U.S. Chamber of Commerce

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May 18, 2022

The Honorable Bobby Scott
Chairman
U.S. House of Representatives
Washington, DC 20515

The Honorable Virginia Foxx
Ranking Member
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Scott and Ranking Member Foxx:

The U.S. Chamber of Commerce opposes Title VII "The Employee and Retiree Access to Justice Act of 2022" of H.R. 7780 "Mental Health Matters" as introduced by Representative Mark Representative DeSaulnier (D-CA). Contrary to its name, by effectively prohibiting arbitration in ERISA claims and prohibiting discretionary clauses, this provision would limit recovery amounts, increase the costs of claims for benefits, and increase the time for courts to resolve claims for benefits, including time sensitive claims such as disability and severance.

Claim for Benefits Standard of Review

The Supreme Court has recognized the importance of the deferential standard of review in ERISA claim for benefit cases.

> Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place. . . . ERISA induces employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.
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> Firestone deference protects these interests and, by permitting an employer to grant primary interpretive authority over an ERISA plan to the plan administrator, preserves the careful balancing on which ERISA is based. Deference promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review. Moreover, Firestone deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan . . . that covers employees in different jurisdictions—a result that "would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Indeed, a group of prominent actuaries tells us that it is impossible even to determine whether an ERISA plan is solvent (a duty imposed on actuaries by federal law, if the plan is interpreted to mean different things in different places. [1]

[1] Conkright v. Frommert, 559 U.S. 506, 516–18, (2010).

The proposal to eliminate the deferential standard of review also undermines the current claims procedure structure which is aimed at resolving claims expeditiously by individuals with the knowledge and expertise needed for such resolution. Under the current framework, a participant is required to exhaust the plan's internal review procedures before bringing a claim. During this process, the claim procedure regulation requires that on appeal the plan allow claimants to submit written comments, documents, records, and other information relating to the claim.[2] Additionally, the plan must provide the claimant, upon request and free of charge, "all documents, records, and other information relevant to the claimant's claim for benefits."[3] A document, record or other information is relevant if it:

- Was relied on in making the benefit determination;
- Was submitted, considered, or generated while making the benefit determination, regardless of whether it was relied on in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards the regulation requires; or
- For a group health or disability plan, is a statement of policy or guidance concerning the denied treatment option or benefit for the claimant's diagnosis, regardless of whether such advice or statement was relied on in making the benefit determination.[4]

Under the regulation and case law, if a plan does not follow the claims procedures, a claimant is not required to exhaust them and may go directly to court. [5] The result is that the court reviews the fiduciary's decision under the de novo standard rather than the arbitrary and capricious standard.[6] This framework provides strong incentives to adhere to the claims procedure regulation that is aimed at safe-guarding participants' rights.

ERISA's administrative process also serves an important purpose of expediting claims at the administrative level rather than requiring courts to conduct a de novo review of claims before the record has been established. Without this, de novo review would require extensive, and expensive, discovery for both the participant and the employer and plan sponsor which frustrates the goal of expedited review.[7] For example, in the United States District Courts "[n]ationally, the average time between filing and trial for a civil case is a little over two years. In many of these overworked courts

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[2] 29 CFR § 2560.503-1(h)(2).
[3] 29 CFR § 2560.503-1(h)(2).
[4] 29 CFR § 2560.503-1(m)(8).
[5] 29 C.F.R. §2560.503-1(l)(1).
[6] *Halo v. Yale Health Plan, Dir. of Benefits & Recs. Yale Univ.*, 819 F.3d 42, 60-61 (2d Cir. 2016).
[7] "A primary benefit to the judicial system of the current standard of review scheme based on trust law is the increased judicial efficiency. This efficiency is accomplished by placing discretion in the hands of an appropriate, responsible figure, which requires minimal judicial oversight, and thus less of the court's time and energy." *ERISA, Trust Law, and the Appropriate Standard of Review: A De Novo Review of Why the Elimination of Discretionary Clauses Would Be an Abuse of Discretion*, Joshua Foster, St. John's Law Review, Volume 82, Spring 2008 available at https://scholarship.law.stjohns.edu/cgi/viewcontent.cgi?article=1092&context=lawreview

the average time between filing and trial is much longer, often three or four years."[8] However, the claim procedure regulation generally requires that appeals be decided within 60 days of the request. Urgent care health appeals must be made within 72 hours and post-service health claims must be decided on appeal with 30 days if there are two levels of appeal or within 60 days if there is one level of appeal.[9]

Arbitration Clauses

Recently, some employee benefit plans have been amended to include arbitration clauses in reaction to the onslaught of class action lawsuits aimed at attorney fee recovery rather than protecting participants' rights. A cottage industry has grown around these cases, with several firms filing cookie cutter cases against plan sponsors in hopes of a quick settlement, with large attorneys' fees. On the health side, there are numerous class action lawsuits claiming minor violations of the COBRA notice provisions, such as naming the COBRA administrator rather than the "plan administrator."[10] Very few have gone to trial, and instead have settled, with individuals receiving very little compared to the attorneys' fee awards.[11] On the retirement side, what began as a steady increase of class action lawsuits in the past 15 years, has exploded in the past two years, culminating in over 100 excessive-fee suits in 2020, which was a five-fold increase over the previous year, and on track for 2022 to far exceed this.[12] Similar to the COBRA class actions, most of these cases settle, with more going to attorneys' fees than on a per participant recovery.[13]

Including arbitration clauses and limiting class representation[14] is not an attempt to

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[8] Statement of the Honorable Brian Stacy Miller Judge, United States District Court for the Eastern District of Arkansas Chair, Judicial Resources Committee Subcommittee on Judicial Statistics on Behalf of the Judicial Conference of the United States Before the Committee on the Judiciary United States Senate, "THE JUDICIAL CONFERENCE'S RECOMMENDATION FOR MORE JUDGESHIPS" JUNE 30, 2020 available at https://www.uscourts.gov/sites/default/files/judge_brian_s._miller_testimony_june_2020_0.pdf.
[9] 29 CFR § 2560.503-1(h)(2).

[10] *See INSIGHT: A New Target of ERISA Class Actions—COBRA Notices*, April 4, 2020, Nancy Ross and Richard Nowak available at https://news.bloomberglaw.com/employee-benefits/insight-a-new-target-of-erisa-class-actions-cobra-notices.
[11] *See Brenntag Mid-South Settles COBRA Notice Class Suit for $65,000*, Jacklyn Wille, Oct. 26, 2021 available at https://news.bloomberglaw.com/health-law-and-business/brenntag-mid-south-settles-cobra-notice-class-suit-for-65-000 (noting individual class members received $53 while the attorneys received a separate amount of $70,000).
[12] *See Understanding the Rapid Rise in Excessive Fee Claims* 2, AIG, https://bit.ly/3k43kt8; *see also* Jacklyn Wille, *401(k) Fee Suits Flood Courts, Set for Fivefold Jump in 2020*, Bloomberg Law (Aug. 31, 2020), https://bit.ly/3fDgjQ5.
[13] See Surge in Excessive Fee Litigation is Impacting Fiduciary Liability Insurance, available at https://www.crcgroup.com/Tools-Intel/post/surge-in-excessive-fee-litigation-is-impacting-fiduciary-liability-insurance *(*"To date, fiduciary liability carriers have paid an estimated $1B+ in settlements and more than $250 million in attorneys' fees to a growing group of plaintiff firms looking to capitalize on outsized fee awards.") For example, in *Hill v. Mercy Health Corp.*, N.D. Ill., No. 3:20-cv-50286, at most, each participant would recover $25 compared to $1.3 million in attorneys' fees. Settlement available at https://www.napa-net.org/sites/napa-net.org/files/mercy%20hospital%20settlement.pdf.
[14] DOL has recognized that only health and disability plan claims for benefits pre-dispute arbitration is regulated under the claims procedure regulation. "The regulation is not intended to affect the enforceability of a pre-dispute arbitration agreement with respect to any other claims or disputes. Accordingly, the regulation should not be read to affect the obligation of a participant or beneficiary to arbitrate such other claims and disputes within the scope of the arbitration agreement. See 29 CFR § 2560.503-1(c)(3)(iii)." *See*

abrogate individual participant ERISA rights. Rather, it is a reaction to the plaintiffs' bar strike suits over alleged inconsequential COBRA notice violation and exaggerated excessive fee and investment options.[15]

Arbitration is often cheaper and more favorable for employees. In fact, a recent study of cases from 2014 through 2021 found that:

- Employees were more likely to win in arbitration (almost 38 percent) than in court (almost 11 percent).
- On average, employees won more money through arbitration (around $444,000) than in court (about $408,000).
- Arbitrations were resolved on average faster (659 days) than litigation (715 days).[16]

Given these findings, it is unclear how limiting arbitration in ERISA cases would provide employees and retirees access to justice.

Conclusion

The Chamber supports legislation that encourages employers to provide benefits, while also protecting participants. Title VII of H.R. 7780 does neither. We look forward to working with the Committee to instead come up with bipartisan legislation to strengthen the American retirement system.

Sincerely,

Neil L. Bradley,
Executive Vice President, Chief Policy Officer,
and Head of Strategic Advocacy
U.S. Chamber of Commerce

cc: Members of the House Committee on Education and Labor

Benefit Claims Procedure Regulation FAQs, Q/A B-6 available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation.

[15] *See Can Mandatory Arbitration Rein in ERISA Litigation? Appellate Courts Weigh In,* Carol Buckmann, Apr. 11, 2021 available at https://cohenbuckmann.com/insights/2021/4/11/can-mandatory-arbitration-rein-in-erisa-litigation-appellate-courts-weigh-in.

[16] *Fairer, Faster, Better III: An Empirical Assessment of Consumer and Employment Arbitration*, March 2022 available at https://instituteforlegalreform.com/wp-content/uploads/2022/03/FINAL-ndp-Consumer-and-Employment-Arbitration-Paper-2022.pdf.