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December 11, 2017

Submitted Electronically via e-ORI@dol.gov

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW.
Washington, DC 20210
Attention: Claims Procedure for Plans Providing Disability Benefits Examination

Subject: Claims Procedure for Plans Providing Disability Benefits; Extension of Applicability Date (RIN 1210-AB39)

Dear Sir/Madam:

These comments are submitted on behalf of Unum Group (“Unum”) which through its insurance subsidiaries is the nation’s largest group disability insurance carrier. Unum appreciates the opportunity to comment on the Department of Labor’s (“Department”) extension of the applicability date of the final rule amending disability claims procedures (81 Fed Reg. 92316 (Dec. 19, 2016), the “Regulation”) under the Employee Retirement Income Security Act of 1974 (“ERISA”).

Unum and its insureds are significantly impacted by ERISA disability claims regulation changes. Pursuant to Executive Order 13777, the Department seeks additional input regarding the regulatory impact analysis in the Regulation so that the Department may consider whether it supports regulatory alternatives other than those adopted in the Regulation. Unum strongly urges the Department to conduct an appropriate cost benefit analysis given that the Regulation was issued by the prior administration without benefit of relevant data. Additionally, Unum asserts that an appropriate review of the Regulation will lead to the inevitable conclusion that the costs of the Regulation far outweigh any benefits.

Unum submitted extensive comments opposing the Regulation during the initial comment period, and those comments, in the attached letter, remain relevant today. Additionally, Unum is a member of the American Council of Life Insurers (“ACLI”) and incorporates comments made by ACLI on its member companies’ behalf as well as the data submitted as an attachment to ACLI’s comment letter (both of which were submitted to the Department on December 11, 2017). Unum supports the Department’s consideration of regulatory alternatives and believes that the data submitted by ACLI, strongly supports the Department undertaking further analysis and advancing regulator alternatives to the Regulation. In

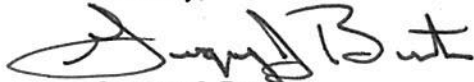
short, Unum believes that the data presents compelling evidence that the Regulations are unnecessary and that the current rules provide robust consumer protections that are not enhanced by importing Affordable Care Act provisions into ERISA disability claims regulations. The data shows that the vast majority of ERISA disability claims are paid upon initial application; that many of those claims that aren't paid are due to reasons other than a determination that a claimant is not disabled; and that meaningful number of denials are overturned during the appeal process. This data reflects current procedures that are working as intended, and that the Regulations are a solution to a problem that doesn't exist.

The data further demonstrates that the proposed Affordable Care Act changes to ERISA Disability Claims Regulations would result in significant additional costs with no tangible benefit to consumers. The additional costs from the Regulation (the vast majority of which are recurring) will be borne by consumers who are increasingly expected to bear a significant and growing share of benefits premiums. As survey data regarding price elasticity data demonstrates, increased premiums will result in fewer working Americans protected by ERISA disability income protection plans. In fact, ACLI's data indicates that each percentage increase in price will result in a nearly two-fold percentage drop in covered lives. Working Americans who lose coverage under ERISA disability income protection plans and then lose the ability to work due to accident or sickness will increasingly fall into federal and state welfare safety nets, placing additional burdens on these taxpayer-funded welfare programs. Group Disability Income protection plans, offered by employers to protect their employees, make up the overwhelming majority of ERISA plans impacted by these Regulations, and the cost of the Regulations are high with little to no corresponding benefits.

Unum appreciates the Department's current effort to gather, review and analyze data and comments regarding the ERISA disability claims regulation changes. Unum believes that an appropriate analysis of the data will lead the Department to conclude that it should not adopt Affordable Care Act requirements into ERISA Disability Claims Regulations, and that the cost of the proposed Regulations significantly exceeds any benefits.

Thank you for considering Unum's input.

Sincerely,



Gregory J. Breter
Senior Vice President
Unum U.S. Benefits Operations

Attachment: Unum's Comment Letter to DOL Dated January 19, 2016



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January 19, 2016

Submitted Electronically

Office of Regulations and Interpretations
Employee Benefit Security Administration
Room N-5666
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

Subject: Claims Procedure for Plans Providing Disability Benefits (RIN 1210-AB39)

To Whom it May Concern:

These comments are being submitted on behalf of Unum Group (“Unum”) which through its insurance subsidiaries is the nation’s largest group disability insurance carrier. Unum and its insureds are significantly impacted by ERISA disability claims regulation changes. Unum believes that the current ERISA framework should not mirror Affordable Care Act requirements for several reasons that are stated below. Additionally, the existing framework for determining disability benefit claims contains significant consumer protections and provides an effective and efficient process by which disability claims are adjudicated. Unum’s experience is that litigation volumes have been declining over the past 10 years and currently are only a tiny fraction of one-percent of disability claims. We believe that some of the changes proposed would significantly increase the costs associated with the administrative process and result in a substantial increase in the volume and costs associated with litigation of ERISA disability claims. Increased costs will be passed along to consumers who are increasingly faced with pressure on their benefit dollars. Unum believes that proposals that result in greater costs associated with claims and litigation are anti-consumer in that fewer working Americans will be able to protect their income from the inability to work due to accident or sickness.

I. Introduction

a. Distinctions Between Disability and Medical Benefit Claims

One of the stated purposes of the proposed amendments is to bring the disability claim

regulations into line with the procedures applicable to medical claims following enactment of the ACA. There are a number of reasons why provisions under the ACA that make sense for medical claims are not appropriate for disability claims given the significant differences in the way medical and disability benefit claims are reviewed and determined:

- The vast majority of medical claims are determined electronically with little or no human involvement. This means that medical claims can for the most part be determined almost instantaneously. Disability claims are almost entirely manual in the sense that they always require one or more claim reviewers to study extensive file materials and to consult with varied professionals in medical, vocational, financial, and other disciplines.
- Medical claims typically involve only a limited treatment or series of treatments over a relatively short period of time. Many times medical claims only involve one doctor visit. The claim determination is a one-time determination. Disability claims require a series of determinations over a period of several years or even decades. Unlike medical claims, the information needed to determine disability claims is not isolated to a specific treatment, but may require the gathering of many months or years of records and information, including historical information that would not even be relevant to most medical claims.
- Most medical claims rarely involve a need to consult with outside professionals. The vast majority of disability claims, on the other hand, require a medical consultation at a minimum, and many times require consultation with vocational experts, financial experts, and other professionals.
- Medical claims involve an isolated issue, e.g., whether a particular service is covered by the health plan. Disability claims involve a more complex, multi-layered analysis, i.e., whether there is an impairment, whether the impairment prevents the claimant from working, whether there is financial loss, etc., each of which requires input from various sources.
- Even when there is an appeal of an adverse benefit determination, medical claim files may consist of only a few pages of material. Disability claim files can consist of hundreds and sometimes thousands of pages of medical, vocational, financial, and other information, all of which takes immense time to review and render a decision.

b. Increased Administrative Costs

Unum believes that, based on its experience in processing millions of disability benefit claims, the Department's cost estimates are significantly understated. Increased cost of claims administration will drive up the cost of disability products and discourage employers from offering those benefits. Claimants too will be adversely affected by delays occasioned by the proposals. A few examples of administrative changes that will increase costs are as follows:

- A requirement that the claimant be allowed to respond to new evidence, even with the limitations proposed below, will extend the claim determination process substantially, particularly if this is required to be done piecemeal as each piece of new evidence arrives.
- Likewise, the ability of a claimant to truncate the claim process and deem it exhausted – for any reason or no reason, at any number of points in the process that the claimant deems appropriate, and without prior notice to the plan – simply by alleging that a procedural violation has occurred, will stretch out claims interminably, not to mention adding litigation costs, as discussed below.
- Similarly, requiring plans to contact third party payers, obtain files, review files, continually update files, etc., will add time and expense to the disability benefit determination process.

All of this is contrary to the Department's stated goal.

c. Increased Litigation

Another stated goal of the proposals is to counter perceived increases in disability litigation. No data are presented to support the conclusion that disability litigation is out of proportion to the number of disability claims and the facts are to the contrary. In 2014, lawsuits challenging Unum's disability claim determinations represented only 1/10th of 1% of submitted claims. Additionally, disability litigation against Unum has declined over the past 10 years.

Unum believes the Department's proposals will increase disability claims litigation. One primary example of increased litigation is the Department's "deemed exhausted" proposal. This proposal would not reduce the volume of disability claims litigation. It allows claimants – at their sole discretion, apparently – to declare a claim process at an end and to launch a lawsuit. Once filed, the lawsuit will involve analysis of multiple ill-defined issues, such as prejudice, good cause, efforts to maintain a good faith exchange of information, whether the alleged mistake was beyond control of the plan, and so on. Unum believes that such a provision will increase and not reduce disability claims litigation. Presumably, the Department is assuming that claimants will be reluctant to sue. However, in Unum's experience, many claimants are represented by lawyers, especially at the appeal stage. The current proposal allows these lawyers to lie in wait and file suit as soon as a perceived mistake has been made, with no regulatory penalty whatsoever or without any prior notice to the plan or opportunity to explain or correct the mistake. The costs of a lawsuit will then be used as leverage for settlement, regardless of the merits of the underlying claim. In fact, depending on when the process is truncated and suit is filed, there may not even be enough of a substantive record to determine the merits of the claim. We would conclude this cannot be the Department's intent.

Unum believes that the proposed regulations will not fulfill the Department's purposes in issuing these proposals, i.e., that disability and medical claims are similar and should be subject to similar requirements, that revised regulations will not result in increased administrative costs, and that the proposals will reduce litigation. In fact, the proposals will likely run counter to those purposes. The unique nature of disability benefit claims and a goal of reducing (or at least not increasing) costs and mitigating the prospects of premature and useless litigation, all form the basis for Unum's comments on the proposed regulations.

II. Comments on Proposed Regulations

a. Right to Review and Respond to New Information and New Rationales

Summary of Comments Regarding Proposed Subsection (h)(4)(i): This subsection should be deleted as redundant and confusing.

Proposed subsection (h)(4)(i) requires that, during the appeal stage of an administrative proceeding, a claimant must be allowed to review the "claim file" and present "evidence" and "testimony" as part of the "disability claims and appeals process." This entire section appears to be redundant and unnecessary. Subsection (h)(2)(iii) already requires that a claimant must have access to relevant documents, so saying specifically that a claimant should be given the right to "review the claim file" adds nothing substantive, especially when the phrase "claim file" is defined as essentially a collection of "relevant" documents. Likewise, subpart (h)(2)(ii) already gives claimants the right to "submit written comments, documents, records, and other information," so suggesting that they can also submit "evidence" and "testimony" also adds nothing substantive. If the Department is suggesting that "evidence" and "testimony" is something different than "written comments, documents, records, and other information," then subsection (h)(4)(i) needs clarification. We also note that the Department's preamble says that "*written* testimony" can be submitted whereas the proposed regulation itself omits the adjective "written" and merely references "testimony." Presumably the Department is not suggesting that disability claims require a right to an oral hearing. Finally, although subsection (h) deals with the appeals portion of the claim process, use of the phrase "disability claims . . . process" in subsection (h)(i) causes confusion as to whether the requirements of that subsection are intended to apply only to the appeals portion of the process which is the subject matter of subsection (h) or also would apply to the initial stage of the claim process, which is the subject of subsections (f) and (g). In summary, Unum believes that subsection (h)(i) is redundant and unnecessary.¹

¹ The Department's reference to a "claim file" is unclear. In common usage, the term "claim file" is typically a shorthand phrase for the regulatory phrase "relevant" documents or information. In fact, the Department's proposed amendment to subpart (m)(9) essentially defines "claim file" as "relevant" documents or information as defined in subpart (m)(8). There does not appear to be any reason to add a new term "claim file" to the regulations when it appears to mean the same thing as an existing term that claimants and plans have used for over a decade.

Summary of Comments Regarding Proposed Subsection (h)(4)(ii): As currently drafted, this proposal creates the risk of an endless series of back-and-forth between the plan and the claimant, unduly extending the claim process without any appreciable benefit to the claimant. Unum proposes that any new evidence be submitted to the claimant at one time and that the claimant be permitted one response with plans being permitted to obtain further clarification from qualified health care professionals with no requirement for further response by the claimant. Unum also proposes that adjustments be made to the decision time periods, including tolling and a minimum period for the plan to issue its decision after it receives a response from the claimant.

Proposed subsection (h)(4)(ii) requires that, during the appeals portion of the claim process, the claimant be given the opportunity to review and respond to “new or additional evidence.” There are two primary concerns with this proposal: (1) the possibility that this proposal creates an endless loop of responses, which would drag out the claim process and thereby harm claimants, and (2) there are no provisions for tolling or other timing provisions that are necessary to carry out the requirements of this subsection.

With regard to the first concern, the vast majority of disability benefit claims are based on medical evidence and a determination of whether the claimant is disabled. Since 2002, the ERISA claim regulations have explicitly required that where a benefit claim requires medical judgment, a plan is required to consult with a qualified health care professional. The way this works in the disability context is that when a plan is presented with medical records and/or a treating physician opinion, the plan refers the file for review by a qualified medical professional or requests an “in person” medical examination (e.g., independent medical examination, functional capacity evaluation, etc.). Unum believes that when this is done during the appeal phase, the proposed amendment would require Unum to disclose such a report to the claimant for response before the plan renders an appeal decision. Therefore, in almost every single appeal this required medical opinion would have to be provided to the claimant with the opportunity to respond.

Assuming the claimant does respond, it is highly likely that the response will come from the claimant’s treating doctor or some other medical professional hired by the claimant or the claimant’s attorney. Unum’s interpretation of this proposal is that the response would then be forwarded for further review by a medical professional who may or may not be the same medical professional who did the review or conducted the examination earlier during the appeal process. The Department’s preamble seems to suggest that the further response from the consulting medical professional would need to be sent again to the claimant for further review and response. If the claimant then submits yet another opinion from the claimant’s doctor, that response again would be sent for further review by a medical professional, which would again need to be sent to the claimant for review and response, etc., etc. An endless process of appeal is neither in the best interest of the DOL, claimants nor claims administrators.

Unum suggests that the Department clarify what constitutes “new evidence.” Unum believes that “new evidence” should only include truly new evidence such as independent medical evaluations and functional capacity evaluations as opposed to opinions regarding existing evidence. Unum also suggests that there only be one level of comment by the claimant so that when a claimant does respond with a report from the claimant’s doctor, any further review by the plan’s consulting professional would not be subject to further review and comment by the claimant. This puts an end to the process while still giving the claimant a chance to respond to key evidence that was generated for the first time during the claim appeal phase. This suggestion also clears up some lack of clarity in the current proposal about whether “new evidence” must be submitted to the claimant piecemeal or whether it must be accumulated and submitted to the claimant at one time.

The second primary concern with subsection (h)(4)(ii) is one of timing. Unum believes that, even if the Department adopts Unum’s suggestion of one level of claimant review and comment, it will be very difficult if not impossible for plans to render a timely benefit determination. At the very least, the time for rendering a decision should be tolled from the time the material is sent to the claimant for review until the claimant responds or the deadline for a response has expired. Unum also suggests that there be a minimum period for the plan to render a decision once it receives a response from the claimant or the deadline for responding has expired. For example, if the claimant is provided 30 calendar days to review and respond, then the plan should be allowed 30 calendar days from the date of receipt of claimant’s response to render a decision.

Summary of Comments Regarding Proposed Subsection (h)(4)(iii): The current procedure, which is universal and a result of established case law, is to provide the claimant with another opportunity to appeal any rationale raised for the first time in an appeal denial letter. This process works well and accomplishes the purposes stated by the Department. If the Department determines that this process must take place within the appeal phase rather than as an additional appeal phase, then the decision period will need to be adjusted accordingly, including tolling.

Proposed subsection (h)(4)(iii) requires that during the appeal phase of the claim process, a claimant be given an opportunity to respond to “a new or additional rationale” for denying the claim. The current practice, resulting largely from case law, is that if an appeal is denied based on reasons that were not discussed in the initial adverse benefit determination, then the claimant is given an additional right to appeal the new reason. This actually occurs rarely and this additional appeal process has worked just fine. The only difference from the proposed amendment is that the amendment requires this to occur during the appeal phase rather than as part of a subsequent appeal phase. That raises issues of timing. If the plan intends to rely on a new or additional reason for affirming the denial, then the time for making the appeal decision should be tolled from the time the plan submits that reason to the claimant until the claimant responds or the time for a response has expired. The plan should then have a minimum period of

time to render its decision that should at least equal the time the claimant is given to respond, as discussed above.

b. Deemed Exhausted Requirement

Summary of Comments Regarding Proposed Subsections (l)(1)-(2): Unum believes that this proposal will result in increased administrative and litigation costs. The Department should delete the “deemed exhausted” proposal and let the claim process take its course under the existing regulations. Alternatively, if the Department decides to move forward with a version of its proposal, Unum suggests that a claimant be required to give prior written notice to the plan of any perceived procedural violations before filing suit and that there be an opportunity for the plan to respond. Unum also proposes that a claimant only be permitted to truncate the claim process once for a given claim. Unum suggests that the Department continue to maintain a *de minimis* threshold that must be crossed before allowing an administrative mistake to be lead directly to litigation.

Under current law, courts require claimants to exhaust administrative processes before bringing suit. There are several reasons for this requirement, but the primary reasons are that an exhaustion requirement ensures that most issues are resolved or at least crystallized at the administrative stage so the parties can avoid a lawsuit and that exhaustion allows the parties to develop a factual record in an informal and less expensive setting rather than doing so through costly discovery in a lawsuit. The exhaustion requirement results in a streamlined litigation process that benefits claimants, plans, and the greater class of participants who rely on their employers to provide disability benefits as reasonable costs. The already existing exceptions to exhaustion are futility and the absence of an adequate claim review process.

Where a claim has been fully exhausted and an appeal determination has been rendered, the claimant is permitted to seek relief in court. This allows the parties to litigate substantive and procedural issues in one forum at one time. If the plan’s administrative process is sufficiently defective, courts can remand the claim to the plan for application of the correct process.

In contrast to current practice, proposed subsections (l)(1)-(2) appear to allow a claimant to terminate the claim review process at any point where the claimant alleges that the plan has violated the claim process, no matter how minor the violation and regardless of whether it prejudices the claimant. That may work in the context of medical claims that involve one-time determinations and limited issues. However, it will not work in the disability claims context, especially when the claimant can apparently do this on more than one occasion. The Department may be assuming that claimants will be reluctant to go to court. That may be true in some situations. However, the reality of litigation is such that, given how the proposal is currently drafted, it raises a strong possibility of gamesmanship by claimants’ attorneys who are very aware that if they can initiate suit on even the most minor perceived violation, they can push the plan into a potential settlement to avoid the costs of litigation even where the claimant is not

otherwise entitled to disability benefits. Of the proposed amendments, this creates the greatest chance of increased delays and costly litigation while at the same time offering no legitimate substantive advantage to claimants who are entitled to benefits.

Unum suggests that this proposal be deleted from the final regulations. If the Department decides to move forward with some version of this proposal, Unum suggests that before a claimant is permitted to file suit, the claimant must first notify the plan in writing of the claimant's contention that there has been a procedural violation and allow the plan a given period of time (e.g., 14 days) to respond. Many perceived "violations" may reflect a misunderstanding. Prior notice to the plan allows the parties to clear up the misunderstanding before a federal court is required to intervene. Finally, Unum suggests that a claimant only be permitted to truncate the claim review process once during a given claim.

With regard to the proposal regarding *de minimis* violations, as the United States Supreme Court stated in *Conkright v. Frommert*, 130 S. Ct. 1640, 1644 (2010), "[p]eople make mistakes," and Unum appreciates the Department's recognition of the fact that not all mistakes are sufficient to fatally taint the claim review process. Minor mistakes also should not be sufficient to result in a federal lawsuit. Under the proposed regulatory requirements, if a claimant truncates the claim review process and files suit, for any reason (including what may eventually be determined a *de minimis* violation), the parties are then required to litigate whether (a) the mistake was prejudicial, (b) the mistake was for good cause, (c) the mistake was beyond the control of the plan, (d) the mistake occurred in the context of an ongoing, good faith exchange of information, and (e) the mistake was not part of a "pattern or practice." If this proposal is not a recipe for long drawn out litigation, nothing is. The only factor that should matter is whether the mistake prejudiced the claimant's right to a full and fair review, period. Even then, whether a mistake is prejudicial may not be capable of determination until after the claim is decided. Certainly if benefits end up being approved, a procedural mistake is irrelevant and an intervening lawsuit would be a waste of resources. The bottom line is that the Department should let the claim process be completed before the parties end up in court.

c. Additional Disclosure Requirements

Summary of Comments Regarding Proposed Subsection (g)(1)(vii)(A): Unum suggests that the Department delete the requirement that a denial letter include "the basis for disagreeing with" third party payers. The definition of "third party payers" can mean almost anything, including medical plans, life insurance plans, worker's compensation plans, pension plans, other disability insurance policies, etc. The current proposal would require plans to seek out entire claim files of third party payers in order to determine the basis for other benefit awards and to determine the relevance, if any, of such awards to the claim at issue. These files, unlike a typical Social Security file, are not static, but are updated and developed over time. A third party payer's decision at one point to award benefits may be changed at a later date as additional evidence is accumulated and definitions of disability change over time. Unum is required to pay benefits

according to the terms of its policies, not according to the terms of other third party payers' plans and policies. This process adds substantial delays to an already complicated claim process with little benefit to claimants who must wait for files to be obtained, reviewed, and updated.

Proposed subsection (g)(1)(vii)(A) requires notice of an adverse benefit determination to include "the basis for disagreeing with" the opinions of (a) treating professionals, and (b) other third party payers, who granted the claimant's "similar" claims. Unum's existing practice is to discuss why it disagrees with the treating doctor and why it disagrees with a Social Security Administration decision, if any. That discussion requires Unum to analyze these opinions and decisions and to obtain all records related to the opinions and decisions, including the Social Security Administration file, all of which can take weeks or months. If plans are also required to discuss decisions of other "third party payers," they will be required to obtain their files as well. Obtaining files from other disability insurers is problematic because such files are fluid, not static. Unlike Social Security where the file is pretty much fixed once a determination is made, information is acquired and added to insurers' disability files all the time, especially from a medical perspective given our ongoing contact with the insured's treating physician(s). A plan might obtain the third party payer's file on one day and the next day, the content of the file could change dramatically. Plans would also be required to keep track of how other third party payers are updating their decisions over time. All of this will require a plan to continually contact the third party payer to confirm that it has the most updated information. Again, such updates are less common in the context of Social Security. The proposal also fails to define what constitutes a "similar" claim. Presumably this means at a minimum the same definition of disability. Does it also mean the same evidence? Finally, the proposal says nothing about situations where third party payers have denied "similar" claims or whether plans are required to discuss such denials.

Summary of Comments Regarding Proposed Subsection (g)(1)(vii)(B): The proposal requiring disability plans to certify that there is no applicable internal guideline should be deleted.

Proposed subsection (g)(1)(vii)(B) requires disclosure of internal rules and guidelines relied upon on making an adverse benefit determination or a statement that no such internal rule or guideline exists. This proposal extends confusion that exists in the current regulations issued in 2000. The reference to internal rules and guidelines is more applicable to certain types of medical claims (e.g., medical necessity, experimental procedure, usual and customary fees, and the like) where health insurers typically have extensive internal medical guidelines to guide these decisions. That is not the case with disability plans. Disability decisions are based on the terms of the plan and the unique facts of the claim. Relevant provisions of the plan are already required to be disclosed in the determination notice. The plan documents are the "guidelines" under which such claims are determined. While disability plans may have "claims manuals" in various forms, these materials are mainly procedural rather than providing guidance for substantive decisions. If there is an applicable guideline and it is relied on to make the benefit determination, it can be disclosed. However, to require claim personnel to comb hundreds of pages of a claims manual to

determine that no provision has any conceivable application in order to certify that there is no such provision, accomplishes nothing and adds significant cost and delay to the claim process.

d. Independence and Impartiality

Summary of Comments Regarding Proposed Subsection (b)(7): Unum suggests that the requirements in subsection (b)(7) that hiring decisions not be made “based upon the likelihood that the individual will support the denial of benefits” and that medical experts may not be hired based on “reputation for outcomes” are unnecessary and should be deleted.

Unum agrees with the concept that claim personnel should be unbiased. Unum’s policy is that employment decisions cannot be made based on claim outcomes, whether they be approvals or denials. The concern with the proposal as currently drafted is that it potentially invites broad discovery and will increase litigation expense substantially. That is contrary to the Department’s stated intention. With respect to medical experts, the preamble refers to an expert’s “reputation for outcomes in disputed cases.” In practice and in theory, there is no way to measure “reputation” in this context. Again, this invites litigation. Moreover, courts already take “conflict of interest” into account when reviewing benefit determinations and parties are certainly in a position to argue reputation issues, whether they apply to experts hired by plans or experts hired by claimant’s or their lawyers.

e. Notices for Contractual Limitations Periods

Summary of Comments on Contractual Limitations Periods: Unum suggests that the Department not include such a requirement. Alternatively, Unum suggests that the Department only require that contractual limitations language be included in the appeal denial letter, if it exists and that no requirement be imposed for stating a specific deadline or for updating the notice.

Unum suggests that the Department not impose such a requirement. The limitations period is already contained in the plan document and the plan summary. The summary is the document designed for consumption by plan participants. There is nothing to be gained by also including plan summary language in the appeal denial letter. If an appeal denial letter is required to include a limitations period that is already in the plan document and plan summary, what other information will be required in the future for appeal denial letters? Will the denial letter simply be a reiteration of the plan? If so, it will no longer serve its purpose under the regulations which is to explain the reason(s) for the denial. If the Department decides to move forward with such a requirement, Unum urges the Department to require that the denial letter include only the contractual limitations language from the plan and not a specification of the precise deadline and certainly not a requirement that the deadline be updated from time to time. A requirement for a precise deadline and updating of the deadline would mean that plans must anticipate tolling or similar arguments from claimants, which places an undue burden on plans.

f. Implementation Date

Once the proposed regulations are finalized, a 60-day effective date is simply not realistic. Plans will need to revise claim procedures, policy documents, and train personnel. When the 2000 regulations were finalized, they went into effect for claims filed on and after January 1, 2002. Unum suggests that any final regulations should apply to claims filed on or after a date that is at least one year after publication of the final regulations.

Thank you for considering Unum's input.

Sincerely,



Gregory J. Breter
Senior Vice President
Unum U.S. Benefits Operations