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December 11, 2017

VIA U.S. MAIL & ELECTRONIC MAIL TO: 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: Re-Examination of Claims Procedure for Plans Providing Disability Benefits
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503-1

Dear Deputy Assistant Secretary Hauser,

Our law firm commented on the proposed regulations for amending the claims procedure regulations applicable to disability plans by our letter dated and submitted on January 19, 2016. We wrote again on October 25, 2017 to request that the Department of Labor ("the Department") not delay the effective date of the final ERISA claims regulations that were adopted on December 19, 2016 and were set to take effect on January 1, 2018. We felt then and still feel now that the protection of workers who become disabled is an important and worthy concern. As such, we write now to discourage the Department from modifying or further delaying these final disability claims regulations that are now scheduled to go into effect on April 1, 2018.

Our practice is primarily focused upon the representation of individuals in ERISA-governed benefit disputes, including in large part, disability benefits. Collectively, we have more than fifty years of experience practicing law and over forty years of experience handling these very claims, during which time we have represented hundreds, perhaps thousands of claimants, possibly more than any other firm in North Carolina. As such, we feel that we are particularly well-suited to inform on the practical realities that disability benefit claimants face in the system as it is presently established and the vast number of claimants that will be deprived of a full and fair review should the Department further delay the final disability claims regulations. Indeed, every day, week, and month that the

Department further delays implementing the Final Rule causes the number of claimants who are deprived of minimum basic requirements to grow larger.

We firmly believe that the regulations should not be modified or further delayed. The process that was undertaken by the Department in 2016 fully complied with the Administrative Procedures Act ("APA") and all other applicable rules and regulations. Importantly, the Department finalized rules requiring plans, plan fiduciaries, and insurance providers to comply with certain minimum requirements when dealing with disability benefit claimants only after an extensive notice and comment period that provided sixty days and yielded numerous comments from nearly one hundred stakeholders, including insurance companies, ERISA plans, and their advocates and the organizations that represent them. The "new" objections and concerns now raised by these very stakeholders are purely re-argument of the merits of the final rules.

Put simply, the final rules are based on policy choices that have been made by Congress, by this Department, and by the federal courts interpreting ERISA, and, as such, another argument about the merits is redundant and unnecessary. Nevertheless, we will address the objections that have been raised that we feel are most in need of a response:

Costs & Access to Benefits:

The industry claims that these new requirements will impair workers' access to disability benefits by driving up costs. These assertions are false.

While this costs argument is and always has been highly speculative and rarely supported by any relevant data, the argument was formerly made and duly considered during the notice and comment period. After the comment period ended, the Department spent nearly a year considering all of the properly submitted comments. It was only after this thorough review, during which time it considered this very argument that the Department concluded that costs would not outweigh the benefits. Even if the Department had already not engaged in this exceptionally lengthy review, an agency is not required to "conduct a formal cost-benefit analysis in which each advantage and disadvantage is assigned a monetary value." *Michigan v. Environmental Protection Agency*, 135 S. Ct. 1699, 2711 (2015).

Despite the fact that it is clear the industry now seeks a second bite at the apple, the Department has nevertheless asked for data addressing whether costs increased in response to the last set of rules applying to ERISA disability plans, which became effective in 2002. Not surprisingly, data supplied by the Bureau of Labor Statistics shows that access and participation in employer-based disability insurance has *increased*, not decreased, between 1999 and 2014. *See*

https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm. This increase occurred despite that employment in the service industry has increased, an industry in which employees are the least likely to have access to employer-based disability coverage. This increase also occurred 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. As such, any data supplied by the industry to the contrary merits heightened skepticism. Moreover, the Bureau of Labor Statistics also demonstrates that the cost of disability insurance is extremely modest. As such, if costs did increase, the increase would be so small that it is unlikely to have any real impact.

The Department has also asked for data about whether disability premiums increased in response to the adoption of statutory bans on discretionary language clauses in disability policies by some states. The Bureau of Labor Statistics can once again supply this data. Indeed, during the time period in which the Bureau of Labor conducted the study, many states enacted discretionary clause bans, including, but not limited to: Arkansas (Arkansas Admin. Code 054.00.101-4 (2013)); California (Cal. Ins. Code §10110.6 (2012)); Colorado (Colo. Rev. Stat. §16-3-1116 (2008)); Illinois (50 Ill. Admin. Codes 2001.3 (2005)); Maryland (Md. Code ann. Ins. §12-211); Michigan (Mich. Admin. Codes. R. 500.2201-2202 (2007)); Rhode Island (R.I. Gen. Law §§ 27-18-79); Texas (Tex. Admin. Code §3.1202-1203; Tex. Ins. Code §1701.062, §1701.002 (2011)); and Washington (WAC §284-96-012 (2009)). Notwithstanding these statutory developments, access and participation in disability plans *increased* according to the data.

As such, any assertion that the new requirements will impair workers' access to benefits by driving up costs is wholly unfounded. Accordingly, we urge the Department not to change the final rules in response to the industry's attempt to re-hash an already rejected and unsupported argument.

Weighing Benefits & Costs:

The industry has also asserted that the costs will outweigh the benefits of the new requirements. Once again, this claim is baseless.

Notably, nothing in the Final Rule creates or requires a massive overhaul to the regulatory environment already in place governing these claims. Indeed, the industry has long been required to make certain disclosures and otherwise administer the claim process in accordance with ERISA's regulations. The new regulation changes do not alter the underlying process of how benefit claims are administered or what is already required of the industry, and as such, the supposed cost increase seems to be wildly speculative. Comparatively, however,

the benefits provided to claimants by the Final Rule is crystal clear. Indeed, the new requirements are a step in the right direction of ensuring that disabled individuals – many of whom cannot even manage their own activities of daily living – receive the full and fair review of their claims, as envisioned by ERISA.

The odds are already desperately stacked against disability claimants, where the right to a jury trial has been stripped away, punitive standards are imposed without exception, evidence and records are controlled entirely by one side, most discovery is limited, and decision-makers with conflicts of interest nevertheless receive judicial deference to their decisions to deny lawfully and contractually-owed benefits. The industry, who already has most of the cards stacked in its favor, had a full notice and comment period to raise its concerns.

Even assuming *arguendo* that premiums could increase slightly, to the extent that they are increased to avoid illusory coverage and provide disability claimants with even a modicum of due process, ERISA participants would likely welcome this and it would present no additional burden to public programs. In other words, if the difference in premiums is the difference between paying something for nothing and paying something for something, the argument surrounding the increase rings entirely hollow. Moreover, 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. Nov. 28, 2016).

Should the Final Rule go into effect as presently drafted, plan participants will still 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 this "higher-than-marketplace" expectation into account and acknowledge that ERISA exists to protect plan participants – not the wallets of insurers, which grow wider with each passing hour.

Costs Associated with Explaining Basis for Disagreement:

The industry has also asserted that costs associated with explaining the basis for disagreeing with any disability determination by the Social Security Administration ("SSA") or other contrary decision are significant. This argument rings hollow – particularly because many of these requirements already apply under current law pursuant to the 2000 regulations and judicial authority. *See, e.g., Montour v. Hartford Life & Acc. Ins Co.*, 588 F.3d 623, 635-37 (9th Cir. 2009); *Bennett v. Kemper Nat. Services Inc.*, 514 F.3d 547, 553-54 (6th Cir. 2008); *Brown v. Hartford Life Ins. Co.*, 301 F. App'x 777, 776 (10th Cir. 2008).

Indeed, the Final Rule simply reinforces the need to comply with claims procedures in a transparent way and to encourage an appropriate dialogue between a claimant and the plan regarding adverse benefit determinations. In other words, the 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.

As the Department has already articulated, it is exceedingly 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. In our experience, the vast majority of disability policies effectively require all claimants to apply for Social Security benefits; if a claimant fails to do so, the insurer can reduce the claimant's benefits under the policy. If the claimant does receive Social Security benefits, then such benefits will be offset from the LTD benefit. As it is that insurers stand to financially benefit from the government's determination that a claimant is disabled, they should also have to give appropriate weight to that determination and articulate the basis for disagreeing with the determination.

A review of litigation trends demonstrates that many plans have failed to comply with the claims procedure requirements related to disclosure requirements under ERISA as it is currently written. A rule clarifying that plans must include the basis for disagreeing with any disability determination by the SSA will likely decrease litigation related to this issue and increase uniformity and predictability in the process, all of which is associated with cost savings, not increases.

Costs Associated with Deemed Exhaustion of Claims & Appeals:

Next, the industry has made the illusory argument that disabled claimants will race to court as soon as possible, increasing the overall volume of ERISA litigation and therefore the costs of administering disability claims. In actuality, however, the insurers are likely taking issue with the fact that the Final Rule imposes repercussions should plans not adhere to all claims processing rules.

Indeed, the Final Rule demonstrates that the DOL has adopted a stricter than a mere "substantial compliance" requirement that the industry has sometimes gotten away with. No longer. Moreover, as with most of the other final rules, this requirement serves as a codification of existing judge-made law in an increasing number of courts. *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); *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).

Even assuming *arguendo* that the industry's concern truly is that this rule will result in increased ERISA litigation, such a concern is unfounded. Indeed, claimants' attorneys are ever mindful of building an administrative 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 potentially resolving the dispute prior to litigation and creating a reviewable record should litigation eventually be necessary. Further, if litigation does become necessary, a court will only award attorney fees for 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's claims ignore the realities of litigation and how any "incentives" are aligned to discourage litigation.

Finally, the industry's concern in this regard suggests that the industry believes that plans will continue to frequently violate the claims processing rules. Indeed, a claim or appeal is "deemed denied" - such that the claimant may immediately pursue the claim in court – only if the plan does not adhere to all claims processing rules. In other words, the volume of ERISA litigation will increase only if plans continue to violate the rules. The industry's continued insistence on depriving disability claimants of due process is the very reason that claimants need the protection of the deemed denied rule.

Costs Associated with the Right to Review & Respond to New Information:

The industry has claimed that providing the claimant with new evidence or rationales before making a final decision is costly. The industry's claim in this regard 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 showed. Second, courts require plans or insurers to do this in many cases. Third, 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 supply these documents is not credible. If the issue is the cost of mailing, such a *de minimis* cost should not be permitted

to interfere with a fundamental due process right.

Without this rule, claimants are deprived of a full and fair review, as currently required by the ERISA claims and appeals procedures, when claimants are prohibited from responding at the administrative stage to new information in their claim. 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 be. Without this rule, claims administrators are encouraged to strategically withhold information that would help the claimant achieve reversal or win his/her case in court. In other words, without this rule, claims administrators are encouraged to sandbag the disabled. There can be no question that this rule is absolutely necessary to protect claimants from this type of behavior and ensure that claimants are permitted to respond to a claims administrator's assertions in a way that will make the response a part of the record.

The industry has suggested that a second administrative appeal, which is offered under some – but not all – plans, serves the same purpose as the right to review and respond to any new information developed by the plan. This is clearly not true, as a second administrative appeal permits claims administrators with the very same opportunity to sandbag the claimant as the first appeal. Additionally, second administrative appeals are not universal and are not required. The second administrative appeal that the industry touts as a solution to the Department's concern are a matter of plan design and can be changed at any time by plan sponsors. Thus, this "solution" is only another example of the industry's attempt to maintain complete and unfettered control over livelihood of disabled individuals, many of whom do not have the ability (whether physically, mentally, or financially) to contest these underhanded practices.

Put simply, 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. None of the industry's comments have (or can) demonstrated why the due process rights of claimants should be further marginalized.

Other Provisions:

1. *The Impartiality Rule*

Few industry commenters took issue with the portion of the Final Rule that provides that the disability claims and appeals procedures must be adjudicated in a manner to ensure independence and impartiality of all persons involved in making such decisions, and, as such, all consulting experts must be impartial. *See* Comment #76 (UNUM), Comment #92 (NFL), Comment #129

(AHIP). The minimal number of objections in this regard are understandable, since it is difficult to dispute 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. *See* 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). Second, if the impartiality rule is already the law, it is not clear how more discovery would result from codifying it. Third, the credibility of experts who are opining on whether a claimant qualifies for benefits should be subject to 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.

In short, this rule addresses a serious problem in the ERISA disability claims process and should remain as currently drafted.

2. The Rule Requiring Disclosure of Internal Limitations Periods

Few industry commenters took issue with the new requirement that claims administrators provide claimants with the date when any internal time limit for filing suit will expire. It is fair to assume, then, that objectors are not claiming that this rule has a cost impact. Either way, claims administrators are in a position to easily 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 regarding the period of limitations is already required to be disclosed in several jurisdictions, so it is unlikely to incur additional costs to create uniformity. *See, e.g., 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).

3. The Rule Requiring Disclosure of Internal Guidelines

Few industry commenters took issue with the portion of the Final Rule that requires claims administrator to disclose internal guidelines or certify that none exist. *See* Comment #50 (DRI), Comment #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 impacts substantive outcomes. Therefore, even if internal guidelines are procedural, that is not a valid basis to withhold 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 reduce 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).

In conclusion, the regulatory improvements provided by the Department's Final Rule are desperately needed to protect disabled workers. There are no compelling legal or equitable justifications to further postpone these necessary basic disclosure and due process regulatory rules. We therefore ask that the Department refrain from modifying or further delaying the final disability claims regulations.

We thank you for the opportunity to comment. If you have any questions, please do not hesitate to contact us at (704)377-4300.

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