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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

Sent via email only
e-ORI@dol.gov

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 am writing to discourage the Department of Labor ("Department") from modifying or further delaying the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) now scheduled to go into effect on April 1, 2018. I previously wrote to the Department as part of comments on those Final Regulations.[1] I also wrote in response to the request for comment on the proposal to extend the deadline for implementing the Final Regulations.[2] I write now in response to the Department's request for comment on several of the Final Regulations that have been criticized by various stakeholders from the insurance industry ("the industry") as unduly costly.

My Interest in ERISA Law/Disability Claims

I have been a licensed attorney since 1985 and have focused my practice on ERISA since 1997. I am one of three attorneys from a law office in St. Paul, MN which primarily represents claimants in ERISA benefit disputes. We handle both the administrative claims process and the litigation associated with employee benefit disputes. Disability benefit disputes comprise the largest share of cases we handle.

[1] Those comments appear as comment 63 dated January 18, 2016.

[2] Those comments appear as comment 74 dated October 25, 2017.

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The ERISA cases I have handled that resulted in reported decisions are listed below.[3] In short, I am very aware of the issues that the Final Regulations present and on behalf of the clients I represent I wish to comment on the claimed costliness of those rules.

Procedural Concerns

Before addressing the merits of the cost concerns raised by the industry, I want to comment on the procedural posture of this comment. While I appreciate the Department's decision to allow comment on the late-raised claims of costliness, I feel the opportunity for comment does not overcome procedural defects in this process. I raised those procedural objections in my October 25, 2017 comment identified above (footnote 2).

But just to reiterate, the current process arose because certain industry representatives privately approached the Department in meetings, letters and interactions that were not subject to public notice or comment. Those industry representatives asserted the fully vetted Final Regulations should not go into effect because they were allegedly too costly. The concerns raised by the industry are not new. Rather, these objections appear to be nothing more than an attempt to get a "do-over" of the merits of the Final Regulation. Where those rules are based on policy choices that have been made by Congress, by this Department, and by the federal courts interpreting ERISA, another argument about the merits is unnecessary. Moreover, for the reasons expressed in my prior letter of October 25, 2017, this after-the-fact closed door effort to undo the Final Regulations raises serious concerns about non-compliance with the Administrative Procedures Act.

In General, Costs Will Not Increase

The industry claims, without empirical support, that the implementation of the Final Regulations will increase premiums and decrease access to employer-provided disability benefits. I disagree.

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[3] *Stover v. Delta Air Lines Inc.*, 2017 WL 4277144 (D. Minn. 9/25/17);
McGillivray v. Wells Fargo & Co. Salary Continuation Pay Plan, 2017 WL 3037557 (D. Minn. 7/18/17);
Broderick v. Hartford Life & Accid. Ins. Co., 2017 WL 652451 (D. Minn. 2/16/17);
Wenzel v. Blue Cross and Blue Shield of Minnesota, 2015 WL 6549594, 2015 U.S. Dist. LEXIS 146815 (D. Minn. 10/28/15);
Lanpher v. Metropolitan Life Ins. Co., 50 F. Supp. 3d 1122 (D. Minn. 2014);
UNUM Life Ins. Co. v. Zaun, 2014 WL 3630340, 2014 U. S. Dist. LEXIS 100425 (D. Minn. 5/29/14);
Brandt v. ALLINA Health Systems LTD Benefits Plan, 2010 WL 2520709, 2010 U. S. Dist. LEXIS 58967 (D. Minn. 6/15/10);
Gordon v. Northwest Airlines, Inc. LTD Income Plan, 606 F. Supp. 2d 1017 (D. Minn. 2009);
Groska v. Northern States Power Co. Pension Plan, 2007 WL 2791119, 2007 U.S. Dist. LEXIS 71081 (D. Minn. 2007);
Alliant TechSystems, Inc. v. Marks, 465 F.3d 864 (8th Cir. 2006);
Abram v. Cargill, 395 F.3d 882 (8th Cir. 2005); and
Wolfe v. 3M Short-Term Disability Plan, 176 F. Supp. 2d 911 (D. Minn. 2001).

The Department can rely upon information supplied by the Bureau of Labor Statistics. https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm. This data shows that access and participation in employer-based disability insurance has increased, not decreased, between 1999 and 2014. Furthermore, this increase took place despite the adoption of the 2000 Claim Regulations, the intervention of certain state insurance commissioners with regulatory settlement agreements for two large industry representatives—UNUM and CIGNA, and the Supreme Court's holding that ERISA disability insurers need to provide higher-than-marketplace standards in handling claims. *Glenn v. Metropolitan Life Ins. Co.,* 554 U.S. 105, 115 (2008). Finally, during the time of that increase several states barred discretionary language clauses in disability policies.[4] Plainly the adoption of added protections for claimants has not had an adverse impact on participation in the past so assuming that it will now seems an unwarranted inference.

Given this history, I dispute that costs will increase in response to the modest changes represented in the Final Regulations. Accordingly, I urge the Department not to change the final rules in response to the industry's strained logic that final rules are too costly and will impair access to disability benefits in the workplace.

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

The industry also claims that the Final Regulation which requires a disability plan administrator to explain why its decision deviates from a decision of the Social Security Administration or other disability-assessing entity will be too onerous. This Final Rule is not burdensome. It simply reflects a fundamental due process principle that is imbedded in ERISA—namely that a claimant is entitled to a well-articulated explanation for the adverse benefits decision so that the participant may fairly dispute it. A claimant is entitled *to "a written opinion that includes specific reasons for the decision. Bald-faced conclusions do not satisfy this requirement." Richardson v. Central States, Southeast and Southwest Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981).

When my clients apply for Social Security Disability Insurance ("SSDI") benefits at the urging of their ERISA disability plan administrator, they are always stumped when the plan cuts off disability benefits while SSDI continues. Inevitably I must have a difficult conversation with the client about how he/she can be disabled for purposes of SSDI but not for purposes of ERISA—particularly where it was the ERISA plan administrator that directed the client to seek SSDI benefits. I have had to have this conversation even when the client is still subject to an "own occupation" definition of disability under the ERISA plan. I am hard-pressed to answer the question of why plan benefits are being terminated when SSDI—with the more challenging "any occupation" standard—pays benefits.

To the lay claimant, SSDI and ERISA disability plans are about the same thing. They both

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[4] 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).

ask about disability. They both require similar medical evidence and reports. They both provide economic support for disabled workers. When there is a difference of opinion between the two systems it is incumbent on the ERISA plan administrator to explain why it has arrived at a different disability determination about the same person.

Moreover, if the industry is claiming it is too costly to explain such a difference—this only makes me wonder if it is because there is not a good explanation to be given. That is, if the industry claims it is unduly arduous to explain why the ERISA disability determination is different from the SSDI result, it strikes me this is most likely because there is no logical explanation for the discrepant decision-making.

Additionally, the disability plans and insurers are already 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. *Montour v. Hartford Life & Accid. 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. Co.*, 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 Ins. Co. v. Glenn*, 554 U.S. 105 (2008). Requiring that ERISA plan administrators explain why their disability decisions diverge from other disability decisions is not going to increase the costs of claims handling.

The Deemed Exhausted Rule is Not Costly

The industry also claims that the deemed exhausted rule in the Final Regulations will propel plaintiffs and their attorneys into court, increasing ERISA litigation. This assumption is incorrect. Speaking as a plaintiff's ERISA practitioner, I can confidently state that I am far more concerned with building a comprehensive record on which the court will make its decision than I am on rushing a claimant into court. I often must talk my clients out of a frantic race to court in favor of a thorough development of the administrative record.

What is difficult for claimants or their counsel to accept is an untimely response on appeal. At that point in the process, the claimant has already been out of benefits for some time and has invested effort and time into creating a record that the claimant believes is compelling for the appeal. When the plan administrator does not issue a decision within the time frame of the regulations, this creates real frustration. Under the Final Rule, the plaintiff will mostly obtain a remand with instructions for the plan to do its job. Because most plaintiffs' attorneys work on a contingent fee basis, it does not make sense for us to undertake litigation that will not result in resolve the case on the merits. In short, there will not be a rash of cases in court except in extreme cases of delay.

Additionally, as with most of the other Final Regulations, this Rule is simply a codification of existing judge-made law. Claimants are already able to get into court when the claims process has failed them in a meaningful way. *See e.g. 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 unlikely 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); *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98 (2d Cir. 2005); *Jebian v. Hewlett-Packard Co. Employee. Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003); *Dunnigan v. Metropolitan Life Ins. Co.*, 277 F.3d 223, 231 n.5 (2d Cir. 2002).

Providing the Right to Review and Respond to New Evidence or a New Rationale from the Plan during the Appeal Review is Not Too Costly

This Rule is fundamental to full and fair review. It is the basic proposition that a party is entitled to respond to the evidence against him or her.

That fairness principle is near and dear to me as I was counsel for the plaintiff in *Abram v. Cargill, Inc.*, 395 F.3d 882 (8th Cir. 2005). In that case, the Court held that where a plan obtains a new report from its expert whom it relies upon to deny the appeal, the claimant should be allowed to review this evidence and respond to it before the appeal decision is issued. Without this opportunity to review and respond, the plan or insurer is engaging in "*gamesmanship*" that is inconsistent with the core requirements of full and fair review. *Id.* at 886. *"A claimant is caught off guard when new information used by the appeals committee emerges only with the final denial." Id.*

The rule from *Abram* was a good one and assured full and fair review. Regrettably, the Eighth Circuit later held that the rule from *Abram* was limited to cases subject to the pre-2002 regulations. *Midgett v. Washington Group International LTD Plan*, 561 F.3d 887, 894 (8th Cir. 2009). The decision in *Midgett* makes it clear that a clarifying regulation is needed to assure the full and fair review on appeal in accord with the principles set out in *Abram* is reestablished.

Yet, at this late juncture the industry complains that providing the claimant with new evidence or rationales before making a final decision is too costly. The industry's claim to cost impact just does not persuade.

First, several disability plans or insurers already provide for the right to review and respond. They do so voluntarily, as their comments to the proposed rules showed. Second, providing the information to the claimant will occur anyway. In litigation, the insurer or plan will be obliged to provide the claimant with the new evidence or rationales. The cost therefore will still exist. Providing the information has a cost and it will be borne later—so why not earlier when a claimant can reasonably respond to it?

This Final Rule is critical to full and fair review. It assures that claimants can respond to new evidence developed in response to the appeal before the case goes into litigation.

Without such a rule, claimants will be unable to rebut the new evidence because ERISA benefit claims are decided on a closed record from the administrative process. Thus, the door shuts on the claimant's proof just when the plan as both decision-maker and opposing party has developed new evidence against the claimant. Such a result is inherently unfair.

The industry claims the process from the Final Regulation is too costly because claims handlers will need to do more in the same amount of time. This concern could be addressed by modifying the rule instead of eliminating the rule altogether. Commentators from both sides have suggested as much.

Moreover, the additional burden, if any, of allowing claimants to see the new evidence against them is minimal in comparison to the unfairness without such a process. That is, the notion that it may be more difficult to provide an opportunity to review and respond does not justify a fundamentally unfair process. The "cost" in this instance is one that Congress anticipated when it required that ERISA plans provide for a *"full and fair review."* 29 U.S.C. §1133. All that the Final Regulation does is assure that these reviews are full and fair. The cost of doing so is one which Congress considered and decided was worthwhile.

Requiring Disclosure of any Internal Limitations Period is Not Too Costly

There was a very limited response to the Final Regulation requiring claims administrators to provide the claimant with the date when any internal time limit for filing suit will expire. Logically this is because there is no persuasive argument that the requirement to do so is too costly. Indeed, if it were being claimed that it is difficult and expensive for the administrators to determine the internal limitations period, it is surely far more expensive and difficult for the untrained lay claimant to do so. The claims administrators are in the best position to satisfy this rule, since the expiration date of an internal limitations period is a plan term that should be accessible to the plan administrator. As with most of the final rules, information respecting the period of limitations is required to be disclosed in several jurisdictions, so it is unlikely to incur additional costs to create uniformity. *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).

In conclusion, the Final Regulations were a thoughtful and balanced approach to the problems that disability claims presented. The Final Regulations will serve the courts, the Department, the industry and the claimants well. It is my hope that the Department will not permit unsubstantiated and late-asserted claims of cost to interfere with the implementation of those Final Regulations.

Sincerely,

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