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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 am writing to discourage the Department from modifying or further delaying the final disability claims regulations that are now scheduled to go into effect on April 1, 2018. I am a disability attorney in Indianapolis and my entire practice consists of representing claimants who are seeking disability benefits under an employer sponsor disability benefit plans.

Costs Will Not Increase

There has been no evidence provided by the insurance industry to establish that the costs will increase due to the new regulations. This costs argument was made in various industry comments to the proposed rules before final adoption. The Department concluded that costs would not outweigh the benefits. The current cry of increasing costs is an argument that has already been considered and rejected. 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).

Further, the new regulations encourage the parties to engage in a full exchange of information before proceeding to court. Obviously, eliminating litigation expense would reduce the costs of employee benefit plans and therefore the insurance industry's argument that the costs would increase is without merit.

The Benefits Outweigh the Costs

ERISA was passed originally by Congress to protect employee benefit plan and to ensure transparency in the administration of employer sponsored benefit plans. Whatever the costs of the final rules, they would outweigh the benefits. The Department has already articulated its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The new regulations further this goal.

ERISA disability claimants who are denied their benefits face a process that is far below the standard for regular civil disputes. These procedural hurdles include: (1) there are no jury trials; (2) there is a closed record from the claims process that can rarely be supplemented in litigation; (3) courts often apply an unfavorable standard of review, and (4) there are no remedies to discourage unfair and self-serving behavior on the part of plans. This will never be a level playing field much less one

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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").) Even with the final rules in place, plan participants will 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.

The Department has already acknowledged that the disability claims industry has been adversarial toward ERISA disability plan participants and has received many comments to that effect. The insurance industry's argument that the final rules are bad for participants – despite all evidence to the contrary - cannot be taken seriously. If there are costs associated with the final regulations, these costs could and should be tolerated in the name of supplying a modicum of protection for plan participants, as this is the responsibility given the DOL by Congress.

Providing the Right to Review and Respond to New Evidence or Rationale From the Insurance Company During the Appeal Review is Not Costly and Provides a Full and Fair Review of Benefit Denials.

This important rule rightfully gives the claimant the opportunity to respond to an insurance company's generated evidence 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. Too many times, I have reviewed claim files where the insurance company generated several medical record reviews at the end of the claim then denied the claim without giving the claimant, or their physician, an opportunity to respond to the record reviews.

There is no question in my mind, after years of experience representing ERISA claimants, that the ability to sandbag the claimant with a new medical opinion that he/she cannot refute, or a new plan provision to rely upon that he/she cannot counter, is a favorite tactic of the disability claims industry. Time and time again, I have received record reviewing reports after the denial of the appeal which do not comport with the medical evidence and are contrary to the statements of the treating physicians and my client was never given the opportunity to respond to the report. Several times, I have had treating physicians become furious at how their statements are misconstrued, taken out of context, or completely fabricated in order to justify the denial of a disability claim. The final rule needs to be kept in place to prevent this conduct on the part of insurance companies and allow claimants to respond to record reviewing physician reports before a final determination is made on their claim.

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Sincerely,

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