December 10, 2017

By Mail: 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

Deputy Assistant Secretary Hauser:

I am writing to strongly urge the Department to not alter or further postpone the implementation of the Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016) ("the final disability claims regulations" or "the final rules") that are now scheduled to go into effect on April 1, 2018.

For over fourteen years, I have represented claimants at all stages of the ERISA benefit claims process (application, the internal appeal process, and in litigation). The vast majority of my clients are seeking to overturn disability claim denials.

The professed concerns proffered by the industry are the same objections previously raised against the implementation of the final rules, which the Department has already considered and soundly rejected.

As addressed in my previous comments, I am extremely alarmed with the lack of transparency in this process and the fact private meetings between the industry and the Department appear to be the catalyst for this reexamination, without any input from representatives of participants. While it is unclear why this matter is being re-litigated, nevertheless, I will address the industry's objections that I feel are most in need of a response.

Costs Will Not Increase

The industry's assertion that implementation of the final rules will increase administrative costs, resulting in higher premiums and a reduction in employees' access to disability plans is entirely void of merit. It is important to consider the source of this argument. The industry is certainly not a disinterested, reliable advocate for participants. As the Department has already acknowledged, the disability claims industry has been needlessly adversarial toward ERISA plan participants. Even a cursory review of is the comments provided

www.dilawgroup.com

Nationwide
tf 888.644.2644

Broward *(Correspondences)*
3201 West Commercial Boulevard
Suite 227
Fort Lauderdale, Florida 33309
ofc 954.989.9000
fax 954.989.9999

Palm Beach
14255 U.S. Highway One,
Suite 235
Juno Beach, Florida 33408
ofc 561.202.9170
fax 561.202.9194

to the Department previously establish the truthfulness of this and the inequities faced by plan participants in the ERISA disability claims process.

The Department has requested data addressing whether costs increased as a result of the implementation of the 2000 claim regulations. This information is already available through the Bureau of Labor Statistics ("BLS") and establishes that not only did costs not increase, but employee access to disability plans actually rose. *See,* Bureau of Labor and 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. This increase occurred despite the implementation of the 2000 regulations and despite the fact that employment in the service industry has increased (an industry in which employees are least likely to have access to employer-based disability coverage). Moreover, this increase occurred despite a plethora of court decisions that continued to heighten the plans' obligations, including decisions discussing a plan participant's right to review and respond to new evidence, the necessity of an administrator to appropriately explain adverse benefit determinations, and cases addressing financially conflicted decision-making and when a claim is deemed exhausted.

The Department has also requested data addressing whether disability plan premiums increased as a result of the implementation of state statutory bans on discretionary clauses in disability policies. Again, the Department can rely on information from its own Bureau of Labor and Statistics. During the time period covered by the BLS publication, numerous states enacted discretionary clause bans, which 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 only not affected access or participation, but the BLS publication establishes that participation in employer-based disability plans actually increased.

There is no credible evidence to suggest that costs will increase as a result of the implementation of the final rules. In light of the credible evidence establishing the contrary, I would be very skeptical of any data supplied by the industry now that suggests that employers would forego disability coverage for their employees. The Department should not modify or further delay the implementation of the final rules in response to the industry's recycled cost argument. Nor should the industry's cost argument cause the Department to extend the effective date further.

The Benefits of the Final Rules Far Outweigh the Purported Costs

The ERISA litigation claims process 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").). ERISA disability participants who are denied their benefits face an arduous process that is far below the standard for regular civil disputes. There are no jury trials in ERISA claims; there is a closed record from the claims process that can rarely be supplemented in litigation; courts often apply the most stringent standard of review - arbitrary and capricious; and there are no remedies to hold administrators accountable and discourage unfair and self-serving behavior on the part of plan administrators (which are very often financially conflicted). Plan participants must still achieve the "higher-than-marketplace standards" in processing ERISA claims, even with the implementation of the final rules. *MetLife v. Glenn*, 554 U.S. 105, 115 (2008). Thus, the Department should take these "higher-than-marketplace" standards into account when considering the benefits of the final rules relative to the purported costs of implementation. But assuming that the final rules have some minor impact on cost, the costs simply will not outweigh the benefits. The Department has indicated that its purpose in this process is to make sure claims are fairly adjudicated and prevent participants from facing unnecessary financial and emotional hardship. The industry's request that the Department abandon these important goals should be denied.

If the enhanced protections of the final rule actually resulted in the premium increases suggested (which is unsupported and disputed by credible evidence), it would certainly be an acceptable price to pay for true coverage. Again, the comments previously submitted to the Department illustrate the inequities that ERISA participants face in the claims process. Paying lower premiums for illusory coverage does not protect participants. Plan participates typically only discover the inequities of the ERISA claims process when their disability claims have been unfairly denied, at which point it is too late to purchase private individual insurance. I can attest to the fact that disability insurance attorneys very often must turn down representation of meritorious ERISA disability cases because the record is closed or the claimant was unaware of a contractual limitations period that has passed. To the extent that the increased protections of the final rules bring an administrator's claims handling process in line with the reasonable expectations of participants, the minimal costs (if any) are outweighed by the benefits.

Requiring the Plan to Explain the Basis for Disagreement with Social Security Decisions or Other Contrary Opinions will Not Increase Costs.

This rule simply requires disability plans to clearly articulate an explanation for an adverse benefit determination so that claimants have a fair opportunity to address it. This fundamental due process principal is entrenched in ERISA and already required by the 2000 regulations.

The Department has already acknowledged that addressing the reasons for disagreeing with a favorable Social Security decision will not likely increase administrative costs. Typically, plan benefits are merely a supplement to Social Security Disability benefits ("SSDI"). Most disability plans require claimants to apply for benefits through the Social Security Administration ("SSA") and often plans will provide representation for claimants towards this

goal. This is because plan terms usually provided that plan benefits are offset by SSA benefits. Insurers are well aware of the SSA process. For example, in order to determine whether claimants qualify for SSDI representation, claims staff must know the applicable criteria. Importantly, many insurers' claims manuals address the SSDI standards. Likewise, both the Unum and Cigna Regulatory Settlement Agreements required the insurers to give great weight to SSA awards.

Also, such a rule would not increase costs or place a higher burden on the government. The BLS publication 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.

It is important to note that courts in many jurisdictions already specifically 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. C*o., 301 F. App'x 777, 776 (10th Cir. 2008). Moreover, the Supreme Court of the United States has found that it is arbitrary and capricious for claims administrators to encourage or require claimants to seek Social Security benefits, benefit from SSA awards by offsetting SSA benefits, and then ignore the SSA's determinations. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008).

Many of the industry's own comments to the Department acknowledged that requiring an explanation of the reasons for disagreeing with the Social Security decision and other contrary evidence is in line with the existing standard. Thus, this rule would not increase costs. Instead, codification of this already existing requirement will increase uniformity in the process and thus, likely decrease costs.

The Deemed Exhausted Rule is Not Costly

The Industry appears to argue that the cost of administering disability claims will increase because the final deemed exhausted rule would purportedly result in plaintiffs and their attorneys racing into court and increasing the volume of ERISA litigation. This argument is entirely void of merit. Similar to the majority of the other final rules, this rule is primarily a codification of existing judge-made law. Claimants are already able to file a lawsuit 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). Accordingly, it is

unlikely that additional costs will result from the implementation of this rule. *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).

Further, there is no incentive for plaintiffs and their attorneys to prematurely file ERISA lawsuits. Courts will only award attorney fees for ERISA 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). Accordingly, there is no motivation to utilize the final deemed denied rule and file a lawsuit except in the most extreme cases. In most circumstances, such a case will be remanded to the administrator with instructions to timely and appropriately evaluate the merits of the claim. It simply does not make sense for plaintiffs or their attorneys to initiate litigation that is not necessary and that will not result in resolving the case on the merits.

Providing the Right to Review and Respond to New Evidence or Rationale From the Plan <u>During the Appeal Will Not Increase Costs.</u>

This rule has its foundation in basic fairness. It prevents administrators from sandbagging participants with new evidence or rationales, at a time that participants have no ability to respond. Such a rule is essential to a full and fair review. In litigation, ERISA cases are typically limited to the record assembled during the internal claims process. As such basic fairness dictates that participants be permitted to address all evidence and adverse benefit rationales before the record closes. Without such a rule, plan administrators (which are very often financially conflicted) are incentivized to stonewall participants during the internal process and ambush them by inserting new evidence or new rationales for an adverse benefit determination just before the record closes. Essentially, plans are able to stack the deck or create a largely one-sided record. Not allowing participants the ability to address all evidence and denial rationales proffered by plan administrators is particularly prejudicial given the fact that in many ERISA litigation cases, participants have the burden of proof under the extremely stringent arbitrary and capricious standard of review.

The Department has already acknowledged the importance of this rule. The industry's assertion that providing the claimant with new evidence or rationales before making a final decision is costly is unsupported and dubious for several reasons.

First, as the Department has already acknowledged, this rule simply codifies the standard in some jurisdictions. Likewise, several disability plans or insurers already provide for the right to review and respond to new evidence and rationales. Further, courts already require plans to do this in many cases. Accordingly, in many circumstances administrators are already following this rule. Second, participants and their attorneys have no incentive to needlessly drag out the process. They are motivated to respond to new evidence or rationales only when absolutely necessary to their claims. If participants are able to respond to all evidence and rationales

during the administrative process, ERISA litigation will likely decrease and in turn so will the cost of administering disability claims. Finally, whether plans provide this information to the claimant during the ERISA appeal process, they will have to provide it eventually. New reasons or evidence will need to be included in the claim file and likely again in 26(a)(1) disclosures.

Again, without this rule, the claims administrator's new evidence or rationale will be included in the record that the court reviews, but the participant's rebuttal will not. This allows and indeed incentivizes plan administrators to strategically withhold information during the administrative process and sandbag participants with that information at a time that they are prohibited from ever challenging it, rendering a reversal of the adverse benefit determination even more elusive during the administrative process or in court. The industry's objection to not being able to stack the record is neither surprising nor new.

The industry's claim that a second appeal (which some plans provide) serves the same purpose as the right to respond to new evidence or rationales before a final decision, is patently incorrect. A second appeal allows claims administrators the same sandbagging opportunity as the first appeal and not all plans permit second appeals.

The Impartiality Rule

While there were only a few industry comments objecting to the rule requiring that consulting experts be impartial, it is important to address this rule and the objections. The industry complaints appear to suggest that litigation costs would rise, alleging that discovery in ERISA litigation would increase. However, the majority of those who object to this rule also admitted that the proposed rule reflects the existing law. Thus, it is unclear why litigation costs would increase simply by codifying what is already required. Moreover, federal judges limit 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).

Additionally, the importance of ensuring that the experts relied on by administrators to render claim determinations be impartial cannot be outweighed by an unsupported claim that the costs of administering disability claims will increase. ERISA claimants are entitled to a truly full and fair review and thus, the credibility of experts who are opining on whether a claimant qualifies for benefits should be subject to some degree of scrutiny.

The Rule Requiring Disclosure of any Internal Limitations Period

Since the expiration date of an internal limitations period is a plan term, this information

is easily accessible to plan administrators and thus, this rule can be implemented with no additional cost to or burden on administrators. Again, many jurisdictions already require plans to disclose the limitations period, so it is unlikely to increase administrative costs. *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

There were a few industry comments objecting to the proposed rule requiring claims administrator to disclose internal guidelines or certify that none exist. Many of these comments suggested that these documents are immaterial, alleging that internal guidelines tend to be procedural rather than substantive. However, a plan's claim procedures certainly affect the substantive outcome of claims. This rule will actually reduce litigation costs, as currently the disclosure of claims manuals and internal guidelines in discovery is often disputed in ERISA litigation cases. *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).

Thank you considering my comments,

/s/ Alicia Paulino-Grisham
Alicia Paulino-Grisham, Esquire