

December 7, 2017

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:

The Massachusetts Employment Lawyers Association (“MELA”) requests that the Secretary refrain from modifying or further delaying the implementation of 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.

I am the ERISA chair of MELA. MELA is a not-for-profit organization comprised of attorneys who devote a majority of their practice to representing employees, rather than employers. We have approximately 175 members. Our mission is to enforce and to advance employee rights. We do this by working to increase awareness, improve advocacy, monitor legislation and support members in their practices.

I offer these comments on behalf of MELA, as I focus my practice in representing individuals in ERISA matters. I have been a lawyer for approximately 30-years. I began concentrating in ERISA in the early 1990s and since that time have devoted more and more of my time exclusively to ERISA work. Currently, more than 80% of my time is spent on ERISA matters; the majority relating to long-term-disability claims. This focus is consistent with the litigation statistics noted by the Secretary and the Federal Judicial Center. Therefore, my comments are tuned to this area.

In addition to my volunteer work at MELA, I have served in other bar capacities focusing on ERISA, or ERISA related areas of the law. I have served as Chair of the Health and Disability Committee under the Torts Trial and Insurance Practices section of the American Bar Association; Chair of the Insurance Section with the American Association for Justice; Chair of the ERISA litigation group with the American Association for Justice; and I am a Senior Editor to *Employee Benefits Law*, Bloomberg/BNA, which is the leading treatise on employee benefits. I am also a Fellow of the American College of Employee Benefits Counsel.

Again, MELA applauds the Secretary of Labor (“DOL”) for the department’s efforts to bring the current claims regulations up to date. As ERISA affects more than 150 million Americans, the regulations demanded updating.

ERISA is a very challenging area of law. For a law that was enacted to protect the rights of individuals, the law has developed through the Courts in the opposite manner. This is evident by the lack of attorneys that practice in this area representing individuals.

When Congress enacted ERISA, it created a strict fiduciary standard for those individuals and entities involved in the administration or management of employee benefit plans or their assets, a standard that requires those persons or entities to make decisions solely in the interests of the plan’s participants and their beneficiaries. Over time this has not panned out. ERISA is concurrently a shield for those actors, insulating them from unfair conduct, and a sword.

Given the importance of pre-suit exhaustion under ERISA, the Secretary’s claim regulations are essential to provide clarity to both employees and plans. Also, considering that Congress did not impose parallel substantive standards on health care plans, long-term-disability plans or other welfare benefit plans as it did for the pension side of ERISA, claims regulations fill an important void left by Congress.

As you have heard from others representing individuals, the ERISA regime is stacked against participants. Recently the United States District Court for the District of Massachusetts summed up this point. *United States v. Aegerion Pharmaceuticals, Inc.*, 2017 WL 5586728, at *7 (D. Mass., November 20, 2017)(“The insurance industry found it could largely immunize itself from suit due to the Employee Retirement Income Security Act .”) Even with the final rules that should go into effect after the New Year, 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). Worthy claimants continually lose the benefits that they paid for and deserve to be paid.

A. Interest Groups' Claim Of Increased Costs Is Refuted By Impartial Data.

The interest groups (primarily insurance companies and their spokespeople) advocating delay had plenty of time during the comment period to bring to the attention of DOL the concerns that they have now raised after finalization of the regulations. These groups claim that costs will rise too much, and the availability of employee benefits will go away.

We located information from the Bureau of Labor Statistics that shows the availability of employer offered long-term-disability insurance (LTD Coverage) has increased since the late 1990s through 2014. (See <https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>.) Given the tightening labor market evidenced by decreasing unemployment, employers will need to offer LTD Coverage to attract and retain employees. In addition, some of the stocks of publicly traded insurance companies offering LTD Coverage (Unum, AETNA and others) have been rising in value over the past few years. Bottom-line, the interest groups' claims of spiraling cost are not backed by credible data.

In addition, we are unaware of any evidence suggesting that state imposed discretionary bans have increased the cost of LTD Coverage. If that allegation were true, I would presume the interest groups would have shared the proof with DOL. This does not appear to be so, given that I made a FOIA request to DOL a few months ago on that point, and was not provided with any information backing this allegation. Moreover, in reviewing information posted by the Society of Actuaries, we were unable to find data supporting such an allegation of the insurance companies.

B. Requiring ERISA Fiduciaries To Explain Why They Disagree with SSA Findings Is Supported By A Mandate From the Supreme Court.

The Supreme Court was troubled 10-years ago when an insurer demanded that an insured apply for benefits with the Social Security Administration ("SSA") representing that she could not engage in any gainful employment, but when it came time to adjudicating her claim under a less demanding long-term-disability plan, the insurance company contended that she that she was not disabled. *MetLife v. Glenn*, 554 U.S. 105, 115 (2008). The DOL regulation merely codifies this directive from the Supreme Court to consider the SSA decision. Following *Glenn* many Circuit Courts focused on this point, most notably the Ninth Circuit in *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). A rule requiring that fiduciaries who disagree with an SSA decision to distinguish a decision is not one to increase costs. Therefore, it seems wholly speculative that addressing an SSA decision will impact premiums.

C. Codifying *Abram v. Cargill*, 395 F.3d 882 (8th Cir. 2005) Is Not Costly.

“Sandbagging” plan beneficiaries is a documented problem perpetrated by fiduciaries during the pre-suit appeals process. Relying on newly developed substantive evidence during the pre-suit appeal is a common fiduciary abuse that undermines “Full and Fair” review. In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), the court articulated the problem as follows:

[w]ithout knowing what “inconsistencies” the Plan was attempting to resolve or having access to the report the Plan relied on, Abram could not meaningfully participate in the appeals process. . . This type of “gamesmanship” is inconsistent with full and fair review.

Id.

Given that in some jurisdictions it is virtually impossible to supplement the record in litigation, the regulatory change offers some assurance that the pre-suit appeal process will not be rigged against the plan beneficiary. Fiduciaries should not be permitted to use new substantive evidence to avoid paying a claim without permitting the plan beneficiary to respond to the evidence. Again, ERISA is about notice and procedure. A fair process is undermined if the fiduciary can withhold evidence until the last minute knowing that the plan beneficiary cannot respond. “We have invoked our equitable and common law powers to prevent a plan from taking actions, even in good faith, which have the effect of ‘sandbagging’ claimants *Bard v. Boston Shipping Ass'n*, 471 F.3d 229, 244 (1st Cir. 2006). The guess-work of weighing the equities and creating certainty is achieved in codifying *Abram* by regulation. Courts will not need to wrestle with whether the later developed evidence by the plan was substantive, known in advance, reasonably known in advance, or otherwise undermined Full and Fair Review.

Considering that judicial review addresses the final ERISA administrative decision, the method of reaching the final decision must be fair. The Courts’ fixation with pre-suit finality speaks for the need to codify *Abram*. “It would offend interests in finality and exhaustion of administrative procedures required by ERISA to shift the focus from that decision to a moving target by presenting extra-administrative record evidence going to the substance of the decision.” *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 519 (1st Cir. 2005).

The interest groups had their chance to explain how this might raise costs, and did not do so. It is hard to fathom how providing a modicum of fairness in the process will make benefits too expensive.

D. Requiring Impartiality of Consultants Is Required Under ERISA.

We note that one commenter, the Unum Group (Comment 76) raised a soft objection to codifying impartiality. ERISA already demands impartiality. As the Court noted in *United States v. Aegerion Pharmaceuticals, Inc.*, through ERISA, insurers have effectively insulated conduct that would otherwise get them in hot-water. John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101. Nw. U. L. Rev. 1315 (Spring 2007)).

E. Deemed Exhaustion Will Not Increase Costs.

The allegation that deemed exhaustion will increase costs is speculative. DOL should not take this claim seriously unless the interest groups provide data to back their contention. Claimants are unlikely to rush to court on day 46 or day 91 if a decision has not been made. Smart counsel will realize that this is not productive given the judicial creation of “substantial compliance” with time-lines.

If DOL needs additional information, then kindly contact the undersigned at jonathan@erisaattorneys.com or 617-357-9700.

Thank you for your consideration.

Sincerely,

/s/ Jonathan M. Feigenbaum
Chair – MELA ERISA Committee