

**From:** Ron Dean [mailto:rdean@74erisa.com]  
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**To:** EBSA, E-ORI - EBSA  
**Subject:** RIN 1210-AB39. Support for Amended Claims Procedures

I write in support of the new Disability Regulations. Implementation of them will not increase costs.

I am a lawyer and I represent both participants and plans.

I understand that a number of insurers and plans oppose the new Regulations, claiming they will increase costs. My experience shows this simply is not so.

Opportunity to Review and Respond to New Evidence. In representing participants, I have seen many a court reject plan denials where new evidence was submitted without giving the participant a chance to respond. The court will review the new evidence itself, reject any decision based on it, or remand the matter to the plan. Each of these alternatives is incredibly more expensive to the plan than would be allowing the participant to respond to the evidence in the first instance. The only time it is less expensive is when the participant is unrepresented by counsel and just gives up, never further pursuing the matter. However it does not seem fair to punish those less sophisticated claimants who are usually more in need of the benefits in the first instance.

I understand the argument that allowing the claimant to respond to the new evidence will lead to an endless loop with no end of back and forth submission of new evidence. In my 47 years of experience this has never happened. Not even once. I have never been in or seen a trial where this occurred, nor have I ever read or heard about such an event. The whole point of due process is for each side to lay out its evidence for examination and response by the other side. It is a minimal expectation of our society. There is no reason to exempt insurers or plans from this, especially where the only possible goal is to discourage claimants from further pursuing legitimate claims.

In representing plans, we have always allowed claimants to respond to new evidence. Sometimes the new evidence will satisfy claimants and there will be no response. Sometimes the claimant will respond to the new evidence with important new information that clarifies the issues and allows us to pay the benefits. But not once, not even once in my entire 47 years, has it resulted in any open-ended back-and-forth increasing costs without any corresponding fairness benefit. Any claims of unreasonable cost increases must fail.

Deemed Exhaustion Requirement. In representing claimants I find that in the vast majority of cases plan responses are reasonably timely and no issue is presented. In those few cases where there is no response, I will always send at least two reminders to the plan asking for an answer. After all, if I go to court the odds are the court will remand the matter back to the plan for review within a specific deadline. The courts do not need the extra cases, and I do not need the extra expense. Not having a “deemed exhausted” requirement means that a plan only needs to respond to claims where it is ordered to do so by a court. While the vast majority of plans would not do so, while the vast majority of plans timely respond to claims, there is always a small minority that will exploit any perceived advantage. Without a “deemed exhausted” provision, a few plans will be able to game the system. On the other hand participants are cabined to a very limited set of remedies in a very limited subset of cases.

There are cases that hold that the statute of limitations to bring a benefit claim in court begins when the time for the plan response expires even though the plan has not yet responded. Not having a “deemed exhausted” rule creates a substantial ambiguity that will require just more litigation. Does the statute of limitations start even though the participant is not yet allowed to bring suit?

From the plan perspective, we consider the timely processing of claims a main fiduciary duty. We do not consider it any kind of burden and no employer would hesitate to provide benefits to its employees simply because the Regulations have been tweaked to provide a slightly greater level of fairness to participants. After all, the vast majority of plans and employers already provide these safeguards. They certainly

do not consider themselves at any kind of competitive disadvantage to plans and employers that cut corners and that do not take seriously their fiduciary duties.

Notification of Contractual Limitations Periods. Whether from a participant or plan perspective, it cannot possibly cost any additional money to tell claimants this very important piece of information. Plans and insurers have skeletal forms to be used and tailored to specific cases. To add a sentence about any contractual limitations period to that form will take a one-time investment of five minutes.

Explanation of the Rejection of a Social Security Determination. Representing claimants, it has always been frustrating when plan's reject out-of-hand social security's finding of disability. Sure, there can be legitimate reasons that a plan may differ with the social security administration. But that is not the point. The point is that plans need to tell the claimant what those reasons are without relying on simple boilerplate words. For example, sometimes I will get boilerplate saying that social security's definition of disability is "different." Well, yes it is different but the plan's definition of disability is a considerably easier definition to meet (e.g., the plan only requires that claimant be disabled from her own occupation while social security requires disability from any occupation). It is clear that the letter's author simply pushed the "reject social security" button on the word processor and moved on.

From the plan perspective, the social security determination is one of the most important pieces of evidence in the disability puzzle. Is social security always right? Of course not. But social security has a level of expertise and objectivity that requires a careful analysis of its decision. Because we engage in that analysis, we believe it is critical also to share that analysis with the claimant. After all, no one is more familiar with the important set of facts than is the claimant.

In sum, the new Regulations are a solid step forward in due process in the benefits administrative process at a small, if any, cost to the plan. For the plans I represent, there has been no cost. The leap forward in transparency benefits both the plans and the participants.

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