

January 15, 2016

U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

RE: Discretionary Clause Rule Comment
RIN 1210-AB39

Dear Members of the Committee:

DRI -- *The Voice of the Defense Bar* is pleased to provide the Department of Labor our comments regarding the proposed Claim Procedure for Plans Providing Disability Benefits, 72014 Fed. Reg. Vol. 80, No. 222, Wednesday, Nov. 18, 2015, Proposed Rules.

DRI is a national organization of over 22,000 defense trial lawyers and corporate counsel involved in the defense of civil litigation. Among its goals is anticipating and addressing issues germane to defense lawyers and the civil justice system. DRI is committed to enhancing the skills, effectiveness, and professionalism of defense attorneys. Because of this commitment, DRI seeks to address issues germane to defense attorneys and the civil justice system, to promote the role of the defense attorney, and to improve the civil justice system. DRI has long been a voice in the ongoing effort to make the civil justice system fairer, efficient, and — where national issues are involved — consistent.

The important issues raised by the proposed rules are, accordingly, of substantial concern to DRI. Since its members have first-hand experience with ERISA disability claims litigation, DRI is well-suited to address these issues. This is particularly true with respect to anticipating the potential ramifications the proposed rules may have on ERISA claims litigation. We welcome the opportunity to engage in constructive dialogue with respect to the proposed regulations.

Summary of Recommendations

The recommendations offered below stem from our members' experience in litigating disability benefits disputes throughout the United States and our evaluation of the practical implications of implementing the proposed rules in their current form. We believe these recommended changes are appropriate to best serve the continued vitality of ERISA plans, and reduce unintended consequences associated with the proposed rules in their current form. We address the following recommended changes:

- Provide clarification as to what constitutes “new evidence” or “new rationales”, with respect to which claimants must be given a right to review and respond;
- Specifically adopt a tolling provision to allow claimants and plans the time necessary to complete the meaningful dialogue contemplated in the new review and response requirements;
- Revise the “deemed exhausted” proposal to provide that in the event of an alleged violation, a claimant may proceed to court, but not until after the plan provides its response as to why no violation occurred and/or why the alleged violation was minor;
- Provide clarification as to the types of “internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying the claim”, that plans must identify to claimants in the context of adverse benefits determinations;
- Eliminate the provision purporting to require courts not to defer to a plan’s determinations in the event of an alleged violation.

Highlighted below are the primary concerns that drive these recommendations, focusing on potential unintended consequences, as well as specific detailed recommendations for the modification of the proposed rules.

- (1) The Department should clarify the review and response requirements and adopt a tolling provision:

The proposed rules require plans to provide claimants with the opportunity to review and respond to “new evidence” or “new rationales” relied on in the context of an appeal. The proposed rules do not define what constitutes “new evidence” or a “new rationale” and seem to contemplate the completion of this process within the already tight regulatory deadlines.

Courts have expressed concern that imposing a requirement to consider new evidence prior to a final decision “would set up an unnecessary cycle of submission, review, re-submission, and re-review” that “would undoubtedly prolong the appeal process [and] . . . unnecessarily increase cost of appeals. *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1166 (10th Cir.2007) (citing *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 382 (10th Cir.1992) (noting that Congress intended to minimize the costs of claims settlement by passing ERISA)). We believe these concerns are well founded, particularly in light of the current regulation’s requirement that administrators consult with an appropriate health care professional where medical judgment is involved. 29 C.F.R. Section 2560.503-1(h)(3)(iii). See *Metzger*, 476 F.3d at 1166.

In order to avoid the unintended consequences of undue delay and increased costs, the Department should clarify that “if a claimant's

assertions [in response to new evidence or a new rationale disclosed by the plan on appeal,] do not include new factual information or medical diagnoses, a plan need not generate report after report rather than relying on the reports it already has in hand.” Brief of the Secretary of Labor, Hilda L. Solis, as Amicus Curiae in Support of Plaintiff-Appellant’s Petition for Rehearing, *Midgett v. Washington Group Int’l Long Term Disability Plan*, 561 F.3d 887 (8th Cir. 2009) (No. 08–2523). Moreover, the Department should make clear that in considering the claimant’s response to the new evidence, to the extent the plan elects to consult with a health care professional, the plan may consult with the same health care professional who rendered the initial report on appeal, to which the claimant responded, without having to provide an opportunity for further response by the claimant.

(2) The Department should adopt a tolling provision:

Additionally, the Department should adopt a tolling provision in order to allow the plan and claimant the time necessary to engage in the “meaningful dialogue” contemplated by the new review and response requirements. While the current regulations allow for an extension on appeal, without an additional tolling provision, plans will simply be unable to render decisions within the deadlines and significant disputes in subsequent litigation are likely to result. In some cases, more than one cycle of review, response and consideration may be required in order for the plan to make a final decision. A significant percentage of claimants filing appeals are represented by counsel. Some counsel may be strategically inclined to hold back certain evidence during the claims process in an effort to have the last word. In that event, if the plan has already taken an extension, a claimant’s lawyer could effectively preclude the plan from obtaining the information it needs to provide a full and fair review in a timely manner. The proposed rules should encourage open communications, not gamesmanship. Plans need to have the flexibility to respond to late provided evidence without running afoul of the deadlines. This is particularly true in light of the fact that pursuant to the proposed rules, the consequence of failing to meet the deadline is that administrative remedies are deemed exhausted and no deference is afforded the determination.

In order to address these issues and avoid unintended consequences, we propose that the Department include a tolling provision whereby the deadline for making a final determination on appeal is tolled from the time the plan provides any new evidence or new rationale to the claimant, to the time the claimant responds. We also suggest that the Department mandate a specified time period for a claimant to respond (e.g., 21 days) and a minimum period for a plan to render a decision once the response is received or from the expiration of the specified response

deadline (e.g., 21 days). A response from a claimant could include anything from one sentence to volumes of material and if the response is voluminous, the plan will need adequate time to review in order to render an appropriate decision.

Moreover, in furtherance of the “meaningful dialogue” contemplated by the proposed regulations, the Department should clarify and facilitate the process by which plans and claimants can agree to extensions. Extensions by agreement further ERISA’s goals as articulated by the Supreme Court. *See Conkright v. Frommert*, 559 U.S. 506 (2010) (ERISA’s exclusive enforcement scheme seeks to promote the formation of benefits plans by “encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation.”). Tolling should also apply from the time that a plan requests that the claimant agree to an extension, until the claimant responds to the request.

- (3) The Department should clarify the requirement that adverse benefit determinations contain “internal rules, guidelines, protocols, standards or other similar criteria . . .”

The proposed regulation requires that adverse benefit determinations contain “the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying the claim (or a statement that these do not exist).” It is common for health plans to adopt rules and guidelines with respect to, for instance, covered procedures and what constitutes “medical necessity.” Disability claims, by contrast, typically rise and fall on the terms of the plan at issue and frequently hinge on volumes of medical records and opinions that are unique to the claimant. Disability plans may adopt internal “administrative interpretations” of specific policy language, such as limitations or exclusions. *See Glista v. Unum Life Ins.*, 378 F.3d 113 (1st Cir. 2004)(internal interpretation of pre-existing condition provision). That is the type of internal rule or guideline that the proposed regulation seems geared towards identifying. However, these types of internal rules or guidelines are only relevant in situations where the claim turns on interpretation of a policy term, which is relatively rare in the disability context.

Insurance companies that administer claims may also have generalized guidelines for employees, not geared towards the administration of any specific plan or plan language. Such generalized guidelines not specifically referenced in the context of a particular plan or claim, would not seem to be contemplated in the language of the proposed rules. But in the absence of clarifying language in the regulation, disputes as to the scope of the requirement are likely to arise in subsequent litigation,

thereby increasing the cost and length of such proceedings, contrary to ERISA's underlying interests. *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) ("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.").

We propose that the Department clarify the proposed regulation to require that adverse benefit determinations contain "internal rules, guidelines, protocols, standards or other similar criteria used in interpreting the plan language at issue with respect to the claim (or a statement that these do not exist)." The suggested clarity would ensure that all parties fully understand the scope of plans' obligations and reduce the likelihood of disputes as well as the cost and length of subsequent litigation, consistent with ERISA's objectives of an efficient, cost effective claims administration process.

(4) The Department should narrow the "deemed exhausted" provision and require the exchange of meaningful dialogue before a claimant can proceed to court:

ERISA's longstanding exhaustion requirement recognizes "the important public policy of encouraging private rather than judicial resolution of disputes under ERISA." *See, e.g., Costantino v. TRW, Inc.*, 13 F.3d 969, 975 (6th Cir. 1994). In other words, the purpose of an exhaustion requirement is to ensure that as much as possible a dispute is resolved at the administrative level and before it goes to court. Among the several purposes of requiring administrative exhaustion are to reduce the number of frivolous lawsuits, promote consistent treatment of benefits claims, provide a nonadversarial method of claims settlement; minimize costs, prevent premature judicial intervention in the decision-making process, and to help assemble a factual record which will assist a court in reviewing the administrative decision. *Id.* The very nature of a multi-layered administrative process must allow a plan the "opportunity to correct its own mistakes with respect to the programs it administers before it is haled into federal court. . ." *Adair v. El Pueblo Boys & Girls Ranch, Inc. Long Term Disability Plan*, 2013 WL 275519 (D. Colo., Jan 24, 2013). *See also, Conkright*, 559 U.S. at 1643 (rejecting "one strike and your out" approach to ERISA claims administration).

The proposed regulations provide that in the event a plan fails to strictly comply with all the regulatory requirements, administrative remedies are deemed exhausted and the claimant can proceed to court, subject to an exception for minor violations. DRI is concerned that an unintended consequence of this proposal will be a significant increase in premature lawsuits, resulting increased costs, and delay in the final outcome of

benefits disputes. Additionally, judges will be forced to adjudicate benefits disputes piecemeal and based on incomplete records, and to step into the shoes of claim administrators, contrary to ERISA's underlying purposes. Again, many disability claimants are represented by counsel and exhaustion issues are already frequently litigated in ERISA cases. If possible delay is the only disincentive to filing suit before the completion of the administrative process, premature lawsuits are bound to increase substantially and many claims that could have been resolved administratively, will involve lengthy and costly disputes in federal court regarding whether violations took place and if so whether the minor exception applies. The costs of these procedural disputes in many cases will be disproportionate to the amounts at stake.

In order to avoid these unintended consequences, DRI proposes that the Department revise the proposal to state that a claimant cannot proceed to court without first notifying the plan of the alleged violation and until the earlier of the claimant's receipt of the plan's written explanation of the alleged violation, or 14 days from the claimant's request for such an explanation. This proposal is consistent with the Department's overall goal of encouraging meaningful dialogue.

(5) The Department should eliminate the provision purporting to require courts not to defer to a plan's determinations in the event of an alleged violation:

In *Conkright*, the Court relied on its prior decision in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, to hold that "a single honest mistake" does not rob the administrator of deference. The Court noted that "*Firestone* deference protects [ERISA's underlying] interests and . . . preserves the careful balancing on which ERISA is based." *Id.* ("Respondents claim that deference is less important once a plan administrator's interpretation has been found unreasonable, but the interests in efficiency, predictability, and uniformity do not suddenly disappear simply because of a single honest mistake, as illustrated by this case. When the District Court declined to apply a deferential standard of review on remand, the court made the case more complicated than necessary."). *Glenn*, in turn, eschewed hard and fast rules, emphasized that when the plan grants discretion review is at all times deferential, but held that factors such as procedural unreasonableness, are relevant to the question of whether an administrator abused its discretion. 554 U.S. 105.

DRI has serious doubts about the Department's authority to regulate judicial standards of review. Having said that, a rule that purports to eliminate all deference in the event of a procedural violation threatens

ERISA's underlying interests, as the Court explained in *Conkright*, adding time, cost and complexity to a process that is already complex and costly. As evidenced by post-*Glenn* ERISA jurisprudence, courts are well equipped to weigh the relevant factors and determine how much weight to give to procedural issues. The Department should avoid adopting a hard and fast rule of the type specifically rejected by the Supreme Court in *Glenn*.

Respectfully Submitted,

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