand with instructions for the plan to do its job. Because plaintiff's attorneys usually work on a contingent fee basis, it does not make sense to undertake litigation that is not absolutely necessary and that will not result in resolving the case on the merits.

Further, a court will only award attorney fees for litigation where the plaintiff has achieved some degree of success on the merits. *Hardt v. Reliance Standard Life Ins. Co*., 560 U.S. 242, 255 (2010). In other words, the industry comments are seriously out of step with litigation in the real world and how the incentives are aligned to discourage litigation. While this rule may appear to create additional trips to court, it will not do so except in the most extreme cases. I take it that addressing these extreme cases is the purpose of the final deemed denied rule.

Additionally, as with most of the other final rules, this rule is mostly a codification of existing judge-made law. Claimants are already able to get into court when the claims process has failed them in a meaningful way. *See e.g. Brown v. J.B. Hunt Transp. Servs*., 586 F.3d 1079, 1085-86 (8th Cir. 2009) (failure to respond to request for documents excused claims from exhaustion requirement because there was no full and fair review). It is not likely that additional costs will result from this regulation. *Hall v. National Gypsum Co*., 105 F.3d 225, 231-32 (5th Cir. 1997); *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010); *Nichols v. Prudential Ins. Co. of Am*., 406 F.3d 98 (2d Cir. 2005); *Jebian v. Hewlett-Packard Co. Employee. Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003); *Dunnigan v. Metropolitan Life Ins. Co*., 277 F.3d 223, 231 n.5 (2d Cir. 2002).

Providing the Right to Review and Respond to New Evidence or Rationale From the Plan During the Appeal Review is Not Costly.

This rule is fundamental to full and fair review. The Department has already acknowledged the importance of this rule and that it is already the standard in some jurisdictions. The industry complains that providing the claimant with new evidence or rationales before making a final decision is costly. The industry's claim to cost impact is suspect for several reasons.

First, several disability plans or insurers already provide for the right to review and

respond. They do so on a voluntary basis, as their comments to the proposed rules admit. Second, courts require plans or insurers to do this in many cases. Last, whether they provide this information to the claimant during the ERISA appeal process, they will have to provide it eventually in one form or another. New reasons or evidence will need to be included in the claim file and likely again in 26(a)(1) disclosures. Thus, the industry's portrayal of the chaos that might ensue if they were required to locate and supply these documents is not credible. If the issue is the cost of mailing, such a concern should not be permitted to interfere with such basic a due process right.

It is important to note what this rule does. It permits a claimant to respond to a disability claims administrator's assertions in a way that will make the response a part of the record if the claimant has to go to court to vindicate 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. Perhaps what the industry is really chafing about is the loss of its ability to strategically withhold information that would help the claimant achieve reversal or win his case in court.

If the industry's concern is that the claims handlers need to do more 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 approach.

I strongly disagree with industry 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. This is absurd, as a second appeal permits the claims administrators the same sandbagging opportunity as the first appeal. Second appeals are not necessarily a boon to plan participants. The disability claims regulations acknowledge as much my limiting the number of appeals a plan can require to two. Additionally, second appeals are not universal and are not required. The second appeals that the industry touts are a matter of plan design and can be changed at any time by plan sponsors. It may be that second appeals will become obsolete where the claimant has a true right to respond.

Other Provisions

The Impartiality Rule

Few industry commenters complained about the proposed rule requiring that consulting experts be impartial. Comment #76 (UNUM), Comment #92 (NFL), Comment #129 (AHIP). These muted objections are understandable, since it is hard to argue that disability claims administrators should be free to hire biased experts. The majority of those who object to this rule admitted that the proposed rule reflects the existing law. Comment #76, (UNUM), Comment #92 (NFL). The industry complaints seem to be based on the fear of increased litigation, particularly in the form of discovery. First, federal judges are well versed at limiting discovery in ERISA cases in proportion to the needs of the case. See e.g. *Paquin v. Prudential Ins. Co. of Am*. 2017 WL 3189550 (D. Colo. 7/10/2017); *Heartsill v. Ascension Alliance*, 2017 WL 2955008 (E.D. Mo. 7/11/2017; *Ashmore v. NFL Player Disability and Neurocognitive Benefit Plan*, 2017 WL

4342197 (S.D. Fla. 9/27/2017); *Baty v. Metropolitan Life Ins. Co.*, 2017 WL 4516825 (D. Kan. 10/10/2017); *Harding v. Hartford Life and Accident Ins. Co.*, 2017 WL 1316264 (N.D. Ill. 4/10/2017); *Hancock v. Aetna Life Ins. Co*., 321 F.R.D. 383 (W.D. Wash. 2017); *Kroll v. Kaiser Foundation Health Plan Long Term Disability Plan*, 2009 WL 3415678 (N.D. Cal. 10/22/2009).

Next, if the impartiality rule is already the law, it is not clear how more discovery would result from codifying it. Additionally, the credibility of experts who are opining on whether a claimant qualifies for benefits should be subject to *some* sort of scrutiny. If a claimant needs to conduct discovery into whether a physician hired by the administrator is well known to support denials, the cost of conducting this discovery cannot possibly outweigh the benefits. ERISA claimants are entitled to a process that does not have a predetermined outcome based on which reviewing physician is hired by the plan.

The Rule Requiring Disclosure of any Internal Limitations Period

Few industry commenters focused on the final rule requiring claims administrators to provide the claimant with the date when any internal time limit for filing suit will expire. I am assuming, therefore, that these objectors are not claiming that this rule has a cost impact. The claims administrators are in a position to satisfy this rule, since the expiration date of an internal limitations period is essentially a plan term that should be accessible to the plan administrator and not be hidden from unsuspecting plan participants. As with most of the final rules, information respecting the period of limitations is required to be disclosed in several jurisdictions, so it is unlikely to incur additional costs to create uniformity. *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).

The Rule Requiring Disclosure of Internal Guidelines

Few commenters objected to the proposed rule requiring claims administrator to disclose internal guidelines or certify that none exist. Comment #50 (DRI), Comments #76 (UNUM). These commenters complained that internal guidelines tend to be procedural rather than substantive, implying that the guidelines are irrelevant. As this lengthy rulemaking process has shown, procedure affects substantive outcomes. So even if internal guidelines are procedural, that is no reason to withhold those guidelines from claimants. The disclosure of claims manuals and internal guidelines, which often contain additional plan terms that are hidden from the ERISA participants, will ultimately cut down on litigation, since discovery of these documents is often disputed. *See Glista v. Unum Life Ins. Co. Of Am*., 378 F.3d 113, 123-125 (1st Cir. 2004); *Mullins v. AT&T Corp*., 290 Fed. Appx. 642, 646 (4th Cir. 2008).

Yours Truly,

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