From: David P. Martin
Sent: Wednesday, December 06, 2017 4:27 PM
To: EBSA, E-ORI - EBSA
Subject: 1210-AB39 -- Re-Examination of Claims Procedure Regulations for Plans Providing Disability Benefits

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:

This e-mailed letter is written in opposition to the Department's consideration of 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. I am the managing attorney, for a small law firm of three attorneys with a total of 13 employees. Our practice is focused on assisting individuals with employee benefit claims. Over 80% of the cases we handle involve long-term disability benefits under the Employee Retirement Income Security Act.

Accordingly, I am acutely aware of the significant unfairness suffered by many individuals with disability claims. Most of the cases we accept are handled on a contingency fee basis as these individuals are truly disabled and have been without benefits for some time. Most have not yet received Social Security disability. Nearly all have depleted savings and do not have the financial resources to hire counsel on an hourly fee basis. I firmly believe that the proposed regulations are step in the right direction to increase fairness for these people.

The Increased Costs Argument Misses the Mark

I am concerned that due process and general unfairness is being overlooked in favor of arguments opposing increased costs. Basic due process rights do not have a correlation to costs. *Michigan v. Environmental Protection Agency*, 135 S. Ct. 1699, 2711 (2015), An agency is not required to "conduct a formal cost-benefit analysis in which each advantage and disadvantage is assigned a monetary value."

Due process is required to be guaranteed under our laws. The changes to the regulation cannot be considered a massive overhaul, but rather adjustments to address due process and unfairness. A decade of litigation under the current 2006 amended regulation has fairly revealed the due process concerns and lack of fairness. There is a plethora of case law, and articles noting

the unfairness and lack of due process relating to disability benefit claims. This served as the basis of the current changes to the regulation. I will not rehash that here, but suffice it to say that there were significant and compelling reasons to issue the changes to the claim procedure regulation.

There has been no credible argument asserted that there is adequate due process guarantees and fairness under the old regulation. Rather the argument asserted is that costs will be increased. Thus a 5% to 8% increase in costs will cause many employers to cease providing long term disability coverage. That argument necessarily assumes at its core, that providing a long-term disability plan that rarely pays, is better than increased costs which will result in more claims being paid. I disagree. Provision of an illusory long-term disability policy benefit that rarely pays should not be tolerated. People should receive the benefit of the contractual arrangement relied upon. This argument about costs being increased misses the mark. That does not matter compared to fairness issues and the right to rely upon a fair claim process in vulnerable circumstances. Congress has enabled the Department to issue regulations to protect due process rights, and the Department should stand its ground and do so.

Increased Litigation is Not Likely

An increase in fairness will not result in increased litigation. I have practiced for over 25 years now, and my experience is that insurance companies and plan administrators typically press the limits of their contractual rights, meaning they do not perform above the minimum requirements. In fact one contributing reason why there has been a steady increase in litigation in the area of long-term disability claims is that insurers and plan administrators usually perform their obligations *below* the minimum requirements. I suspect that this is to increase profitability. It is no secret that "[a] finding that ERISA governs a benefits plan typically will impact a plaintiff's appeal of her insurer's denial of benefits in ways that will make that challenge more difficult." *See Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1131–32 (1st Cir.1995) and *Gross v. Sun Life Assur. Co. of Canada*, 734 F.3d 1, 5 (1st Cir. 2013).

Making the claim process more fair and reasonable logically will reduce litigation. More claims will be paid, if minimum standards require more fairness. The assumption that there is an abundance of frivolous claims being filed, and changes will increase that is without any factual support. In fee shifting litigation, there is a natural deterrence which largely precludes filing nuisance litigation.

Costs Will Not Increase

Notwithstanding that the cost argument is misplaced, I also firmly believe that costs will not increase, assuming an open and free market. Even if there was an increase, the amount of the increase in contention is not a deterrent. A small employer paying $500 per month for a disability benefit will not be discouraged from providing the benefit if the cost is increased $25 or $40. As the managing attorney in a small law firm, I am also responsible for providing benefits for employees. One of the benefits which we have provided for over 7 years is a long-term disability benefit. There has been an annual increase in the cost of this benefit for the last

six years under the old regulation. I tolerated such modest increases of 5 or 8% as a small business owner here for 6 years.

In April 2017 after the regulation in question was in place, our firm switched long term disability providers. We saw a significant *decrease* in cost. In fact, the cost was significant enough that we were able to add a vision plan to our benefit package, and we were still paying less than what we paid to the prior long-term disability carrier. My actual experience in this market is far different than being asserted. I'm very suspicious of the arguments made. In fact, to me it is very curious in fact that several insurers have joined together in making these arguments. That further raises suspicion for me, that there is a veiled threat here. The optics of these joint meetings is not favorable for the industry.

Similar cost arguments have ben asserted before. However, despite the arguments made that costs would increase in 2000, when prior changes were made effective, the Bureau of Labor Statistics data, https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm shows that access and participation in employer-based disability insurance has *increased* between 1999 and 2014. This BLS document demonstrates that the cost of disability insurance is modest. I have personal experience of this modest cost for group long-term disability insurance as well. A private disability plan which I have had in place for well over seven years costs over 5 times more, than the group long-term disability coverage that is also in place through our firm. I am again suspicious of data supplied by the insurance industry.

In the state of Alabama there has been no ban on discretionary clauses in group long-term disability plans. This is disappointing, as attorneys, including myself, have made the effort to urge the Department of Insurance to issue such a regulation. Unfortunately, often the head of the Department of Insurance in our state is typically an executive from the insurance industry. *e.g.* Jim Ridling is an executive from Fireman's Fund Insurance and Southern Guaranty. Naturally there is suspicion that there is inadequate effort to protect consumer rights, and that the head of this state agency is actually more interested in insurers "playing fair" with one another. Regardless of the motivation or tendencies here, it is a fact that there is no ban on discretionary clauses in our state. Given the citizens of my state have less protection then offered by other states, the role of the federal government is especially critical in providing fairness and addressing the due process concerns of consumers.

Concern over the increase in premiums causing a decrease in the participation of employers in providing long-term disability benefits for employees is also misplaced. There is data that participation by employers in providing disability plans has *increased* after the adoption of statutory bans on discretionary language clauses in disability policies in many states. The list 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). Again, notwithstanding these statutory developments, access and participation in disability plans increased according to the BLS data.

Interestingly some of the arguments about increased costs asserted include those who have been fined for market wide claim process violations. During the period covered by the BLS document, two major insurers with a significant market share, UNUM and CIGNA, were examined by states for poor claims handling and became subject to fines and Regulatory Settlement Agreements that raised the bar for their claims administration. http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2004/unum_multistate/unum_multistate.html; http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2009/pdf/cigna_mcreport_2009.pdf. https://www.insurance.ca.gov/0400-news/0100-press releases/2013/release044-13.cfm.

The cost argument is not factually based according to my own experience, past experiences in our nation and according to BLS statistics. Furthermore, the arguments asserted are infected by the profit motive of insurers. Accordingly, I urge the Department not to change the final rules in response to the industry's strained logic that the costliness of the final rules will impact access to disability benefits in the workplace.

The Benefits Outweigh the Costs

At the outset it is difficult to understand how a 5% to 8% increase in long-term disability premiums is better than providing what often amounts to an illusory benefit. A simple cost-benefit analysis reflects that this argument is completely without merit. The modest changes of the new regulation will not reverse the playing field. They will only guarantee an incremental increase in fairness. A recent case notes that after 10 years under the current regulation, "The insurance industry found it could largely immunize itself from suit due to the Employee Retirement Income Security Act …" *United States v. Aegerion Pharmaceuticals, Inc*., 2017 WL 5586728, at *7 (D. Mass. 11/20, 2017 ("ERISA").) The entire purpose for the change to the regulation is to make sure claims are fairly adjudicated and to prevent unnecessary hardship. It would be far better for individuals to pay more for long term disability insurance coverage that reliably provides a fair and full claim process, and thus may be relied upon to pay a benefit in the greatest time of need. No credible argument may be asserted that the old regulation is fair enough given the prior investigation and numerous court rulings.

Furthermore, the Department is not required to avoid all regulations that affect the market in some way. *Mkt. Synergy Grp. v. United States Dep't of Labor*, 2016 U.S. Dist. LEXIS 163663, 2016 WL 6948061 (D. Kan. 11/28/2016). In this instance the costs of the final rules, do not outweigh the benefit a providing a fairer claim process that better guarantees due process rights. Again, the cost arguments miss the mark. To further bear this out, I will discuss some of the specific changes and their impact.

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

This rule change merely requires disability plans to observe a fundamental due process principle - a well-articulated explanation as to why a claim is denied. A good example of this failure is the scenario played out when a claimant receives a disability benefit, and applies for

Social Security. Every group long-term disability plan that I have seen over 25 years has required the claimant to file for Social Security disability if there is any possibility of receiving the SSA benefit. Many go so far as to pay for representation to advance the claim before an administrative law judge. However, once Social Security pays the claim, the insurer then seeks to terminate the benefit without articulating how the claimant's condition suddenly improved and why the Social Security Administration decision finding disability as to any gainful occupation it is so easily disregarded. A good example of this occurred recently in the case, *Shultz v. Aetna Life Ins. Co.*, No. 1:16-CV-94-MHT-DAB, 2017 WL 4803806, at *5 (M.D. Ala. July 13, 2017), *report and recommendation adopted*, No. 1:16CV94-MHT, 2017 WL 5633259 (M.D. Ala. Nov. 22, 2017) whre the court noted "Aetna, by its own admission, determined that the prior occupation, from which Plaintiff was unquestionably disabled, was the direct equivalent of the "reasonable occupation" Aetna used to terminate those same LTD benefits."

As the Department well knows many court opinions have articulated the unfairness of a long-term disability insurer urging the Social Security Administration to find a claimant disabled while at the same time disaffirming that the claimant is disabled. This begs a clear explanation. Again, in *Shultz v. Aetna Life Ins. Co. at* *5 the court remarked "Though Aetna must reach its own separate decision, it is notable that the Social Security Administration uses a standard of inability to perform any substantial gainful activity. This is a much more stringent standard than the 'reasonable occupation' standard under the LTD policy."

It is doubtful that there are costs associated with the requirement of discussing the reasons for disagreeing with a favorable Social Security decision. The Department has correctly recognized this. The Bureau of Labor Statistics publication again provides:

> 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 Supreme Court has weighed in on this issue, holding that it is arbitrary and capricious for the claims administrator to advocate for Social Security benefits, reap the benefit of an offset via the Social Security award, and then ignore the SSA's determination. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008). Second many courts already require insurers to provide a discrete explanation why it is denying a long-term disability claim when the Social Security Administration awarded benefits. *Gellerman v. Jefferson Pilot Fin. Ins. Co., 376 F.Supp.2d 724, 735 (S.D.Tex.2005); Schully v. Cont'l Cas. Co., 634 F. Supp. 2d 663, 680 (E.D. La. 2009), aff'd, 380 F. App'x 437 (5th Cir. 2010); 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. C*o., 301 F. App'x 777, 776 (10th Cir. 2008). Logically, it should not increase costs to simply make this part of the claim procedure, however admittedly it may make it more difficult to deny deserving claims.

The Deemed Exhausted Rule is Not Costly

The insurers contend that with the change regarding deemed exhaustion, claimants will rush to court without first fully exhausting the claim process. This is a curious contention as it assumes that insurers are not capable of following very simple and basic rules regarding claims administration. I certainly hope that assumption is not valid, but it is not a ground to eradicate basic due process and fairness rights. Again, the changes are not significant to require more than a few minutes of training. Most insurers provide claim manuals which give step-by-step guidance to their employees. If an employee is not capable of following the claim manual, that is an internal matter that should be addressed. However, it does not justify unfairness to a claimant.

Furthermore, and as a practical matter most plaintiff's attorney must work on a contingent fee basis, since most claimants cannot afford to pay an attorney on an hourly fee basis. Therefore, it is against common sense and even illogical to undertake litigation that is not necessary and that will not result in resolving the case on the merits. Further, a court will only award attorney fees for litigation when there is some degree of success on the merits. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010). This is a two-edged sword since fees can be awarded to either party. There is risk to a claimant in incurring fees of the insurer if a suit lacking merit is filed.

The more likely result is that litigation will be reduced. Statistics show that under the old regulation, litigation gradually increased as insurers learned ways to circumvent the fairness requirements of the regulation. *United States v. Aegerion Pharmaceuticals, Inc*., 2017 WL 5586728, at *7 (D. Mass. 11/20, 2017). It is expected that the regulation will require insurers to be more careful with their claims process which is a desirable result. Thus, litigation will be reduced, and it will only be years later when litigation again begins to increase as insurers develop ways of circumventing the fairness requirements.

This rule is simply taking existing judicial decisions, and generating an across-the-board standard that applies equally to all states. That should have the effect of decreasing costs since insurers will not need to keep constant track on nuances of the law within various jurisdictions. With the changes there is a uniform standard which I seem to recall being one of the goals of ERISA. That would seem to allow claim processing to be much more uniform and thus make it easier to train employees and administer claims. See "deemed exhausted" or failure to conduct a fair review cases: *Halo v. Yale Health Plan*, 819 F.3d 42, 57-58 (2d Cir. 2016); *Otero v. Unum Ins. Co. of Am.*, 226 F. Supp. 2d 1242, 1264-1266 (N.D. Ala. 2017); *Brown v. J.B. Hunt Transp. Servs*., 586 F.3d 1079, 1085-86 (8th Cir. 2009); *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 change is very basic to due process rights. Those opposing the changes to the regulation on this ground would hardly contend that a judicial of proceeding was fair, where evidence was presented against them and they were not allowed to respond. Thus, claimants should also be permitted to respond to all evidence that serves as a basis of the claim decision. This rule takes a modest step in that direction.

The critical need for this rule is that courts have considered the claim process to be an administrative type process, thus reducing the time required for judicial review. In the 11th Circuit, where my firm is located, under the arbitrary and capricious standard of review, generally the evidence the court will consider those facts known to the plan administrator or claims administrator at the time the final decision was made. "[T]he function of the court is to determine whether there was a reasonable basis for the decision, based upon the facts as known to the administrator at the time the decision was made." *Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1139 (11th Cir. 1989). Thus, if new evidence is generated with the final appeal decision and the claimant is never allowed to see and comment on or present counter evidence, before that final decision. Therefore, there is no full and fair review.

In fact, the strategy savvy insurers follow is to "sandbag" the evidence until the final review. This strategy enables insurers to deny most claims. White v. Reliance Standard Life Ins. Co., No. 1:05-CV-2149-WSD, 2007 WL 187939, at *6 (N.D. Ga. Jan. 22, 2007) "Because "ERISA and its accompanying regulations essentially call for a meaningful dialogue between the plan administrators and their beneficiaries," "[p]lan procedures cannot be 'full and fair' without providing for this communication." [*Abram v. Cargill, Inc.*, 395 F.3d 882 (8th Cir.2005)] *Id.* at 886 (citing *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir.1998), for the proposition that ERISA claimants are "entitled to timely and specific explanation of benefit denials, and may not be 'sandbagged' by post-hoc justifications of plan decisions").

If the court is going to limit its review to the facts known and such facts were not *permitted* to be presented during the claim process, that is a denial of basic due process rights. The Department should not give this argument advanced by insurers any weight. There should be no further delay on this.

I have experienced firsthand this unfairness over the last 25 years. As insurers have adjusted to the old regulation, they found ways to defeat its purpose of requiring a full and fair review. Typically, this involves generating new evidence upon a final review and unreasonably extending the time frames during the course of an appeal determination to allow for that. For example, in a recent case the insurer largely ignored the reasons why the initial claim was denied and set about to develop new reasons during the final review. To do this, it arranged for a doctor, which was known to provide favorable opinions to insurers, to conduct an independent medical evaluation. However, this evaluation was to take place long after the time frame permitted for an appeal decision under the claim procedure regulation and the plan document. *Stevens v. Sun Life & Health Ins. Co. (U.S.),* No. 3:16-CV-76-WKW, 2017 WL 900005, at *13 (M.D. Ala. Mar. 7, 2017). The claimant is the one suffering without any benefit and usually without a Social Security benefits as well. There is no point to having a shorter time frame for an appeal review, if an insurer may merely re-create the initial claim decision and extend the time frame significantly.

What should occur is a straightforward process much like our litigation process. A claim determination with all evidence the insurer desires to utilize is made. Upon request all evidence is presented to the claimant, and the claimant comments on and counters with her own evidence. The entire matter is then reviewed by the insurance company on appeal. If the initial claim decision is wrong, then the decision should be reversed, the benefit paid, and the claim remanded back to the initial claim decision makers for further review. The rule does not simplify this process as far as it should in my view, but at least it takes it in the right direction.

The litigation process is a reasonable model to follow. It guarantees due process rights and affords each side an opportunity to be heard. Generating new evidence on an appeal is counter to that. The 11th Circuit Court of Appeals does not permit appellants to submit new evidence during an appeal. There are only special motions that permit that which are rare. The review conducted by the 11th Circuit is only of the record before the district court. This is the model to follow here with insurers. Too often however the insurer is more focused on determining how it may uphold the claim decision rather than simply looking at the evidence that existed at the time of the appeal. When new reasons for denying a claim are generated during a final review, what we have is an original claim decision being made all over again, but without a challenge. It is not fair or reasonable for insurers to use the claim process as an adversarial undertaking. The rule change is reasonable.

Other Provisions

The Impartiality Rule

There were only a few reluctant objections to this proposed rule asserted by insurers and plan administrators. Comment #76 (UNUM), Comment #92 (NFL), Comment #129 (AHIP). It is hard to credibly argue that disability claims administrators should be free to hire biased experts. The proposed rule reflects the existing law, which some candidly admit. Comment #76, (UNUM), Comment #92 (NFL). There is a veiled contention that this rule will result in increased litigation again. This is an illogical and disingenuous assertion given that the proposed rule reflects existing judicial standards and is nothing more than a mere clarification an across-the-board nationwide standard. It seems that this rule but again advanced the desire for ERISA standards to be uniform thus making it easier for insurers and plan administrators to administer claims.

The Rule Requiring Disclosure of any Internal Limitations Period

Few insurers and plan administrators commented on this, but this again is nothing more than making it clear to claimants when they must file a lawsuit. That could not conceivably increase costs, but could result in a few more individuals understanding their rights. The claims administrators are in an advantageous position to satisfy this rule, since the insurers legal department can make this determination and provide easy to follow direction in the claim manual for each employee. 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). As noted above uniformity is generally perceived to be desirable for insurers and certainly for courts.

The Rule Requiring Disclosure of Internal Guidelines

Any time a document impacts how a plan document is to be interpreted whether it relates to procedure or substance, a claimant should be entitled to receive that document. As this lengthy rulemaking process has shown, procedure affects substantive outcomes. The claim process is to be perceived as a quasi-type administrative process. Therefore, it should be less secretive and adversarial and more open and forthcoming. Otherwise why should deference be provided to an insurer's decision? 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). 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). Sincerely,

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