December 11, 2017

***Submitted via*: e-ORI@dol.gov**

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Re: Claims Procedure for Plans Providing Disability Benefits
Re-Examination [RIN 1210-AB39]

Ladies and Gentlemen:

AARP[1] appreciates the opportunity to comment on the Department of Labor's (the Department or DOL) proposed regulation re-examining the final claims procedure for plans providing disability benefits. On behalf of our millions of members, we have a strong interest in ensuring that participants and beneficiaries receive the benefits to which they are entitled. In order to do so, participants must be able to successfully access and resolve benefits disputes through ERISA's claims procedures.[2] Without meaningful access, participants

[1] AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families with a focus on health security, financial stability and personal fulfillment.

[2] Ensuring that participants have full and fair review in accordance with Section 503 of ERISA is crucial as EBSA does not have the resources to protect disability plan participants from improper denials of claims. *Cf.* U.S. Dep't of Labor, OIG, *EBSA Did Not Have The Ability To Protect The. Estimated 79 Million Participants In Self-Insured Health Plans From Improper Claims Denials* (Rpt. No. 05-17-001-12-121, Nov.18, 2016) (similar to health plans, we assume that EBSA lacks primary knowledge of denials of employer-sponsored disability claims).

cannot adequately protect their claims to benefits, which may spell the difference between independence and impoverishment in their old age.[3]

For the reasons below, AARP submits that the Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016), should not be modified. Moreover, the Department should not grant any additional delay of the final disability claim process regulation's applicability date.

The Right To Review And Respond To New Information Before A Final Decision Does Not Significantly Increase Costs Or Burdens.

The final regulation confirms that the participant has the right to review and respond to new information before the plan makes its final decision. This requirement is a fundamental due process right without which no claimant can receive a full and fair review within the meaning of Section 503 of ERISA.

Industry stakeholders complain that this requirement will lead to a protracted claims process that will result in unnecessary costs for plans. But these stakeholders know that, in a benefits denial claim with a deferential standard of review, courts generally do not allow participants to present evidence to the court that was not presented to the administrator; the administrative record generally is considered closed.[4] Under the industry's view, a claimant has no right to respond to new information. This cannot meet Section 503's requirement of a full and fair review of a benefits claim denial.

Moreover, if a court finds that the plan should have permitted the claimant to respond to the new information, the court will remand the claim to the plan administrator, leading to an even more costly (particularly for the claimant) and protracted claims process. To state the obvious, the plan can easily take care of

---

[3] We know that, as workers age, disability rates increase. *Persons With A Disability: Labor Force Characteristics – 2016*, 2 (June 21, 2017), goo.gl/t6X6BW. For example, with $832 as the median weekly earning of a fulltime worker, see *U. S. Dep't of Labor, Labor Force Statistics from the Current Population Survey: Table 37*, Bureau of Labor Statistics (last modified Feb. 8, 2017), goo.gl/MK6AgD, and a replacement percentage of sixty percent, see America's Health Ins. Plans (AHIP), *An Employer's Guide to Disability Income Insurance* 9 (2007), goo.gl/E5mvCy, a disability claimant would receive the modest amount of approximately $499 per week.

[4] *E.g*., *Mitchell v. Eastman Kodak Co*., 113 F.3d 433 (3d Cir. 1997).

this issue by providing the claimant with all of the reasons for its denial when it initially denies the claim. If this is done, there will be no additional cost to either party.

The Requirement Of Deemed Exhaustion Of Claims And Appeal Processes Does Not Increase Costs Or Burdens.

Another provision of the final claims procedure regulation that the industry contends will increase costs and burdens is the deemed exhaustion of claims and appeals process.

Although the decision in *Amato v. Bernard*, 618 F.2d 559 (9th Cir. 1980), recognized that a participant or beneficiary may not bring an action in court for a denial of a claim without first exhausting the plan's internal claims procedure -- including an exhaustion requirement for denied claims[5] -- the Department of Labor and the courts have also established exceptions to this requirement. Exceptions include futility,[6] a lack of meaningful access to the plan's review procedures,[7] irreparable harm,[8] and other circumstances where requiring exhaustion would be unfair to the claimant.[9] Courts have permitted plaintiffs to proceed directly to court, finding a claim is deemed denied for failure to follow

[5] Every circuit court has recognized this exhaustion requirement.

[6] *E.g., Fallick v. Nationwide Mut. Ins. Co*., 162 F.3d 410,418, 421 & n.4 (6th Cir. 1998) (collecting cases) (holding because insurer has proven itself unwilling to alter its methodology for determining reasonable and customary limitations, exhaustion is futile).

[7] *E.g*., *Brown v. J.B. Hunt Transp. Servs*., 586 F.3d 1079, 1085-86 (8th Cir. 2009) (holding that failure to respond to request for documents excused claims from exhaustion requirement because there was no full and fair review).

[8] *E.g., Turner v. Fallon Community Health Plan*, 127 F.3d 196 (1st Cir. 1997) (failure to exhaust is forgiven for an imminent threat to life or health).

[9] *E.g., Hall v. National Gypsum Co.*, 105 F.3d 225, 231-32 (5th Cir. 1997) (various factors including ever-changing story of why benefits could not be paid and plan's failure to follow the appropriate procedures).

applicable time limits[10] or where other regulatory requirements have not been met.[11]

The Department's position is consistent with the courts' holdings[12] as well as its stated position in amicus briefs.[13] The final regulation simply codifies these positions. The final regulation provides participants, plans and insurers with an explanation of the prerequisites that are necessary in order for a court to find that the insurer has complied with the claims regulation and has provided a full and fair review to the participant's denied claim. The regulation provides national uniformity that insurers and plans crave.

Under the guise of allegations of increased cost and administrative burden, industry stakeholders are really asking the Department to reverse its position and reject established jurisprudence. Contrary to the allegations of industry stakeholders, Plaintiff's counsel have no incentive to rush into court if the plan has provided full and fair review. Moreover, inasmuch as most plaintiff's counsel tend to litigate in the same court, the judges will determine pretty quickly if counsel is abusing the regulation and can order sanctions under Rule 11, which can include monetary sanctions.

The Final Regulation Clarifies Provisions of The 2000 Regulation That Should Lead To More National Uniformity In The Claims Process And Less Litigation.

The final regulation clarifies the 2000 claims regulation in at least three ways. First, ensuring that the claims decision-makers are independent and impartial should lead to less litigation over conflicts of interest and, relatedly,

---

[10] *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. Emple. 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).

[11] *E.g., Halo v. Yale Health Plan*, 819 F.3d 42 (2d Cir. 2016) (holding substantial compliance is inconsistent with the 2000 DOL claims regulation).

[12] *See* nn. 5-10, *supra*.

[13] Brief Amicus Curiae of Acting Secretary of Labor in *Halo v. Yale Health Plan*, goo.gl/uPJ4vj.

discovery; this should lower litigation costs.[14] Second, clarifying that the plan must distinguish its claims denial from a Social Security grant of a disability benefit if the participant has provided such information to the plan not only makes sense for a full and fair review, but is consistent with court jurisprudence.[15] Finally, the 2000 regulation required that the plan provide the claimant a notice that the entire claims file, internal guidelines and other protocols were available upon request where a benefits denial was appealed.[16] The final regulation now requires such a notice upon the initial claims denial. This may reduce administrative burdens because claimants may not appeal the denial if they better understand the plan's position and rationale.

The Requirement To Provide Culturally and Linguistically Appropriate Notices Does Not Increase Costs Or Burdens.

"The final rule requires plan fiduciaries to provide disability benefit claimants with the requisite level and amount of assistance necessary to assist the claimants in understanding their rights and obligations so that they can effectively file claims and appeals in pursuing a claim for disability benefits." 81 Fed. Reg. at 92329.

Employers are more likely to offer group disability insurance to those individuals working in management, professional and related occupations and, to a lesser extent, to those individuals working in sales and office occupations. Priyanka Anand & David Wittenburg, *An analysis of private long-term disability insurance access, cost, and trends,* MONTHLY LABOR REVIEW 6 (U.S. Bureau of Labor Statistics, Mar. 2017), goo.gl/4m2wF8. Employers are less likely to offer group disability insurance to workers in service, natural resources, construction and maintenance, and production, transportation and material moving. *Id*.

---

[14] *E.g., Melech v. Life Ins. Co. of N. Am*., 857 F. Supp. 2d 1281, 1284-85 (S.D. Ala. 2012) (ordering production of information used to evaluate claims handlers).

[15] *E.g., Harrison v. Wells Fargo Bank, N.A*., 773 F.3d 15 (4th Cir. 2014) (chastising administrator cannot decline to undertake nominal efforts to obtain readily available information); *Melech v. Life Ins. Co. of N. Am*., 739 F.3d 663, 674-75 (11th Cir. 2014) (finding inappropriate for the plan administrator to ignore Social Security record where plan required claimant to apply for Social Security benefits).

[16] *E.g., Glista v. UNUM Life Ins. Co. of Am*., 378 F.3d 113 (1st 2004) (internal guidelines and training materials are relevant in reviewing plan's denial).

Foreign-born workers are more likely than native-born workers to be employed in service occupations, production, transportation, and material moving occupations and in natural resources, construction and maintenance occupations. Economic News Release, *Foreign-born Workers: Labor Force Characteristics Summary* (U.S. Bureau of Labor Statistics, May 18, 2017), goo.gl/LxJgkp. Foreign-born workers are less likely than native-born workers to be employed in management, professional and related occupations. *Id.*

While these statistics are not a perfect equivalent to the American Community Survey data, it is clear that there will be a small percentage who speak a language other than English as their first language, and who will have group disability insurance coverage. Thus, the additional cost, if any, to employers, plans, insurers and other stakeholders to provide culturally and linguistically appropriate notices should be minimal.

Any Information Provided To The Department To Support Allegations Of Significant Increased Costs Due To The Requirements Of The Final Regulation Must Consist Of More Than Conjecture Or Opinion.

AARP appreciates the Department's pledge to provide adequate time for review of any information provided to the Department to support industry stakeholder's allegations of significant increased costs due to the final regulation's requirements. According to the confidential survey that the Department has admitted that it does not have in its possession,[17] industry stakeholders claim that the final disability regulation will raise premium costs 5 to 8%.[18]

[17] Oct. 31, 2017, email from Jeffrey Turner to David Certner (on file with AARP).

[18] An agency commits serious procedural error when it fails to reveal portions of the technical basis for a proposed rule in time to allow for meaningful commentary. *See Owner-Operator Indep. Drivers Ass'n v. Fed. Motor Carrier Safety Admin*., 494 F.3d 188, 199 (D.C. Cir. 2007); *Chamber of Commerce v. SEC*, 443 F.3d at 899; *Solite Corp. v. EPA*, 952 F.2d at 484; *see also Air Transp. Ass'n of Am. v. FAA*, 169 F.3d 1, 7 (D.C. Cir. 1999) ("'[T]he most critical factual material that is used to support the agency's position on review must have been made public in the proceeding and exposed to refutation.'"].The Department still has not explained why this particular "confidential" survey is trustworthy or reliable.

The Department should be cautious when evaluating the credibility of the data provided by the insurance industry. Researchers look at various criteria to determine the validity of a survey. Such criteria include the following:

- whether a credentialed, reputable, independent company that generally administers such surveys performed the survey;

- whether the survey is representative (*e.g*., sample size, by types of disability claims, geography);

- whether the questions are validly constructed (*e.g*., no leading questions, clear, unbiased). Predictive questions should be followed up with a question asking for the underlying rationale for the response;

- whether the methodology is transparent such as explaining assumption and not cherry picking data points;

- what is the response rate (*e.g.*, number of insurers who were asked for data vs. number who provided data) as well as any differences between those who responded and those who did not *(e.g.,* were the respondents primarily insurers who specialize in covering certain types of industries); and

- if there are other reputable data sources that provide similar data, then the survey findings should be compared to those other data sources in order to see how much they differ.

Finally, AARP detailed in our October 26, 2017, letter on the proposed delay our experience with industry stakeholders' surveys on changes to disability claims processes and potential increased costs. See copy of October 26, 2017, letter attached. Accordingly, we are skeptical of the industry stakeholders' estimates of increased costs.

The Department Should Not Grant Any Additional Delay Of The Final Regulation's Applicability Date.

The regulation delaying the applicability date of the final disability regulation clearly stated that the Department was not inclined to provide additional time to industry stakeholders to submit the information concerning significant cost increases. We note that although the delay was proposed in the

Federal Register on October 12, 2017, industry stakeholders knew that they would have an opportunity to provide additional information in August 2017, if not earlier.[19] The Department should not provide any additional delay.

Conclusion

AARP appreciates this opportunity to state that it opposes any modifications of the final disability claims regulation. If you have any questions, please feel free to contact Michele Varnhagen of our Government Affairs office at 202-434-3829.

Sincerely,

David Certner
Legislative Counsel and
Legislative Policy Director
Government Affairs

[19] *See* Aug. 3, 2017 e-mail from Howard Bard at ACLI to Joe Canary & Jeffrey Turner, EBSA ("confirming that ACLI would be comfortable with the Department's inclusion of language in a rulemaking proposal stating that stakeholders have committed to work with EBSA to obtain data); *see also* Other Letters on File with EBSA, goo.gl/uT5H5T (indicating discussions with the Department over necessary information began as early as March 2017).