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Via U.S. First Class Mail and Electronic Mail (*e-ORI@dol.gov.*)
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: Claims Procedure Regulations for Plans Providing Disability Benefits Examination
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503-1

Dear Deputy Assistant Secretary Hauser:

I vehemently oppose any action by the Department to modify or further delay the final disability claim regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)), now scheduled to go into effect on April 1, 2018.

For more than 20 years, I have represented claimants in ERISA-governed disability benefit disputes. Many deserving claimants have difficulty navigating the claims process at a time when they are vulnerable, but rely on benefits to support themselves while they address the medical conditions that forced them to apply for benefits. I have seen dozens of claimants who have been denied needed benefits, merely because they have not mastered the technicalities and gamesmanship often encountered in the administration of disability benefit plans, particularly those underwritten and administered by insurance companies. I offer my comments from the perspective of plan participants.

The Final Regulation merely incorporates many of the practices that courts have imposed on insurers of employer-sponsored disability plans for many years. The Final Regulation will require those practices uniformly throughout the United States. For example, the Final Regulations (following the case law in many jurisdictions) requires insurers to discuss the reasons for disagreeing with a favorable decision by the Social Security Administration. Indeed, 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).

Another example are the rules requiring disclosure of internal guidelines and limitations periods, which again are embodied in case law in many jurisdictions. It is incomprehensible that a claims administrator should object to disclosing these hidden criteria.

If insurers and other administrators of disability plans followed the practices set forth in the Final Regulations, claimants would be better able to navigate the claims process and obtain fairer results without the need to hire lawyers to embark on litigation to obtain needed benefits to which they are entitled under ERISA disability plans.

Further, the supposed cost arguments are unsupported. To the contrary, information supplied by the Bureau of Labor Statistics, https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm, shows that access and participation in employer-based disability insurance has *increased*, not decreased, between 1999 and 2014, despite the 2000 disability claims regulations and a series of court decisions addressing conflicted decision-making, deemed exhaustion, the need to discuss and explain adverse benefits decisions, and the participants right to respond to new evidence. I am highly suspicious of industry arguments that employers would abandon disability coverage due to the costs of codifying these principles.

I am skeptical of any argument by the insurance industry that the implementation of the Final Regulation would dramatically increase premiums. Such arguments admit that premiums are now set with the expectation that legitimate claims will not be paid because the process is unfair and actually supports the need for a fairer claims process. ERISA participants would welcome a slight increase in premiums to avoid illusory coverage.

Speculative arguments regarding costs should not be a basis to modify the Final Regulation.

The regulations were adopted to implement ERISA §503, 29 U.S.C §1133, which requires every employee benefit plan to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a ***full and fair review*** by the appropriate named fiduciary of the decision denying the claim." The Final Regulation create uniform, nationwide standards for a full and fair review. There should be no modification to the "full and fair review" regulations, due to baseless cost arguments that have been considered and rejected by the Department.

Thank you considering my comments.

Very truly yours,

Tybe A. Brett

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