

From: Corinne Chandler [mailto:CChandler@kantorlaw.net]
Sent: Thursday, December 07, 2017 1:28 PM
To: EBSA, E-ORI - EBSA
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 understand that the Department is considering 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.

I write this letter to discourage any modifications of the Regulations which were approved to go into effect. I believe I have a unique perspective on the importance of these Regulations since I have spent over 35 years in legal practice representing both disability carriers and insureds. The new Regulations clarify and provide uniformity to two issues which frequently arise in ERISA litigation: (1) Administrators must meaningfully address a favorable Social Security Award and (2) Administrators must provide, upon request, a copy of their reports and files to their insureds.

The first issue requires carriers to discuss any basis for disagreement with a favorable Social Security decision. ERISA plans are typically structured so that the insurers take the benefit of any Social Security Award by reducing their own benefits by the amount of the Award. As a result, insurers require insureds to apply for Social Security benefits and frequently retain vendors such as Alsup or Advantage 2000 to represent the insureds in the Social Security Administrative proceedings. The insurers receive periodic reports from their vendors regarding the status of the Social Security proceedings. Since they work closely with their own vendors, insurers could easily obtain the medical evidence accumulated in the Social Security proceedings, including medical and vocational reports. If the insurer is required to consider the evidence relied upon by the Social Security administration, it may actually *decrease* costs incurred by carriers since they will not have to retain their own experts to conduct medical examinations.

In addition, in many jurisdictions, disability plans and insurers are *required* to discuss why they are denying a disability claim when the Social Security Administration awarded benefits under an obviously more strenuous standard. *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 favorable Social Security Award. *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.

The second issue involves the responsibility of an administrator to provide its insured with new evidence or rationale developed during the appeal review. 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, such as MetLife and Aetna, already provide for the right to review and respond. They do so on a voluntary basis, as their comments to the proposed rules showed. 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 FRCP 26(a)(1) disclosures. Thus, the industry's portrayal of the chaos that might ensue if they were required to 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 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. 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/her case in court.

I also 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. This is clearly not true, 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. 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.

Corinne Chandler
Kantor & Kantor
19839 Nordhoff St.
Northridge, CA 91324
cchandler@kantoralaw.net
(818) 886 2525