

December 8, 2017

VIA E-MAIL (e-ORI@dol.gov) ONLY

U.S. Department of Labor
DOL Regulations Department
200 Constitution Ave. NW
Washington DC 20210

Re: RIN 1210-AB39

To Whom It May Concern:

I have represented hundreds of disability claimants in internal appeals and litigation in both ERISA (the vast majority) and non-ERISA claims. I previously commented on the then proposed Claim Procedure Regulations, and the proposal to delay their implementation. I read many of the numerous comments submitted by representatives of the insurance industry. I also read the Final Rule, adopted on December 19, 2016.

Substantively, the new - - actually old - - concerns of the insurance industry representatives are invalid. They claim that implementing the new regulations will cost the insurance industry more money. They have made similar claims before and the Department of Labor found that those claims to be without merit. What the insurance industry is really saying, in my opinion, is that the additional transparency of the new regulations will make it much more difficult for claims personnel to deny valid claims and therefore, instead of denying valid claims for improper reasons, the insurance industry will have to grant those claims - - which will cost it more money. One of the purposes of the Final Rule is to encourage transparency and honesty. If transparency and honesty result in more valid claims being paid instead of valid claims being denied, that's a good thing.

ERISA is intended to be a system which accurately and fairly processes claims with minimal litigation and administrative expenses. But the process only works when plan administrators follow the plan, honor their fiduciary and regulatory duties, are honest and fair in processing claims, and make decisions grounded in the facts. Essential to the ERISA administrative adjudicative process is the fiduciary's duty of loyalty to claimants and its obligation to provide full and fair claims investigations and appeals consistent with regulatory standards. Basically, a fiduciary must tell the claimant what he/she needs to present to perfect his/her claim, do so at a time when he/she can present such evidence, and fairly consider the evidence presented. One of the underlying purposes of the Final Rule is to implement these fiduciary obligations.

A threshold issue presented in every ERISA disability benefits claim is the requirement that the administrator reasonably interpret and apply the provisions of the plan. ERISA plans are construed according to federal common law and the plan is reviewed as a whole giving terms

their plain meanings. *Fay v. Oxford Health Plan*, 287 F. 3d 96, 104 (2d Cir. 2002). A claim under §1132(a)(1)(B), "in essence is the assertion of a contractual right." *Feifer v. Prudential Insurance Company of America*, 306 F. 3d 1202, 1210 (2d Cir. 2002). ERISA's written instrument requirement, set forth in 29 U.S.C. §1102(a)(1), essentially operates as a strong integration clause, statutorily inserted in every plan document. *Feifer, supra*, at 1210. Administrators may not override this inclusive integration clause with a reference to terms that do not exist in written form. *Id.* at 1210-1211.

Administrators also may not "rewrite, under the guise of interpretation, a term of the contract when the term is clear and unambiguous." *Burke v. Pricewaterhouse Coopers LLP LTD Plan*, 572 F.3d 76, 81 (2d Cir. 2009). "[W]here the administrator imposes a standard not required by the plan's provisions, or interprets the plan in a manner inconsistent with its plain words, its actions may well be found to be arbitrary and capricious." *McCauley v. First Unum Life Insurance Company*, 551 F. 3d 126, 133 (2d Cir. 2008). If the plan sponsor wanted other terms, "it could have drafted a plan that made this clear." But, a plan sponsor "may not transform an existing plan to achieve [a specified] end by construing it in a fashion contrary to its terms." When it does so, the construction of the plan is unreasonable and a determination denying benefits is an abuse of discretion. *D&H Therapy Associates, LLC., v. Boston Mutual Life Insurance Company*, 640 F. 3d 27, 41 (1st Cir. 2011).

Sometimes, some insurers "game" the system by denying disability benefits claims based on strained interpretations of policy language, frequently contrary to their own internal protocols. Those insurers do not want to be required to disclose such documentation because that will prevent them from denying valid claims by misconstruing policy terms in a manner inconsistent with their own internal protocols. One purpose of the Final Rule is to prevent or at least minimize such conduct.

The administrator procedurally must handle the claim fairly. ERISA represents a careful balancing between insuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans. *Conkright v. Frommert*, 130 S. Ct. 1640, 1648-1649 (2010). Congress sought to create a system that is not so complex that administrative costs or litigation expenses unduly discourage employers from offering ERISA plans in the first place. *Id.* Deferential review promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation. *Id.* The system does not utilize the adversarial process to investigate the truth of assertions made, but instead utilizes an inquisitorial process in which the plan must provide an opportunity for a full and fair review of any claim denial. *Vaught v. Scottsdale Healthcare Corporation Health Plan*, 546 F. 3d 620, 631 (9th Cir. 2008).

This process is undermined - - and the result is expensive and often protracted litigation - - when insurers fail to disclose all of their reasons and all of their evidence to claimants before making final decisions on internal appeals. The Final Rule seeks to remedy that problem. It will minimize litigation and litigation expenses by giving both sides access to all the information without resort to litigation. So, it won't cost money, it will save money and it will make the process more fair, more transparent, and consequently more reliable.

ERISA imposes higher-than-marketplace quality standards on insurers. ERISA obligates administrators to discharge their duties in respect to discretionary claims "solely in the interest of the participants and beneficiaries" of the plan. 29 U.S.C. §1104(a)(1). It simultaneously underscores the particular importance of accurate claims processing by insisting that administrators "provide a full and fair review" of claim denials. 29 U.S.C. §1133(2). Finally, it supplements marketplace and regulatory controls with judicial review of individual claim denials. 29 U.S.C. § 1132 (a)(1)(B).

Central to an ERISA fiduciary's obligations is a prohibition against knowingly and significantly deceiving a plan's beneficiaries in order to save money at the beneficiaries' expense. *Varity Corporation v. Howe*, 516 U.S. 489, 506, 116 S.Ct. 1065 (1996). "[L]ying is inconsistent with the duty of loyalty owed by all fiduciaries" and codified in 29 U.S.C. §1104(a)(1). *Varity Corp.*, *supra*, 516 U.S. at 506. Thus, "a fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even when a beneficiary is not specifically asked for the information." *Barker v. American Mobile Power Corp.*, 64 F. 3d 1397, 1403 (9th Cir. 1995). The administrator may not deceive the claimant. "[T]he notice and review principles of ERISA require that a plan member be given the ability and opportunity to effectively respond to [an administrator's] denial of benefits, which includes the ability to take whatever further action might be necessary to entitle him or her to the benefits in question. [A plan] cannot be rewarded for successfully playing a game of 'hide and seek' with its participants." *Juliano v. The Health Maintenance Organization of New Jersey, Inc.* 221 F. 3d 270, 291 (2d Cir. 2000). Thus, plan administrators have a fiduciary duty to provide complete information. The Final Rule merely formalizes that obligation.

Central to accurate claims processing is 29 U.S.C. §1133 and its accompanying regulations, which set forth the minimum procedures for a full and fair review. An administrator's compliance with 29 U.S.C. §1133 in making an adverse benefit determination is probative of whether the decision to deny benefits was arbitrary and capricious. *Miller v. American Airlines, Inc.*, 632 F. 3d 837, 851 (3d Cir. 2011). The existing Regulations require: administrative processes and safeguards designed to insure and verify that benefit claim determinations are made in accordance with governing plan documents and that plan provisions have been applied consistently with respect to similarly situated claimants; notification of adverse benefit determinations which state the specific reason or reasons, reference specific plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; a full and fair review on appeal in which the claimant has the opportunity to submit written comments, documents, records, and other information, and which provides for review into all comments, documents, records, and other information submitted by the claimant, requiring the fiduciary to consult with a healthcare professional who has appropriate training and experience when deciding an appeal, and specifying that an appeal denial shall state the specific reason or reasons, and reference the specific plan provisions. 29 C.F.R. § 2560.503-1.

In brief, what this process calls for is a "meaningful dialogue" between the administrator and the beneficiary. *Booton v. Lockheed Medical Benefit Plan*, 110 F. 3d 1461, 1463 (9th Cir. 1997). The "plan administrator has a fiduciary duty to the insured to conduct an investigation

and to seek out information necessary for a fair and accurate assessment of the claim." *Rasenack v. AIG Life Insurance Company*, 585 F. 3d 1311, 1324 (10th Cir. 2009). This is not an adversary process. If the administrator needs or wants additional information or if the information is insufficient, the administrator has an affirmative duty to tell the claimant and let the claimant provide it.

The Final Rule more comprehensively sets forth what constitutes a "meaningful dialogue" and thereby enhances accurate claim processing.

"When an administrator asks for additional information in broad terms, it is too easy to find later a reason to deem what it was given to be insufficient." *Holmstrom v. Metropolitan Life Insurance Company*, 615 F. 3d 758, 774 (7th Cir. 2010). An administrator may not "move the target" by inviting additional evidence to establish disability, but when such evidence is provided repeatedly find that the new evidence is not sufficient under new standards or expectations that have not been communicated to the claimant. "Such conduct frustrates fair claim resolution and is evidence of arbitrary and capricious behavior." *Id.* at 776. The Final Rule minimizes the possibility of such gamesmanship.

A practical problem arises because the claimant is not entitled to receive or rebut medical opinion reports or other evidence generated in the course of an administrative appeal. *Metzger v. Unum Life Insurance Company of America*, 476 F. 3d 1161, 1166 (10th Cir. 2007). This means that new grounds may be raised in response to an appeal without the claimant having the opportunity to respond to them. This is unfair. "When an administrator tacks on a new reason for denying benefits in a final decision, thereby precluding the plan participant from responding to that rationale for denial at the administrative level, the administrator violates ERISA's procedures." *Abatie v. Alta Health & Life Insurance Co.*, 458 F. 3d 955, 974 (9th Cir. 2006). This "has the effect of insulating the rationale from review, [which] contravenes the purposes of ERISA. This procedural violation must be weighed by the district court in deciding whether [the administrator] abused his discretion." *Id.* The Final Rule corrects this defect.

Another obvious procedural violation is raising new reasons for the first time in litigation and thus denying ERISA claimants the timely and specific explanation to which the law entitles them by "sand-bagging" them with after-the-fact plan interpretations devised for the purposes of litigation. *Juliano v. The Health Maintenance Organization of New Jersey, Inc.*, *supra*, 221 F. 3d at 289. It is improper for an administrator to "try the easiest and least expensive means of denying the claim while holding and reserving another, perhaps stronger, defense, should the first one fail." *Lauder v. First Unum Life insurance Company*, 284 F. 3d 375, 382 (2d Cir. 2002). "To ensure the full and fair review contemplated by ERISA, the specific reason or reasons for denial must be clearly identified at the administrative level in order to give the parties an opportunity for meaningful dialogue." *LaFleur v. Louisiana Health Service and Indemnity Company*, 563 F. 3d 148, 156 (5th Cir. 2009). The Final Rule will tend to minimize such issues.

Thus, the effect of the Final Rule is to minimize gamesmanship and enhance the transparency, integrity, and effectiveness of the process. Even if that costs money, it is worth it.

After the Final Rule was adopted, the insurance industry claimed that a confidential survey of carriers estimated that the new regulations (the Final Rule) would cause average premium increases of 5 to 8% in 2018. Of course, the industry representatives provided no data to support this, did not provide the referenced survey information, and made no representation that they ever would or could. Let's be realistic: survey data is notoriously susceptible to influence by the nature of the inquiries made. Without actually seeing the data and evaluating the protocols utilized to collect and evaluate that data, these representations are pure speculation.

Furthermore, the variables that might impact disability benefits claims experience and litigation are numerous. The industry's "survey" is meaningless unless all relevant variables have been evaluated. These variables include, but are not limited to:

1. The impact of state bans on discretionary clauses. Obviously, the Department has no standing or authority on this point because state insurance laws are saved from ERISA preemption. Logically, state bans on discretionary clauses have made it more likely that claimants prevail in litigation. On the other hand, the standard of review has no impact on claim decisions or appeal decisions as such; I have deposed claims and appeals personnel from numerous insurance companies and have asked virtually all of them such questions they assert that the standard of review is irrelevant to their decision. (The depositions are typically in non-ERISA cases.)

2. The industry representatives note a referenced increase in premiums resulting in a decrease in covered employees due to Vermont mental health parity statutes. Again, that is an issue of state regulation, saved from preemption and beyond the scope of the Department's authority. Furthermore, other states have similar mental health parity statutes; apparently there is no claim of similar increases in premiums and decreases in participation there. But in any event, the Department has no jurisdiction over state action.

3. The Department is obviously aware that the insurance industry litigation practices substantially increase the cost of litigation - - and thus the overall cost of claims - - by aggressive defense practices intended not to enhance reliability of decision-making in litigation, but to delay the process, impose costs on claimants, and hide evidence developed during the claims process which demonstrates the invalidity of a claim denial. For example:

a. Insurers routinely dispute that review is *de novo* in litigation under circumstances in which either state bans on discretionary clauses clearly apply or no discretion is reserved in the policy.

b. Insurers and plans routinely omit, delete, or withhold from the Administrative Record documents created, relied upon or otherwise relevant to a claim and force claimants to engage in protracted and expensive discovery contests merely to obtain the complete Administrative Record of a claim.

c. Insurers and plans train/instruct their personnel to routinely violate their fiduciary duties to claimants by misrepresenting or withholding relevant

information about, e.g., contractual or statutes of limitation, forcing claimants to engage in expensive litigation contests to enforce their rights not to get benefits, but to pursue claims for benefits.

In my opinion, the Final Rule will likely have no impact on the cost of administering and managing most (likely the vast majority) of disability claims because most disability claims are routine and are routinely granted. In my opinion, what likely drives cost factors (beyond the actual costs of paying claims and state-specific, saved-from preemption standards beyond the Department's authority) are those disability claims which are denied or terminated - - and which likely are ones with more complicated medical issues resulting in longer duration claims and producing virtually all the litigation.

Most of the procedural requirements of the Final Rule are mandated (although not necessary always followed) by case law in some circuits. For example, the requirement to give appropriate weight to a Social Security award and the requirement that medical reviews post-appeal be provided for comment to the claimant are enforced (usually) in the Ninth Circuit. Therefore, whether or not that standard is adopted by regulation, it is nonetheless in effect for at least part of the country.

The Final Rule requires more detailed disclosure requirements by requiring insurers and plans to provide the claim file and internal protocols, allow review and responses to new information, minimize conflicts, and deemed exhaustion standards are routinely enforced by courts - - although admittedly not consistently so. The assertion that these regulations, as such, will increase premium rates and thus decrease participation rates, appears to me to be utterly disingenuous and not founded on facts. Here is the reality: Every insurance carrier and third party administrator has standard processes and practices for evaluating, adjudicating, and managing disability claims. All of them routinely train their personnel and routinely provide updated on-the-job training. (I have deposed claims and appeal representatives of numerous insurance companies, mostly in bad faith claims, but also in ERISA claims, about precisely these issues.) It will be simple enough - - and not at all costly - - to implement new procedures to effectuate the Final Rule. These procedures only impact the outcomes and thus cost factors to the extent that they increase the likelihood that claims will be paid rather than not paid. Since the procedures encourage transparency, that is wholly appropriate. But it is likely, in my opinion, that these procedures do not increase the number of claims being paid at the claim level, they just make it more likely that the claimant can prevail at the litigation level because the claimant will have access to complete information. That is a good thing. So it is likely that is what may drive cost increases, if any - - because likely improving prospects for claims to be granted - - are issues beyond the scope of the Final Rule or beyond the scope of the jurisdiction of the Department, such as bans on discretion and parity acts.

Finally, I don't have data, while the insurance industry claims it does. Obviously, the industry cannot really have data regarding actual costs of compliance with the Final Rule - - because the Final Rule has not yet been implemented. Second, as I explain above, even if implementation increases industry costs, that would be proper because the Final Rule also will increase transparency, accuracy and fairness and it effectuates the goals of section 1133. Third, analyzing cost, factors in ERISA disability benefits claims is not a simple thing. One would

need to design and implement a multi-variable study - - identifying all the possible factors that potentially drive costs, creating a study protocol, obtaining usually confidential data from both industry sources and claimants' attorneys, and then analyzing the data. That would require an elaborate and time-consuming process and assumes that relevant persons will disclose confidential information.

I have some appreciation of how daunting a task that would be: as a law student in the early 1980s I was a research assistant on a multi-year study of California's then-newly reintroduced death penalty. I was also one of the subjects of a far-less elaborate analysis by the California State Bar of the impact of changes in California's bar exam in 1983. I have identified several cost-drivers which would have to be analyzed, but certainly there are more and certainly the insurance industry's speculation - - and that's all it is - - that complying with the Final Rule will raise costs - - is not credible or reliable.

I know that the insurance industry routinely provides objective data to an independent actuary in order to analyze trends and developments in disability claims; the industry does not share either the data or the comprehensive reports with me, but some information becomes available from these studies. It appears that there is generally a multi-year lag between the data and the reports, suggesting that it takes years to collect, organize and analyze the data. Second, it appears that these studies analyze objectively determinable data points. So, any "data" analyzing costs of the Final Rule: won't exist for a couple of years; will then have to be collected and analyzed; will have to take into account numerous variables not readily reduced to objective information or data points; and will have to weigh the social benefit of more fair, transparent and accurate disability claim processing. Let's face it: implementation of the Final Rule likely will result in more disability claims being paid but also likely will save the insurance industry money by reducing its litigation costs because it will reduce the number of disability claims improperly denied, thus the subject of litigation. Overall the insurance industry may save money by implementing the Final Rule, paying more valid claims and reducing litigation costs!

In conclusion, the Final Rule should be implemented, as adopted.

Very Truly Yours,
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