From: Alan H. Casper [mailto:acasper@alanhcasperesq.com]
Sent: Thursday, December 07, 2017 4:59 PM
To: EBSA, E-ORI - EBSA
Cc: Alan Casper
Subject: 1210-AB39

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

Dear Deputy Assistant Secretary Hauser:

I write to exhort the Department to resist strenuously all insurance industry efforts to convince the Department to modify or to delay further the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) that are now scheduled to go into effect on April 1, 2018.

Before presenting my comments in detail, I wish to provide you with a summary of my background, as well as my involvement with ERISA and ERISA Welfare Benefits claims, especially Disability Benefit claims. I am a solo practitioner with an office in Philadelphia, Pennsylvania. I received by JD *cum laude* from American University's Washington College of Law in 1986. I am admitted to both the Pennsylvania and New Jersey Bars, the Third Circuit Court of Appeals, the Eastern, Middle and Western District Courts of Pennsylvania and the District of New Jersey.

I first began actively litigating ERISA Pension and Welfare Benefits cases in 1989 while an associate attorney for a law firm in Philadelphia. From 1992 when I went out on my own until 2014, I represented the Insured with regard to a variety of insurance policies: property, disability, life and health insurance – both private and ERISA plans. Since 2014, I continue to represent the Insured exclusively in ERISA disability, life and health insurance claims and in Non-ERISA disability insurance and bad faith claims. I have been selected as a SuperLawyer in Pennsylvania in the areas of Employee Benefits and Insurance Coverage since 2009.

I have obtained numerous significant decisions in both ERISA and Non-ERISA Disability claim cases. *See, e.g., Novick v. Metropolitan Life Ins. Co.,* 764 F. Supp.2d 653 (S.D.N.Y. 2011)(holding that the ERISA Regulations require an insurer to notify a claimant of any contractual limitations or suit deadlines in the adverse decision letter), *cited with approval by Moyer v. Metropolitan Life Ins. Co,* 762 F.3d 503 (6th Cir. 2014); *Zaloga v. Provident Life and Accident Ins. Co.,* 671 F. Supp.2d 623 (M.D. Pa. 2009)(recognizing the existence in Pennsylvania of a common law cause of action for breach of the implied covenant of good faith and fair dealing entitling the insured to compensatory damages, including emotional distress damages); *Saldi v. Paul Revere Life Ins. Co.,* 224 F.R.D. 169 (E.D. Pa. 2004)(still one of the most comprehensive bad faith discovery rulings nationwide).

I greatly appreciate this opportunity to comment upon the Department's re-examination of the costs of the final regulations governing disability claims. Unfortunately, the concerns raised by the insurance industry are not new. Rather, their objections seek simply to reargue the merits of the final regulations. Inasmuch as those regulations are based upon policy choices previously made by Congress, by this Department, and by the federal courts interpreting ERISA, further argument about the merits should be unnecessary.

Nevertheless, I will address the objections that have been raised that I consider most in need of a response.

<u>The Claim That Costs Will Increase Is Without Merit</u>

The insurance industry claims that if the final regulations go into effect there will be an increase in costs that will increase premiums resulting in less access to disability benefits. Such assertions at this point in time in the Administrative process are suspect and deserve close and demanding scrutiny.

This very same costs argument was made in various industry comments to the proposed regulations before final adoption. The Department has already considered these arguments and concluded that the costs would not outweigh the benefits. The insurance industry's reiterated complaint of increasing costs is therefore 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).

Nonetheless, the Department has asked for data addressing whether costs increased in response to the last set of regulations applying to ERISA disability plans that became effective in 2002. In fact, the Department can rely upon information supplied by its own Bureau of Labor Statistics (https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm). The data shows that access and participation in employer-based disability insurance has ***<u>increased</u>***, not decreased, between 1999 and 2014. The increase occurred despite the fact that employment in the service industry – an industry in which employees are least likely to have access to employer-based disability coverage – increased dramatically. This increase in participation in employer-based disability insurance also occurred despite the 2000 Disability Claims Regulations and the issuance of 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.

The Department should therefore view with suspicion any new data supplied by insurance industry that now suggests employers would abandon disability coverage due to the costs of codifying these principles. This BLS document also demonstrates that the cost of disability insurance is extremely modest. Thus, even if costs did increase, the limited increase would be so insignificant as to make any difference in employers' decisions to provide ERISA benefits.

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. Notably, during the time period of the BLS study, many states enacted discretionary clause bans. This 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). Notwithstanding these statutory developments, access and participation in disability plans increased according to the BLS data.

Also, during the period covered by the BLS document, two major insurers with significant market share, UNUM and CIGNA, were examined by the states for poor claims handling and became subject to fines and Regulatory Settlement Agreements that raised the bar for their claims administration. *See* the following:

- http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2004/unum_multistate/unum_multistate.html;
- http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2009/pdf/cigna_mcreport_2009.pdf.
- https://www.insurance.ca.gov/0400-news/0100-press releases/2013/release044-13.cfm.

Nonetheless, during this same time period access and participation increased.

Given this history, any claim that costs will increase in response to the modest changes in the final regulations is specious. The Department should therefore refrain from changing in any way the final regulations in response to insurance industry's unsupported "premium cost increase" argument.

The Benefits Of The Regulations Outweigh Any Potential Claims Handling Costs

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. 11/28/2016). Furthermore, the insurance industry has yet to establish that any potential consequential costs to their individual benefit claims handling practices will outweigh the substantial benefits of the final regulations toward reducing the burden placed upon plan participants seeking to vindicate their rights through an appeal and litigation regime that is already so slanted in favor of the plan administrators.

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 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 regulations 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 regulations 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 needlessly adversarial toward ERISA disability plan participants and has received many comments to that effect. The industry's argument that the final regulations are bad for participants – despite all evidence to the contrary - cannot be taken seriously. The industry is not a credible advocate for plan participants.

Furthermore, from the perspective of plan participants, an inexpensive but illusory disability plan is worse than no plan at all. It is important to note that when disability claimants are unfairly denied benefits that they thought were promised through an employer's plan, it is too late to go out and purchase private individual insurance to cover the risk of becoming destitute. Disabled claimants are often shocked when they are told about ERISA's procedural hurdles. So, to the extent that increased protections bring disability claims administration in line with the reasonable expectations of the employee-participants, the costs are outweighed by the benefits. If there are potential claims handling costs associated with the final regulations, such costs should be viewed as the necessary price for insuring a greater degree of fairness to plan participants.

Providing The Plan Participant The Right During The Appeal To Respond To A Plan’s New Evidence Or Newly Asserted Rationale Will Increase Fairness

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. The insurance industry complains that providing the claimant with new evidence or rationales before making a final decision is costly. The industry’s claim to cost impact 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. Last, 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 concern should not be permitted to interfere with such basic a due process right.

It is important to note what this rule does. It permits a claimant to respond to a disability claims administrator’s assertions in a way that will make the response a part of the record if claimants have to go to court to vindicate their rights. This is a critical consideration because most ERISA cases are decided on a closed record. Without this rule, the claims administrator’s new evidence or, more frequently, new denial rationale will be included in the record that the court reviews, but the claimant’s rebuttal will not. Perhaps what the industry is really worried about is losing its current right to “sand bag” claimants’ appeals and “to move the goal posts” in order to make a claimant’s success through litigation more difficult to achieve.

Such “sand bagging” activity occurs on a regular basis. One need only review carefully, for an apt illustration, Judge Eaton’s findings regarding Metropolitan Life’s conduct in my *Novick* case

mentioned above. *See Novick v. Metropolitan Life Ins. Co.,* 914 F. Supp. 2d 507 (S.D.N.Y. 2012). Ms. Novick was lucky to have a judge willing to review her claim in a careful and searching manner. In my experience, too many claimants are not so fortunate; the industry is too frequently successful in "moving the goal posts." The final rule needs to be kept in place to prevent this behavior from stamping out otherwise meritorious disability claims.

I also dispute the industry's comments to the effect that a second appeal, which is offered with some plans, serves the same purpose as the right to respond to new evidence or rationales before a final decision. This is clearly not true, as a second appeal permits the claims administrators the same sandbagging opportunity as the first appeal. Again, see *Novick v. Metropolitan Life Ins. Co.,* 914 F. Supp. 2d 507 (S.D.N.Y. 2012) for an apt illustration. Second appeals are not necessarily a boon to plan participants. Additionally, second appeals are not universal and are not required. The second appeals that the industry touts are a matter of plan design and can be changed at any time by plan sponsors. It may be that second appeals will become obsolete where the claimant has a true right to respond.

Requiring the Plan to Discuss the Basis for Disagreement with Social Security Decisions or <u>Other Contrary Opinions is Not Costly.</u>

This 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. The 2000 Regulations require no less.

As the Department has already noted, it is 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. Most disability plans require claimants to apply for the SSA benefit, and the plans usually provide representation for claimants before the SSA. This is done so that the plan may take advantage of the plan term that the SSDI benefit will offset the LTD benefit. Indeed, in many cases the ERISA disability benefit is *de minimis* or non-existent once this offset is taken. In order to decide which claimants qualify for this representation, plan claims handlers need to know the standard that the SSA uses. Comment #114, p.8 (ACLI). Disability claims administrators' operational manuals devote many pages to deciding whether the claimant is disabled enough to be referred to counsel for representation before the Social Security Administration, and how to offset or recover the benefits once they are successful, and how to express all of this to the claimant

To the extent that the industry argues that increasing the cost of disability insurance will burden the government, and more specifically the SSA, the Bureau of Labor Statistics publication speaks to this:

> 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.

Additionally, the disability plans and insurers are required in many jurisdictions to discuss why they are denying a disability claim when the Social Security Administration awarded benefits under an obviously more strenuous standard*. See, e.g., 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). 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). As the industry comments often acknowledged, requiring an explanation of the reasons for disagreeing with the Social Security decision and other contrary evidence tracks the existing standard. Logically, it should not increase costs to simply codify this standard.

A rule clarifying that an explanation of the basis for disagreeing with a Social Security decision is a requirement that will increase uniformity and predictability in the process, which is generally associated with costs savings and not cost increases.

The Impartiality Rule

Few industry commenters complained about the proposed rule requiring that consulting experts be impartial. Comment #76 (UNUM), Comment #92 (NFL), Comment #129 (AHIP). These muted objections are understandable, since it is hard to argue 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. 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).

If the impartiality rule is already the law, it is not clear how more discovery would result from codifying it. Additionally, the credibility of experts who are opining on whether a claimant qualifies for benefits should be subject to some sort of 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. This final rule addresses a serious problem in the ERISA disability claims process and should remain.

The Rule Requiring Disclosure of any Internal Limitations Period

Few industry commenters focused on the final rule requiring claims administrators to provide the claimant with the date when any internal time limit for filing suit will expire. I am assuming, therefore, that these objectors are not claiming now that this rule has a cost impact. The claims administrators are in a position to 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 noted above, I had to litigate this issue in my *Novick* case at increased cost and delay to my client's interests. *See, e.g., Novick v. Metropolitan Life Ins. Co.,* 764 F. Supp.2d 653 (S.D.N.Y. 2011)(holding that the ERISA Regulations require an insurer to notify a claimant of any contractual limitations or suit deadlines in the adverse decision letter), *cited with approval by Moyer v. Metropolitan Life Ins. Co,* 762 F.3d 503 (6th Cir. 2014). So far, only three Circuit Courts have affirmatively adopted this critically important requirement. *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). This rule needs to be applied in all the Circuits.

Alan H. Casper

Alan H. Casper, Esquire
1845 Walnut Street – Suite 1500
Philadelphia, PA 19103
(215) 546-1124
(215) 981-0600 (fax)
acasper@alanhcasperesq.com
www.alanhcasperesq.com