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December 11, 2017

By Mail: 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:

I am writing to discourage the 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)) that are now scheduled to go into effect on April 1, 2018.

I am a partner of MILLER MONSON PESHEL POLACEK & HOSHAW in San Diego, California. I have nearly exclusively represented employee plan participants and their beneficiaries for over 25 years, primarily in welfare benefits issues of disability, life and accident, and, on rare occasion, pension. My practice includes all states of ERISA claims issues: at the claim level, appeals of adverse 'administrative' decisions, litigation in the district court and at the court of appeals.

This is the second time I have written objecting to the potential for delay, the first being October 24, 2017. I have personally witnessed the proliferation of claim denials forcing claimants to litigate their claims in court, all the while left with no life insurance benefits in the loss of their loved one, and no disability benefits yet still unable to work. I have witnessed the non-neutrality, non-objective nature of claims reviews in numerous fields —vocational/rehabilitation, medical, behavioral, psychologic/psychiatric, etc.— and the

claims manager(s) themselves who each take an outright adversarial and sometimes hostile approach to the claim, particularly by the underwriting/insuring insurance companies which have unquestionably learned how to game the system in their own benefit. The required neutral, objective investigation and administration of claims is nonexistent. And while I am appreciative of the opportunity to submit my comments on the Department's re-examination of the costs of the final rules that will govern disability claims, I must emphasize that the industry's voicing of alleged cost issues and the reasons for them are simply not new; in fact, so much so that I view them as simply re-argument of the merits of the final rules. Their re-argument and even attempting to expound of their prior versions implicates policy choices that have already been considered and addressed by this Department, or by Congress, and by the federal courts. That said, I will take this opportunity to address what I view as responsive to the industry's objections for your consideration.

The new regulations will not result in Increased Costs

The industry has alleged that the final rules will cause a significant increase in costs which will increase premiums and thus, —as the argument goes— lower access to group disability coverage. These assertions do not ring true.

Over the years, I have had opportunities to assess various group insurers' bids to employers of all sizes, and *have never seen* a difference in premium bid for any one level of proposed coverages, where it is concurrently proposed that the plan administrator will grant the insurer discretion (in the legal sense as to result in a deferential abuse of discretion standard of review) as versus one in which no grant of discretion is conveyed. In fact, I have not even seen an application form for group coverage in which the employer checks off certain coverages levels, and selects what level of discretion is proposed and its legal effect, versus standard insurance claims handling.

The level of claim investigation and meaningful dialogue required by the insurer to the insured should not be changed in any material respect since the insurer is legally obligated to conduct a thorough investigation and ask the claimant and his/her treating specialists for any *specific types* of information relevant to the particular diagnosis/ses and limitations that should be readily available *if only the insured and his/her treating specialists are timely notified* at the start that is what the insurer will be looking for. Much of the time, there are generic "physical capacities" questionnaires that can be used for any claim, and typically the insurer does not ever send specific questionnaire forms or diary logs, or other inquiries that are directed at the particular diagnosis or disability,

whether it be meniere's disease, chronic intractable migraines, spine disease of a particular diagnosis, Parkinson's, Lyme Disease, blindness from Retinosa Pigmentosa, etc. The court has long held — for decades— that the insurer must engage in 'meaningful dialogue' through the claim. Instead, denials are based on a failure to submit certain information that was never specifically requested to begin with, and now at a time some of that information can no longer be timely documented, since no notice was given at the beginning of the claim. Instead, claimants and their treating specialists receive a generic laundry-list of boilerplate information that could apply to any disability, even after all medical records have already been obtained, thereby creating such an opaque list as to be utterly meaningless to the particular lay person claimant, and nearly as meaningless to the treating specialist. If the insurance industry is now objecting to the alleged increased costs the new proposed regulations will allegedly create, first, it is highly unlikely unless they never put into place the tools that would satisfy the text and the spirit of the current regulations. Again, the insurance industry has learned to game the system to make it 'appear' as though something specific is requested and defined as needed, without ever doing so. There are certain insurers who I have found to be particular bad actors in this regard and, to make things worse, they are some if not the primary major players in group disability insurance and at best, should know better, and at worst, DO know better, indicating the purposefulness; the planned approach to claims, as employee claimants' attorneys have unfortunately encountered.

The Department concluded both in 1999, and again prior to approving the new proposed regulations after considering all of the notice and comments, that the costs would not outweigh the benefits. The Department's Bureau of Labor Statistics reveals that access to, and participation in, employer group disability insurance has increased between 1999 and 2014 ----it has not decreased. It has increased despite the current regulations becoming effecting January 1, 2001, requiring much the same things as the proposed new regulations, including but not limited to the (logically-required) de novo reviews of suits filed after administrative remedies are deemed exhausted under the terms of the plan as a matter of law due to the lack of a timely decision following the claimant's appeal. There is absolutely no solid evidence that there has been or would be an abandonment of group disability coverage due to some alleged costs increases attendant to meeting the requirements of the proposed regulations. One would have to reject such suspicious data if the same or similar requirements are already part of or implicated by the 2000 regulations. One would have to ascertain whether part or all of those alleged costs increases are not because of any amended requirements, but from the new gaming of the system that the insurance industry will have to facilitate to avoid payment of valid claims, as claimants were subjected to after January 1, 2001 to date. The greater likelihood, if

there has been any actual change in employer group disability coverage offerings, is that employers have learned to their outrage about how their disabled employees have been treated by the group insurers, including during the claims investigation and decision-making process which is supposed to be objective an neutral, but instead is adversarial and outright (informal) litigation against the employee insured, such that group insurance policies for which employers already pay healthy premiums, aren't worth the cost of the paper they're written on. At the same time, the employee claimant's costs to fight this 'informal' adversarial process is usually a large percent of their benefits under a contingency fee agreement, for which the disabled claimant will NEVER be made whole even if benefits denials/terminations are reversed, no matter how outrageous or unreasonable the denial they had to appeal.

A good part of the above informal litigation has been set up and accomplished in part by insurers hiring, as their investigation agents and reviewers, third party entities from which they receive a final report that they insert into the record. They make no effort to obtain from these agent(s) and reviewers all of the relevant evidence (as currently defined in (m)(8)) to make it a part of the 'Administrative Record,' thereby leaving a HUGE gap in the record about all communications activity, transfers of information, re-writing of opinion letters, exact copies of which documents were considered. And yet every group insurer I have encountered have flat out refused requests to obtain and add to the claim file(s) so that a complete "Administrative Record" can be assembled, and then send them to the claimant or me. The insurer apparently does not consider it their obligation to obtain and disclose this part of the administrative process, even though their agents act on their command, according to their definitions and requests, under payment by them —(and in some cases, the agents' records are expressly deemed the insurer's property per an insurer/third-party contract signed)— inasmuch as (at least some of those) documents were not generated by the insurer, they were received by or generated by the agents in the investigation of the claim at the request and on behalf of the insurer. Claimants, whose requests for those parts of the 'administrative' process and papers are refused, have no way to adequately respond to any concerns or misapplication of definitions during that part of the 'administrative' claims process. And yet it is a part of the process that the Regulations require.

Data from the Bureau of Labor Statistics, on which this Department can rely, shows that there has been *an increase* in both access to and participation in employer-based disability insurance between 1999, ending the period prior to the current effective regulations, and 2014. This increase occurred despite that employment in the service industry has increased, an industry in which employees are the least likely to have access to

employer-based disability coverage. This increase also occurred despite the January 1, 2001 effective date of the current regulations on disability claims and despite many court decisions addressing conflicted decision-making infected by the insurers' conflicted interests, deemed exhaustion, the need to discuss and specifically explain adverse benefits decisions with the evidence in the record as a whole, and the participants' right to respond to new evidence. https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm.

After the January 1, 2001 effective date of the then-revised regulations, many states enacted bans on discretionary clauses, requiring that courts review ***de novo*** any claim denial —just as all state insurance denials are reviewed under state insurance law. Examples of states with such bans include Arkansas, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Michigan, Minnesota, Montana, New Jersey, New York, Rhode Island, South Dakota, Texas, Utah, Washington, Wyoming. See: Ark.Admin. Code 054.00.101-4 (2013); Cal. Ins. Code §10110.6 (2012); Colo. Rev. Stat. §16-3-1116 (2008); HI Commr's Memorandum 2004-13H (12/8/ 2004); 50 Ill. Admin. Codes 2001.3 (2005); Md. Code Ann. Ins. §12-211; MI Admin. Codes. R. 500.2201-2202 (2007); MN Stat. §60A.42, §62A.241 (2016); MT Code Ann. §33-1-502 (2011); 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)). Despite enactment of such bans, the BLS shows that participation in and access to group disability plans ***increased***.

Inasmuch as they already have the legal requirement to thoroughly investigate the claim and ask for any specific types of information that should be readily available if only requested or the treating physicians notified at the start that certain types of information are what they will be looking for, there should be no differences in the costs UNLESS those types of requests have not been made in the past but will (continue to) be required under the new regulations. Before the proposed rules reached their final adoption, the same costs argument was made by various actors in the industry, and in fact, I believe were made before the current regulations made effective for claims submitted on or after January 1, 2001, as much the same changes and requirements to which this Department demanded compliance were being addressed. It is more than concerning that insurers did not actually *bid* on two different scenarios, one of which does *bargain for*, and one of which does not bargain for, a legal grant of discretion such as to afford it a deferential review of the denials it made, by any court, at the group insurance proposal stage. Despite this, the 'magic words' "we" (insurer) "have the full discretion to interpret and decide" everything, would appear in a one-to-three page quoted regulation section *together with an insurer self-grant of discretion as though it was an automatic entitlement. The latter document was and is usually* appended to the final contract that

was distributed to the employer, sometimes listed in a Table of Contents, sometimes not mentioned. In no instance did I ever see such policy issuance in the above circumstances transmitted with a written cover letter or other notice of the actual addition or insertion that was appended to or inserted into the policy, and explaining its import.

Given the above history, there is no legitimate data that shows that costs will materially increase in response to the modest changes in the final rules, for if there truly were, those points would surely have been advanced with full data, front and center, by the insurance industry during the notice and comment period. Accordingly, I urge the Department not to change the final rules in response to the industry's strained logic that the costliness of the final rules will impact access to disability benefits in the workplace. Moreover, whatever general costs of business may be supportable —and I haven't seen any yet— ERISA's central underlying purpose is, unequivocally, employee protection, as I emphasized in my earlier communication to the Department. *Schikore v. BankAmerica Supplemental SI (MEJ) Retirement Plan*, 269 F.3d 956, 962-63 (9th Cir. 2001), citing 29 U.S.C.S. § 1001(b). The courts and the Department of Labor through its study of cases in the last *16 years* since the 2000 regulations took effect have recognized that the poor state of affairs reflected by the ERISA group disability case law. The economic incentives for insurers to deny (or within a short time, terminate) valid claims across these 50 states, and release all reserves previously held to pay the claim into their general operating funds for investment which achieves high returns on that equity makes their practice understandable from a standpoint of protecting their shareholders —even if after 2-5 years later they have to pay out just the benefits that should have been paid to begin with. It readily explains the explosion of such claims that have for some time and increasingly clogged the courts and constantly proliferate such innumerable new case opinions they are quickly becoming impossible to keep up with. During litigation, claimants can not receive jury trials to expose insurer misconduct; the record is 'closed' even if purposefully incompletely assembled and can rarely be supplemented in litigation, and if so, may be cost prohibitive due to the huge road block insurers put up against any discovery or supplementation; and there simply are no remedies to discourage or remedy unfair and self-serving behavior by insurers. The courts have recognized this inequity, their hands otherwise tied by a statue and its regulations about which the insurance industry wages every fight against even leveling the playing field for employee participants and their beneficiaries: "The insurance industry found it could largely immunize itself from suit due to...ERISA." *United States v. Aegerion Pharmaceuticals, Inc*., 2017 WL 5586728 at *7 (D.Mass. 11/20/2017). The DOL's decision to take aim at regulations affecting plan administration of disability claims and devote focused and enhanced attention on the protections for plan participants and beneficiaries was *long overdue.*

The Requirement that Insurers Discuss the Basis for Disagreeing with a Decision by the Social Security Administration or Other Contrary Opinions is Reasonable, Logical, and Consistent with the above-referenced primary underlying purpose of ERISA.

The typical response by insurers to the fact that the SSA has granted Social Security Disability Insurance (SSDI) benefits whereas the ERISA insurer is denying/terminating a claim either under the Own-occupation disability definition, or the any-occupation disability definition which is usually accompanied by an earnings requirements of at least 60 percent of the predisability earnings level is: 1) SSA's claim analysis rules are not the rules we follow (such as treating physician rule) (even though the treating physician is a specialist who has long treated the claimant, has prescribed strong medications and other invasive maneuvers to relieve pain, and has months if not years' of first-hand observation of and experience with the patient); 2) SSA's original decision was issued 1 or 2 years ago, and (a) we don't know if they had and considered all of the same medical, vocational and witness-statement information we did; or (b) they haven't made a new decision in at least a year. There is generally no actual discussion of the ability to perform each of the material duties of the particular occupation, — not just whether it is 'sedentary' or 'light' under the 'physical strength category' of the old 1991 now-replaced (by O*NET) occupational sources, but from all of the other 19 physical requirements and nonexertional requirements, including cognitive (of various types), fingering, handling, stamina, ability to work regularly, reliably, predictably where symptoms have an unpredictable episodic manifestation, and to earn, compared to the $1170 monthly income level that the SSA defines as substantial gainful employment, versus the amount listed in the contract, such as over 60% of predisability earnings, which may be the cutoff for disability under the contract.

In contrast, the typical response by insurers which are denying/terminating a claim — whether own-occupation or any occupation under the Policy— where the SSA has also denied SSDI benefits, is: 1) the SSA has also denied your claim, because you are not disabled from performing the material duties of a gainful occupation that would pay the disqualifying amount ($1170 per month); 2) SSA says you can do a sedentary occupation, and we contend your occupation as it is re-defined in the (old) D.O.T. is "sedentary" and you can lift up to 15 pounds occasionally, and sit most of the day, and stand and walk occasionally. Never mind that the D.O.T. occupational definition that the insurer has picked has a "DLU" (Date of Last Update) of 1982, or 1985 —32 years ago, and something the claimant has to do in his/her occupation in order to perform the occupation isn't listed in the DOT definition paragraph of whatever associated DLU it is, and the

insurer *never* considers the support material from one or both of the two recommended sources from the DOL: the *Occupational Outlook Handbook* and/or the *Guide for Occupational Exploration.*

The above reveals the approach: if the SSA denies, the claim, the insurers rely on it, argue it and use it as yet another reason why the claimant's group disability claim should be denied. If the SSA grants the claim, the SSA decision is not relevant: it's rationale is not applicable for one or more different reasons; its rules too different to allow the decision any weight.

The fact is, the courts of the various circuits look for relevant logical reasoning when looking to all of the actual medical and vocational information and witness information in the record as a whole, before dismissing its merit for some disingenuous cryptic, vague and disingenuous reason stated generally in two or three sentences, as though it could apply to any and every claim of every type of disability. In my circuit, see for example, *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). And now the SOL's proposed regulations logically require what common sense under a genuine non-adversarial, neutral and objective fiduciary responsibility dictates —that group insurers and their claims representatives or any group ERISA plan observe the fundamental due process principle imbedded in ERISA—namely the principle that a claimant is entitled to a well-articulated explanation for the adverse benefits decision so that the participant may fairly dispute it. Notably, the 2000 regulations require no less.

In addition, group insurers actually require claimants to apply for the SSA benefit; Plans usually offer and/or provide representation for claimants before the SSA —often paying the same entity they propose for the representation of the claimant, that the claimant pays through the receipt of the SSDI benefits —another fact that is usually not disclosed to the claimant, and the related file not made a part of the claimant's group disability claim file. The plan does the above so that it can immediately recoup nearly all of the SSDI benefits awarded by the SSA, to reduce its own benefit liability. This is acknowledged by the Supreme Court in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). Sometimes, immediately after receipt of the SSDI offset benefits, the group insurer will then terminate the claim, having lessened its benefits output significantly even down to $100 per month, even if it knows the SSA claim is being paid and is continuing.

If compliance with the Department's requirement imposes an additional cost, it is a cost that should long ago have been incurred, *as this is a basic common sense requirement,*

and hopefully will remove gaming the SSA decisions from the adversarial quiver of opaque arrows insurers use as excuses to shoot holes in legitimate claims. A rule clarifying that a meaningful non-boilerplate explanation of the basis for disagreeing with a Social Security decision, given the actual medical and vocational and third-party witness information present in the claim file, and about which the insurer typically re-states as well as summarizes in its own claim diary notes, for easy access, is a requirement will increase uniformity and predictability in the process, which is generally associated with costs savings and not cost increases. It is what a fiduciary should do, in any event.

The Deemed Exhaustion Rule is not new, and is not costly

The industry's concern about this rule seems to be that plaintiffs and their attorneys will race into court if timely decisions are not made, somehow increasing the volume of ERISA litigation and the overall costs of administering disability claims. The deemed exhaustion provision in the new regulations simply reinforces that which subsection "l" assured employees in 2000. The principle of effective access to the court afforded by this remedial statute of ERISA is express notice of the contractual suit limitations period and an accurate assessment of the accrual of the particular claim issue. These each are absolutely necessary to the process. Section 503, 29 USC § 1133, clearly requires conformance with the claims regulations, and as stated above, the 2000 regulations provided for a deemed exhaustion of the Plan's procedures by §2560.503-1(l), 65 Fed. Reg.70246 at 70255 (Nov. 21, 2000)(codified at 29 C.F.R. § 2560.503-1 (a), as do the new regulations. The new regulations' position on the resulting de novo review in a suit adjudicated under subsection "l" is unchanged from 2000. See ERISA, Rules & Regulations for Administration & Enforcement; Claims Procedures, 65 Fed Reg at 70255.

I have personally had to adjudicate such as case where CIGNA did not make a timely decision on a detailed appeal. Several weeks after the decision on the appeal was due, and with no further word communicated from CIGNA, the plaintiff filed her lawsuit. In clarify the propriety of the filed litigation, the Plaintiff filed an early motion to determine the administrative remedies under the plan were deemed exhausted and Plaintiff was properly in court on the existing record. The district court affirmed that the administrative remedies under the plan were 'deemed exhausted' pursuant to subsection (l) of the 2000 regulations, and the case was properly in court. *Neathery v. Chevron Texaco Corp. Group Accident Policy*, 2006 U.S. Dist. LEXIS 9658**5** (S.D. Cal. Feb. 13, 2006), aff'd 303 Fed. Appx. 485, 2008 WL 5233207, 2008 U.S. App. LEXIS 26106 (9th Cir. 12/15/08). Unfortunately, despite this holding, the lower court improperly (and inconsistently) considered new expert reports and denial letters created and proffered by

CIGNA during litigation. Plaintiff was later required to appeal the district court's decision to the Ninth Circuit, exhaustively discussing the regulations and the notice and comment discussions underlying the new 'deemed exhaustion' subsection (l). The Ninth Circuit affirmed the deemed exhaustion, reversed the judgment favoring CIGNA, holding that the district court's consideration of the new evidence CIGNA proffered in litigation was improper, and remanded to the district court. *Neathery v. Chevron Texaco, etc*., No. 07-56325, 303 Fed.Appx. 485, 2008 WL 5233207, 2008 U.S.App.LEXIS 26106 (9th Cir. Dec.15, 2008) (Circuit Judges John T. Noonan, Jr., Barry G. Silverman, Carlos T. Bea).

From the above and the case law that supports claimants' ability to go to court when the claims process has failed them in a meaningful way. See e.g. *Halo v. Yale Health Plan*, 2016 U.S. App. LEXIS 6659 (2d Cir. 2016) (discussing the whole issue); *Tash v. Metro. Life Ins. Co.*, 14-01914, 2016 U.S. Dist. LEXIS 66888, *10-*12 (at ¶¶ 30-34) (C.D. Cal. 5/19/2016) (30. ...this process is undermined where, as here, the fiduciary fails to issue a proper denial and fails to provide notice to the insured as to the issues in dispute. 31. MetLife's failure to issue a timely denial letter violated [*11] ERISA. This violation of ERISA caused Plaintiff the type of prejudice warned about in *Harlick*. Plaintiff was unaware until February 24, 2016 — two days before trial briefings were to be filed — of the reason MetLife refused to pay benefits since the "own occupation" period ended on February 10, 2013. As such, Dr. Tash was denied the ability to submit evidence challenging MetLife's grounds for denial before starting this litigation. 32. MetLife's failure to issue a timely denial violated ERISA and has both prejudiced Dr. Tash & disrupted this litigation' – prejudiced Tash because he didn't know basis for denial to prepare for further administrative review and appeal to the federal courts, etc.).

See also, *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz, Inc*., 770 F.3d 1282 (9th Cir. 2014) (11/5/14)(that a claimant need not exhaust administrative remedies if such exhaustion isn't required by the given plan, citing *Barboza v. Cal. Ass'n of Prof'l Firefighters*, 651 F.3d 1073, 1076 (9th Cir. 2011).); *Tarasovsky v. Stratify, Inc. Group STD Plan & LTD Plan (Guardian Life*), 2013 U.S. Dist LEXIS 70651, 2013 WL 2156262 (N.D. Cal. May 17, 2013), citing *Jebian v. Hewlett-Packard Co. Empl. Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003); *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); *Eastman Kodak Co. v. STWB, Inc*., 452 F.3d 215 (2d Cir. N.Y. 2006) (held: under the "deemed exhausted" provision of 29 C.F.R. § 2560.503-1(l), an ERISA benefits claimant is not required to exhaust a claims procedure that was adopted only after a suit to recover benefits has been brought). It is not likely 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., etc.*, 349 F.3d 1098 (9th Cir. 2003); *Dunnigan v. Metro. Life Ins. Co.*, 277 F.3d 223, 231 n.5 (2d Cir. 2002)

The Department can see that any concerns about the deemed exhaustion rule today are no different that the rule that has been in effect since the current regulations which took effect on January 1, 2001. The rule in the proposed regulations will not create any additional significant costs. The industry had the opportunity to fully address, and did address, that issue in the Notice and Comment period of the 2000 regulations, as implicated by the quoted parts of those notice and comments in the attached appeals briefs of 2007. The industry again had the opportunity to address that issue in the most recent Notice and Comment period to the new proposed regulations.

The Right to Review and Respond to New Evidence or Rationale From the Plan following an appeal is Consistent with the Primary underlying purpose of ERISA and is Not Costly.

This rule is fundamental to full and fair review. The Department considers this rule important. It is the standard in some jurisdictions, including my own Ninth Circuit. *Salomaa v. Honda LTD (LINA*), 642 F.3d 666, 680 (9th Cir. Cal. 2011) (5/26/11), aligning the circuit with *Abram v. Cargill, Inc*., 395 F.3d 882, 886 (8th Cir. 2005). The defendant in Salomaa sought reconsideration and en banc hearing on this very issue, which was denied, and certiorari thereafter denied.

The industry complains in its obvious self-interest that providing the claimant with new evidence or rationales before making a final decision is costly. The industry's claim to cost impact is more than suspect. First, the general process is to wait until after the appeal to farm select claim documents out for so-called 'independent' review only after an appeal of the initial denial. Many insurers wait until only after an appeal to seek an Defense Medical Examination (DME) or a Functional Capacity Evaluation (FCE) or Neuropsychological Examination (NPE), control the process, including, as mentioned above, making no effort to obtain any and all records from the third party scheduling or reviewing entity and paper reviewer, or testing entity, but placing only the final report after all amendments and reviews have been suggested and/or made, leaving a huge 'gap' in the record as to the entire process and communications used in the process. Usually the instructions and definitions required to be used are not readily discernible, references to

the "provided documents" may be vague without identifying each –including references to letters from the insurer— and then either contend that the claimant may ONLY respond to the report and insurer's decision (which generally parrots the report) without knowing the full process used, and in any event subjecting the claimant to a manipulated and potentially selective review process through a second (costly) 'voluntary' appeal, or disallows any appeal at all because ERISA does not allow it. The latter position *outright disallowing a second appeal* was recently taken against one of my own clients even though the 'final' denial reversed the previously stated position on what the claimant's 'own occupation' actually involved. The insurer instead claimed in that "final" denial that her occupation was entirely different, did not involve most the material duties she could no longer perform due to disabling multi-level spine disease, and took a new position on the medical evidence through a selective physician paper review where the "provided records" given the reviewer were, at best, selectively incomplete, or at worst, outright ignored and/or medical findings in the records completely misstated such that the reviewer was essentially tasked to opine whether a 49 year old with NO abnormalities or spine-disease could lift up to 50 pounds, sit, walk and stand full time to perform the new and different alleged-'own-occupation' that the insurer had just identified.

Without this rule in the regulations, the 'administrator's' new evidence or rationale will be included in the record that the court reviews, but the claimant's rebuttal will not, and the insurer will argue (as they always do), it's the insured's "burden of proof" of his/her disability, and given the new evidence with no opportunity to rebut it, he/she can never meet his/her burden of proof. The Department likely appreciates the gaming of the system by insurers in this additional respect: wait until after the appeal, when it's too late to do anything about it, to criticize the insured for not submitting specific types of evidence that was never specifically requested in language that could be understood by a lay employee with no medical, vocational or other training in assessment of disability and impairment, and then argue that for this reason, the claimant cannot meet his/her burden of proof of disability based on the absence of such (never-previously described) type of evidence. Additional gaming the system is to wait until after the appeal to request various types of "independent" examinations, the results of which are not provided to the claimant until after the 'final decision' –not even then allowing rebuttal or comment, again providing the insurer support for the argument the insured failed to meet their burden of proof given the rest of the (new) evidence of alleged non-disability in the file.

Implicated by the above is the fact the industry is being called on the carpet for their basically orchestrated adversarial informal-litigious process against =disabled employees who naively trust in the good faith of the process that is *supposed to be* objective, neutral,

fair, informative with actually "meaningful dialogue" about what is needed under the circumstances, and why. The above process is seen so frequently as a practice of the entire industry, with small variations, that it helps to explain why the industry believes ERISA is the goose that laid the golden egg for insurers.

The Impartiality Rule is only common sense.

The purposeful, knowing hiring of biased reviewers who want to maintain their separate stream of income from insurers for their reviews is relevant regardless of whether a standard of review is abuse of discretion –implicating conflict of interest issues, or de novo, still implicating bias and credibility issues relevant to the weight a court would give to that opinion, is clearly at issue. The lack of any damages or other remedies to hold the orchestrated opinion providers to account raises the importance of this issue. Repeatedly reviewer appear to allow themselves to be manipulated by receiving highly-selected or 'tabbed' "provided documents." Another indication that the hired reviewers are allowing themselves to be manipulated and controlled by insurance claims representatives, who are not medical experts in the relevant field, are the highly selected questions posed for the reviewer to answer, —and only those questions— generally with little explanation of the disease generally, how it generally manifests and the patient variations, etc. The third way the allowed manipulations occur is to look at the final word choice used in the reviewer's reports, and how vague, general or opaque they are without needed specificity as applied to each of the claimant's required occupational duties as are affected by the combination or collection of all symptoms that result in the disability. Given the absence of most discovery, it becomes difficult to obtain records, including summary letters, that have been electronically submitted via a third party business website of the entity that arranges or provides the medical or vocational paper reviews to the insurer. All of the records related to the covered employees claim should be part of the 'record' –not just those placed in a Claim File. There are so many ways insurers can manipulate and orchestrate the external reviews to immunize –at least in their minds– against having such records compiled as part of the 'administrative record,' that the Impartiality Rule becomes even more important. The question of what range of remedies should be available under either (a)(1)(B) or (a)(3) when these rules are violated.

The Rule Requiring disclosure of any internal suit limitations period comports with the requirements of several jurisdictions already.

See: *Moyer v. Metro. Life Ins.Co*., 762 F.3d 503, 505, 507 (6th Cir. 2014) (8/7/14), citing a Second Circuit decision that involved the failure to provide notice of time limits for

administrative review, *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 107 (2d Cir. 2003); *Mirza v. Insurance Administrator of Am., Inc*., 800 F.3d 129, 134 (3rd Cir. 2015) (8/26/15); *Campbell v. Sussex County Federal Credit Union*, 602 Fed. Appx. 71, 2015 U.S. App. LEXIS 2500, *9-10, 2015 WL 690435 (3rd Cir. 2/19/2015) (aff'd equitable tolling for employer's failure to comply with regulatory notice requirements in its denial, citing *Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675, 680 (1st Cir. 2011) (concluding that the plaintiff was entitled to equitable tolling because the defendant failed [*10] "to provide [the plaintiff] with notice of his right to bring suit under ERISA, and the time frame for doing so, when it denied his request for benefits"); *Santana-Díaz v. Metro. Life Ins. Co.*, 816 F.3d 172 (1st Cir. 2016) (discussed in n8 at p.181, that 29 C.F.R. § 2560.503-1(j)(4) "appears to apply specifically to final denial letters" ---although had assumed that (g)(1)(iv) applied to final denial letters because the parties had made "no mention of section 2560.503-1(j)(4) in their briefs."); *Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675, 680 (1st Cir. 2011) (plaintiff, who missed the critical one-year deadline because he was materially mislead into doing so by the company, was entitled to equitable tolling because the defendant failed "to provide [the plaintiff] with notice of his right to bring suit under ERISA, and the time frame for doing so, when it denied his request for benefits.")

The rule requiring such disclosure also comports with the unmistakable fact that judicial review is an appeal procedure for an adverse benefit determination and is or should be a part of the claim procedures that the regulations cover, especially when the time limit for filing the judicial action is contractually established by the plan. Again, the underlying primary purpose of ERISA –that of employee protection– is not to trick the employee, but to communicate information that the fiduciary knows or should know the claimant needs to know and understand.[1] This is particularly true where many internal suit limitations

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[1]E.g.: *Krohn v. Huron Memorial Hosp.*, 173 F.3d 542, 547-549 (6th Cir. 1999) [lengthy discussion of fiduciary duty to inform all material facts, particularly when asked]; *Bartling v. Fruehauf Corp.,* 29 F.3d 1062, 1070 (6th Cir. 1994) ("all other things being equal, court should favor disclosure [under ERISA — 104(b)(4)] where it would help participants understand their rights."); *Electro-Mechanical Corp. v. Ogan*, 9 F.3d 445, 451-52 (6th Cir. 1993) ("ERISA imposes a duty upon fiduciaries to respond promptly and adequately to employee-initiated inquiries regarding the plan or any of its terms"); *Drennan v. General Motors Corp*., 977 F.2d 246, 251 (6th Cir. 1992) ("a fiduciary must give complete and accurate information in response to participants' questions . . ."); *Killian v. Concert Health Plan*, 742 F.3d 651 (7th Cir. 2013), en banc, discussing *Kenseth*, 610 F.3d at 465-66,

> "HN8."once an ERISA beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary's status and situation, the fiduciary has an

periods are required because of state insurance code requirements about the standard provisions that have to be included in disability policies or plans, but which, read together with ERISA's required 'administrative' exhaustion process, does not make much if any sense. *Spence v. Union Sec. Ins. Co.*, 2015 U.S. Dist. LEXIS 33458, *5 (D. Or. Mar. 17, 2015) citing *Moyer*, 762 F.3d at 505 and *Solien v. Raytheon Long Term Disability Plan # 590*, No. CV 07-156 TUC, 2008 U.S. Dist. LEXIS 43194, 2008 WL 2323915, at"*7 (D. Ariz. June 2, 2008) ("Judicial review is an appeal procedure for an adverse benefit determination and is therefore a part of the claim procedures covered by these regulations, especially when the time limit for filing a judicial action is established contractually by the Plan."). And noting, "When a benefits termination notice fails to explain the proper steps for appeal, the plan's time bar is not triggered. *White v. Jacobs Eng'g Group Long Term Disability Plan*, 896 F.2d 344, 351 (9th Cir. 1989)."; *John H. v. United Healthcare [JP Morgan Chase Health Plan*], 16-cv-00110, 2017 U.S. Dist. LEXIS 73593 (N.D. Utah 4/26/17) (Held: to enforce a contractual limitation of action such as this Plan's one-year time to sue, insurer must identify that time period in the denial letters per 29 C.F.R. §2560.503-1(g)(1)(iv) and (j)(4). It is not sufficient to just refer claimants to lengthy plan documents to figure it out. The John H court's approach aligns with *Starr v. Metro Sys., Inc*., 461 F.3d 1036, 1041 (8th Cir. 2006), *Mirza v. Insurance Administrator of Am.Inc*., 800 F.3d 129, 134 (3d Cir. 2015) & *Moyer v. Metro.Life Ins.Co*., 762 F.3d 503, 505 (6th Cir. 2014), *Santana-Dias v. Metro.Life Ins.Co.*, 816 F.3d 172, 180 (1st Cir. 2016).

The Rule Requiring Disclosure of Internal Guidelines

All policies contain terms specific to the issuing insurer, many of which implicate issues involving interpretation or uniformity (consistency) of construction and application of the terms. Uniform application of the terms of the policy require not only illustration of the actual application, but implicate review of the internal guidelines to ensure that, if the guidelines have been applied, the manner of their application is actually consistent with

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> obligation to convey complete and accurate information material [*35] to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire."

Id. at 466 (emphasis in original) (alteration omitted) (quoting *Gregg v. Transp. Workers of America Int'l*, 343 F.3d 833, 845-46 (6th Cir. 2003)). "Regardless of the precision of his questions, once a beneficiary makes known his predicament, the fiduciary 'is under a duty to communicate ... all material facts in connection with the transaction which the trustee knows or should know.'" Id. at 467 (alteration in original) (quoting Restatement (Second) of Trusts § 173, cmt. d (1959)).

the policy terms, for the administrator cannot apply guidelines that are inconcistent with the policy terms. In addition, the guidelines are relevant to ensure that their directive actually governs policy terms that are consistent with them, for if they are consistent, but the adminsitrator fails to comply with the consistent guidelines, that in itself proves abuse of discretion. Certainly internal guidelines help to ensure claims handlers do not just arbitrarily make things up as they go, but are held to apply internal rules insofar as they are consistent with the policy terms.

Genrally speaking, the principle of uniformity of construction, which relates to following consistent internal guidelines, or rejecting and not following those that are inconsistent with the policy, is itself a factor that ERISA courts consider in evaluating an abuse of discretion. 29 C.F.R. §2560.503-1(b)(5) ("the plan provisions" must be "applied consistently with respect to similarly situated claimants".

For instance, these courts have addressed uniformity of construction of the plan: *Stephan v. Unum Life Ins*., 697 F.3d 917, 936 (9th Cir. 2012). See e.g., *McDaniel v. Chevron Corp*., 203 F.3d 1099, 1113 (9th Cir. 2000), citing *Hansen v. Western Greyhound Retirement Plan*, 859 F.2d 779, 781 (9th Cir. 1988) (upholding a consistent interpretation of an early retirement provision under the arbitrary and capricious standard); see also *James E. Jordan et al., Handbook on ERISA Litigation*, 3d. Ed., § 5.04[C] p.5-87 to 5-88 (2014 Supp.) (Listing seven factors courts consider in determining reasonableness of an interpretation of the policy or plan during an assessment of whether there has been an abuse of discretion, including, "Is the interpretation consistent with previous interpretations?") The issue requires analysis of whether the alleged "consistency" or "uniformity" of interpretation has been applied equally to all participants of the plan. See e.g., *Wildbur v. Arco Chemical Co.*, 974 F.2d 631, 637-38 (5th Cir. 1992): "Determining whether the administrator has given a uniform construction to a plan may require a court to evaluate evidence of benefit determinations other than the one under scrutiny." (Emphasis added). Id. at 638. *Blau v. Del Monte Corp*., 748 F.2d 1348, 1356 (9th Cir. 1984), *Dytrt v. Mountain State Tel. & Tel. Co.*, 921 F.2d 889, 894 n. 4 (9th Cir.1990), *Dennard v. Richards Group, Inc.,* 681 F.2d 306, 318 (5th Cir. 1982).

With respect to the insurer's internal guidelines, which travel by a variety of names, Claim Guidelines / Claim Manual / Policies and Procedures Manual and any related Training Manual or individual memorandum addressing the issue of rules or guidance in applying the specific policy terms at issue, a number of cases have addressed this issue. *Ennis v. Prudential Insur. Co. of Am.*, 12cv00432, 2013 WL 203293, 2013 U.S. Dist.

LEXIS 7118 (E.D. MO Jan 17, 2013); *Oster v. Std. Ins. Co.*, 759 F. Supp. 2d 1172, 1188 (N.D. Cal. Jan 3, 2011); *Egert v. Conn. Gen. Life Ins. Co.,* 900 F.2d 1032 (7th Cir. 1990).

The court in *Egert* held that benefit plan administrators cannot adopt any guidelines they choose and then rely upon these guidelines with impunity; rather, they may rely only upon those guidelines that reasonably interpret their plans; denial of benefits was arbitrary and capricious where basis for denial conflicted with internal claims manual; *Alexander v. United Behavioral Health*, 2015 U.S. Dist. LEXIS 46046 (N.D. Cal, Apr.7, 2015) (same); *Glista v. UNUM Life Ins. Co. of Am.*, 378 F.3d 113 (1st Cir. 2004): By creating and promulgating internal guidance documents, plan administrators choose to exercise their discretion to define terms. When courts place weight on those definitions, they do not narrow the plan administrator's discretion beyond what the administrator itself has chosen to do." *citing Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999). Glista also cites *Cannon v. Unum Life Ins. Co. of Am.,* 219 F.R.D. 211, 214 (D. Me. 2004) ("If an internal memorandum existed that favored [the claimant's] receipt of continuing benefits, the fact that it was *disregarded* would be powerful evidence of an arbitrary and capricious claims determination."). The court in Glista also stated:

> The Training Materials and the associated deposition testimony regarding their use are relevant as well. In particular, we note the relevance of the statement in the Training Materials that "if the [medical review] does not establish a clear link between the treatment in the pre-ex period & the disabling condition, the disabling condition is not pre-ex" (emphasis added).7 The Training Materials indicate that this statement is intended [**31] to apply to pre-existing condition clauses of the 3/3/12 type in CXC contracts -- precisely the sort at issue here.

Id., 378 F.3d at 125. The *Glista* court explains:

> By creating and promulgating internal guidance documents, plan administrators choose to exercise their discretion to define terms. When courts place weight on those definitions, they do not narrow the plan administrator's discretion beyond what the administrator itself has chosen to do.
>
> There is nothing uncommon about [**27] reviewing courts considering such internal memoranda containing ERISA interpretations. For example, in Doe, this court considered internal guidelines upon which Travelers, the plan administrator, had relied in applying the mental health provisions of its plan.

> 167 F.3d at 59. We ultimately found the administrator's denial of benefits unreasonable, in part because that denial conflicted with Travelers' own guidelines. Id. Similarly, in *Egert v. Conn. Gen. Life Ins. Co.*, 900 F.2d 1032 (7th Cir. 1990), the Court of Appeals for the Seventh Circuit relied on an internal memorandum in finding arbitrary and capricious the plan administrator's denial of a claim for in vitro fertilization on the ground that the plan authorized reimbursement only for the treatment of an "illness" and infertility was not an illness. Although the court found that "illness" could be credibly interpreted either to include or to exclude infertility, id. at 1037, it held that the denial was arbitrary and capricious because "Connecticut General had described infertility as an 'illness' in its own internal guidelines," id. at 1038, which "outlined [**28] appropriate applications of the Plan to individual circumstances," id. at 1034. 4 The court stressed the importance of "uniformity of construction" when evaluating whether an action was arbitrary and capricious. Id. at 1037 (quoting *Reilly v. Blue Cross & Blue Shield United of Wisc.*, 846 F.2d 416, 420 (7th Cir. 1988), which cites *Dennard v. Richards Group, Inc.*, 681 F.2d 306, 318 (5th Cir. 1982)).

See also, *Potter v. Blue Shield of Cal. Life & Health Ins. Co.*, SACV 14-0837-DOC (KESx), 2017 U.S. Dist. LEXIS 53948 (C.D. Cal. Apr. 7, 2017) (abuse of discretion for insurer and its reviewers to rely on internal guidelines —as they did to deny the claim— where they were not incorporated into the plan: "[A] compilation of secret, internal guidelines not disclosed to the employer or to participants or beneficiaries of the Plan" cannot be dispositive," citing *Egert,* 900 F.2d at 1033-34.

The court in *Potter* also rejected Defendant's suggestion that "Plaintiff was aware of the guidelines because they were referenced in Defendant's initial denial letter." (Referencing the "Blue Shield Life medically necessary criteria for coverage of psychiatric residential treatment"), however the court found noted that, "the initial denial letter is not a Plan document, and in any event the Court finds this reference manifestly insufficient to incorporate Blue Shield's "Residential Acute Behavioral Health Level of Care, Adult" guideline into the Plan by reference."

Regarding 29 C.F.R. § 2560.503-1(h)(2)(iii) and 29 C.F.R. § 2560.503-1(m)(8), the court in *Ennis v. Prudential Insur. Co. of Am.*, 12cv00432, 2013 WL 203293, 2013 U.S. Dist.

LEXIS 7118 (E.D. MO Jan 17, 2013) held that internal claims handling manuals are therefore discoverable, noting:

> [A] plan administrator's internal claims handling manuals are relevant documents or records as defined by the regulation. If nothing else, they certainly constitute "a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination." Thus, under the regulation, the manuals must be disclosed.

The *Ennis* court discussed *Chronister v. UNUM Life Ins. Co. of America*, 563 F.3d 773, 775 (8th Cir.2009), explaining,

> In Chronister, as here, the plan administrator refused to consider that the SSA had determined that plaintiff was disabled and entitled to full disability benefits. That refusal, however, was "contrary to the clear dictates of [defendant's] claims-handling policies" which expressly provided that SSA determinations must be considered, and it constituted a "most egregious" factor in the Court's holding that defendant abused its discretion in denying plaintiff's claim. *Chronister,* at 776-77. Given this holding, plaintiff here is entitled to know whether similar provisions are set out in defendants' internal claims handling manuals. By implication, though, the larger point is that a plan administrator's serious and significant deviation from its own internal policies and procedures-whatever those deviations may be- is substantial proof that the administrator's structural conflict of interest is exacerbated and that an abuse of discretion has occurred. Accordingly, plaintiff is entitled to know whether defendants abided by their internal policies and procedures, and the claims handling manuals shall be produced for that purpose."

Respectfully, I urge the Final Rules be implemented, as adopted.

Very truly yours,
MILLER MONSON PESHEL POLACEK & HOSHAW

Susan L. Horner

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