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LICENSED IN TEXAS AND CALIFORNIA

December 7, 2017

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:

"To delay justice is injustice."

- William Penn

I write once again to discourage the Department from further delaying the final disability claims regulations that are now scheduled to go into effect on April 1, 2018.

As I have previously written, I am a lawyer who has focused on litigation involving claims governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. ("ERISA") since 2005. ERISA claims currently make up about 70% of my practice. They include claims on accidental death and dismemberment insurance policies, health insurance policies, and disability insurance policies. Each of these policies was issued by one of the major insurance carriers selling ERISA governed policies. In order to stay current with the evolving nature of ERISA common law, I subscribe to a subscription service and review new opinions on a weekly basis.

The concerns raised by the insurance industry are not new, nor are they genuine. Instead, they are an effort to delay implementation of regulations that simply reiterate what courts around the country have ruled in the ERISA context. Another argument about the merits of those rules is unnecessary. The insurance industry has already lost on these issues, and it is not entitled to another bite at the apple.

As before, the insurance industry raises tired but familiar objections. I will respond to each in turn.

Costs Will Not Increase

The industry claims if the final rules go into effect, there will be an increase in costs that will increase premiums, resulting in less access to disability benefits. These assertions are false.

This argument was made in various industry comments to the proposed rules before final adoption. The Department concluded that costs would not outweigh the benefits. 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 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 *increased*, not decreased, between 1999 and 2014. This increase 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. Any evidence provided by the insurance industry that suggests employers would abandon disability coverage due to the costs of codifying these principles is suspect, at best.

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. During the time period of the study, many states enacted discretionary clause bans, including, but 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). Despite these new statutes, access and participation in disability plans actually increased.

Also, during the period covered by the study, two major insurers, UNUM and CIGNA, were examined by the states for poor claims handling and were fined and forced to enter Regulatory Settlement Agreements to improve shoddy claims administration. 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. Still, access and participation increased.

The evidence shows that costs will not increase in response to the modest changes in the final rules. The Department should not change the final rules in response to the insurance industry's strained logic that the costliness of the final rules will impact access

to disability benefits in the workplace.

Benefits Outweigh Any Potential 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). Going further, there is no clear evidence that any theoretical costs of the final rules would outweigh the benefits. The Department has already noted the purpose of the rules is to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The Department should ignore the industry's invitation to abandon these purposes. These benefits cannot be outweighed by costs where the ERISA process is already so slanted in favor of the plan administrators.

ERISA disability claimants who are denied their benefits face a process ridiculously below the standard for regular civil disputes. Such 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 may never be a level playing field. *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 needlessly adversarial toward ERISA disability plan participants and has received many comments to that effect. The industry's argument that the final rules are bad for participants cannot be taken seriously and is downright laughable. The insurance industry only cares about its own profits, not its fiduciary duties to plan participants.

Furthermore, an inexpensive but illusory disability plan is worse than no plan at all. When a disability claimant is unfairly denied benefits, 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 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.

The Deemed Exhausted Rule is Not Costly

The industry's concern about this rule seems to be that plaintiffs and their attorneys will race into court, increasing the volume of ERISA litigation and hence the overall costs of administering disability claims. This is incorrect. Plaintiff's attorneys are careful to build a record on which the court will make its decision and would usually rather engage in the appeal process and exhaust internal remedies. This serves the dual purpose of possibly resolving the dispute and creating a record for the court to review if the dispute cannot be resolved internally. Under the final rule, the plaintiff will mostly obtain a remand with instructions for the plan to do its job. Because plaintiff's attorneys usually work on a contingent fee basis, it does not make sense to undertake litigation that is not absolutely necessary and that will not result in resolving the case on the merits.

Further, a court will only award attorney fees for 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). This standard leaves plenty of discretion to the judge, who often chooses not to award fees to the successful plaintiff. The insurance industry comments are out of step with litigation in the real world and how the incentives are aligned to discourage litigation. While this rule may appear to create additional trips to court, it will not do so except in the most extreme cases.

Additionally, this rule is just a codification of existing law. Claimants can already get into court when the claims process has failed them in a meaningful way. *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). It is not likely that additional costs will result from this regulation. *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); *Jebian v. Hewlett-Packard Co. Employee. Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003).

If you have any questions or wish to discuss these issues in more detail, do not hesitate to contact me.

Very truly yours,

BERG PLUMMER JOHNSON & RAVAL

By: ______________________________
Amar Raval

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