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*By the National Board of Social Security Disability Advocacy

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Via electronic filing and 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: Claims Procedure Regulations for Plans Providing Disability Benefits
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503-1

Dear Assistant Secretary Borzi:

I write to offer comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. I am interested in the content of these regulations because, as a partner at McMahan Law Firm, LLC, I primarily litigate ERISA disability, health and life insurance claims on behalf of individuals who have been wrongfully denied their benefits. I also have a Social Security disability practice and am certified as a specialist in Social Security Disability Law by the National Board of Social Security Disability Advocacy. I am a 1996 graduate of Washington University School of Law and am licensed in Georgia, Tennessee and Illinois. I have been a leader in prominent organizations such as the American Association for Justice (AAJ), Tennessee Association of Justice (TAJ) and the Tennessee Bar Association (TBA). I am past-Chair of AAJ's Disability law Section, a former member of TAJ's Board of Governors, past-Chair of TBA's Disability Law Section and past-President of the Chattanooga Trial Lawyers Association (CTLA). AAJ, TAJ, TBA and CTLA are all associations of lawyers who advocate on behalf of disabled or injured individuals. Additionally, I have lectured regularly on disability issues to other attorneys in multiple jurisdictions.

In any case, I have organized my comments as follows. First, I address the most important substantive issues for the DOL to address as it finalizes the proposed regulations. These comments relate to where I believe the DOL should make a substantive change in the proposed

regulations. Second, I have set out what I see as the most important technical issues in the proposed regulations. These are matters that do not change the substance of a proposed regulation but request language changes for purposes of greater clarity or conformity with other regulations.

I. Comments on Substantive Matters in the Proposed Regulations

Discussion of the Decision and Its Relationship to SSDI or other Disability Awards

As the EBSA well knows, many individuals who have ERISA long term disability ("LTD") claims also have claims for Social Security Disability benefits. As a consequence, most insurance companies require their disability claimants to file for Social Security disability. This is done because most plans offset the LTD benefit by the Social Security disability benefit and this reduction is considered by the insurers to be one of the most important cost containment features of their LTD contracts (and is usually termed "recovery of an overpayment"). In fact, insurance companies that issue LTD plans will commonly direct an insured to contact a specific representative to assist him or her in obtaining Social Security disability benefits. In my experience, however, when the Social Security Administration finds favorably for a claimant the insurance company will commonly reject the analysis of the Administration. In other words, it is not unusual for an insurer to require that an insured file for Social Security disability benefits, suggest a specific representative to hire, recover the "overpayment" from its insured once the Social Security Administration finds in the claimant's favor, and then deny the LTD claim though it is based on nearly identical arguments that the suggested representative made in front of the Administration.

Alternative A

Accordingly, the regulation as presented, requiring a claims administrator to meaningfully distinguish the views of treating physicians or other entities that are paying benefits, will be helpful. Often, administrators ignore evidence that is favorable to the claimant. Generally, if the administrator pays any attention to contrary opinions, my clients receive pre-packaged or boilerplate paragraphs in the denial letters that have nothing to do with their claims. Because of this they cannot mount a response. This stands in the way of full and fair review. Sometimes courts do not understand the difference between the type of explanation required by ERISA and these empty paragraphs. Assuming that this regulation is intended to change plans' reliance on this sort of explanation or a wholesale failure to address the contrary evidence, I am in favor of the regulation.

Alternative B

The regulation requiring a discussion about the difference between the plan's decision and awards made by other systems, such as Social Security, should be expanded to set forth a deferential review requirement. The regulation could utilize the same language as the regulatory settlement agreements that have been used by many state insurance commissioners in response to concerns about disability claims processes used by insurers such as UNUM. For example, in the regulatory settlement agreement UNUM was required to follow, this language was used:

> The Companies must give significant weight to evidence of an award of Social Security disability benefits as supporting a finding of disability, unless the Companies have compelling evidence that the decision of the Social Security Administration was (i) founded on an error of law or an abuse of discretion, (ii) inconsistent with the applicable medical evidence, or (iii) inconsistent with the definition of disability contained in the applicable insurance policy.

Including similar language in the proposed regulation would be helpful to assure that plans give the appropriate weight to an award made by another entity.

II. Comments on Technical Matters in the Proposed Regulations

Notice of Right to Request Relevant Documents

ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4) states, "The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated." In addition to the specific documents described in the ERISA statute itself, at ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4), such as the summary plan descriptions and other documents under which the plan is operated, the ERISA statute, at § 109(c), 29 U.S.C. § 1029(c) provides that the Secretary of Labor may also prescribe what other documents should be furnished. Thus, reading sections §109(c) and 502(c) together, along with ERISA § 505, 29 U.S.C. § 1135 (allowing the Secretary to "prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this title"), the Secretary is given authority to establish the format and content of what documents are required to be produced by an administrator in an ERISA matter. The Secretary of Labor's ERISA claim procedures regulations, set out in 29 C.F.R. § 2560.503-1 (h)(2)(iii), describe what documents an administrator must provide. The regulations state that, in order to provide a full and fair review, the Plan must provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Although attorneys understand this language, lay persons, who are the actual participants and often not represented, may not realize what rights are given here. The regulation concerning notice of the right to request relevant documents contained in 29 C.F.R. §2560.503-1(g)(1)(vii)(C) [proposed regulation] is an improvement since it was formerly missing from the regulation. However, it would be more helpful to claimants to use the words "claim file," which is plain language and is consistent with the amendment at 29 C.F.R. §2560.503-1(h)(4)(i) [proposed regulation].

Accordingly, I suggest the following amendment to the proposed regulation (added language is underlined and bolded):

> 29 C.F.R. §2560.503-1(g)(1)(vii)(C)[proposed regulation]

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to **the claimant's claim file, including** copies of all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

III. Other Issues of Concern with the Regulations

Disclosure of Internal Rules, etc.

An insurance company, typically the party obligated to pay benefits and the administrator given discretion in construing and applying the provisions of a group health or disability plan and assessing a participant's entitlement to benefits, is an ERISA fiduciary. *See* 29 U.S.C. § 1002(21)(A)(i) and (iii); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 220, 124 S. Ct. 2488, 2502 (2004); *Mondry v. Am. Fam. Mut. Ins. Co.*, 557 F.3d 781, 803 (7th Cir.), *cert. denied*, 130 S. Ct. 200 (2009). Significantly, as a fiduciary, an insurance company is required to carry out its duties with respect to the plan "solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries;...[and] (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims..." 29 U.S.C. § 1104(a)(1). Under the law of ERISA an insurance company owes the participants in its plan and their beneficiaries a duty of loyalty like that borne by a trustee under common law, § 1104(a)(1)(A), and it has to exercise reasonable care in executing that duty, 1104(a)(1)(B). *Mondry*, 557 F.3d at 807. In my experience, this rarely happens.

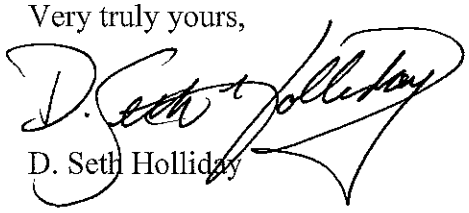
Additionally, an insurance company, as an ERISA fiduciary, is required to provide certain information to its claimants because "[t]he duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA." *Eddy v. Colonial Life Ins. Co. of Am.*, 919 F.2d 747, 750 (D.C. Cir. 1990). Significantly, this duty includes an affirmative obligation to communicate material facts affecting the interests of beneficiaries. *Id.* "This duty exists when a beneficiary asks fiduciaries for information, and even when he or she does not." *Id.* (citing *Eddy*, 919 F.2d at 750); *Solis v. Current Dev. Corp.*, 557 F.3d 772, 777-78 (7th Cir. 2009); *see, Gregg v. Transp. Workers of Am. Int'l*, 343 F.3d 833, 845-46 (6th Cir. 2003) ("'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 obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire'") (quoting *Krohn v. Huron Mem. Hosp.*, 173 F.3d 542, 547 (6th Cir. 1999)); *see also, Unisys Corp. Retiree Med. Benefits Erisa Litig. v. Unisys Corp.*, 579 F.3d 220, 228 (3d Cir 2009), cert. denied sub nom. *Unisys Corp. v. Adair*, 559 U.S. 940 (2010) (an ERISA fiduciary "must speak truthfully, and when it communicates with plan participants and beneficiaries it must convey complete and accurate information that is material to their circumstance."). However, in my experience insurance companies typically fail to

satisfy their duty to disclose critical information to their claimants that materially affects their interests.

Accordingly, the DOL's proposed regulation regarding disclosure of the internal rules or criteria used to make a disability benefit decision, 29 C.F.R. §2560.503-1(g)(1)(vii)(B)[proposed regulation], is helpful because internal rules, guidelines, protocols, standards, claims manuals, and similar materials often create hidden plan terms that the claimant is unable to learn of or discover in order to address them in the appeal. As is true in the healthcare context, plans sometimes argue that internal criteria are confidential or proprietary. But keeping the rules that are used to administer a plan a secret is inconsistent with the most basic premise of ERISA. Benefits must be administered "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104. In addition, much litigation would be avoided if the claimant could know what criteria he or she needed to meet in an appeal. *See e.g. Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111, at *10 (S.D.N.Y. Jan. 30, 2004); *Craig v. Pillsbury*, 458 F.3d 748, 754 (8th Cir. 2006)(decrying the use of "double-secret" plan terms); *Samples v. First Health Group Corp.*, 631 F. Supp. 2d 1174, 1183 (9th Cir. 2007). Given that the regulations require adverse benefit determinations to include the reasons for the denial and the applicable plan terms, this additional requirement should not be onerous and would promote the dialogue between claimant and plan that ERISA contemplates. *Booten v. Lockheed Med. Ben Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) ("in simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries.").

Thank you for the opportunity to comment on the Claims Procedure Regulations for Plans Providing Disability Benefits.

Very truly yours,



D. Seth Holliday