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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 January 14, 2016

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 have read the proposed amendments to claims procedure regulations for plans providing disability benefits under ERISA. My comments are based on nearly twenty years of providing legal services to the disabled. Well over a thousand clients of my firm have been subject to the standards established by ERISA regulations. Based on this well established practice, I can readily comment on some of the weaknesses in the law which have impaired my clients' ability to obtain the fair and just handling of their claims.

Improvements to Disclosure:

A disabled client whose claim is denied is understandably distraught because they have been informed their benefits are terminated. After getting over the shock of the decision, they must determine what steps are necessary to advocate for the reversal of the denial. In order to accomplish this, they need to be made aware of several basic pieces of information. These include:

a. A detailed explanation of what evidence was relied upon to support the denial, and the basis for disagreeing with the SSA, or treating physician and what evidence should be gathered to submit for the appeal.

Comment: This is necessary to enable the claimant to understand and then respond to the proofs submitted by the Plan supporting their denial of a disability claim where all of the claimant's proofs support the case.

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.

b. Clear notification that they have a right to obtain their entire claim file, including all claim notes, medical and occupational data relied upon and surveillance video and investigation (if any).

Comment: The present regulations deprive claimants of much of this information. Many potential clients contact our office when they receive the denial letter, and do not know that they can obtain the plan administrators' entire file so that they may review and contest the basis for the denial. Often clients are stunned by the denial and wait 4-8 weeks before contacting our firm, not understanding that immediate action is necessary. Having waited months before contacting our firm, we and they are at a distinct disadvantage because when we ask for their claim file, under ERISA, the plan has 30 days to provide it.

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]. Attorneys understand the language of (g)(1)(vii)(C), but lay persons, who are the actual participants and often not represented, may not realize what rights are given here.

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.

c. The identity and credentials of all medical and vocational personnel whose opinions were relied upon to decide the case should be included in the denial letter.

Comment: In order to conduct a full and fair review of the denial, the claimant is entitled to know, right away, whether the personnel deciding their disability benefit fate are qualified in the necessary specialty involved in the claim.

d. Internal rules, guidelines, protocols, standards or other similar criteria of the plan used in denying the claim.

Comment: The procedure followed to investigate, and ultimately deny the claim must be standardized for all similarly situated plan participants. Hence the companies all have procedures available to their employees to follow. The production of these procedures for claims handling is basic, and some companies do regularly provide them, such as Unum. Other companies, including LINA, despite the Regulatory Settlement Agreement requiring them to establish such procedures and to follow them, resist producing them during the appeal and even in litigation without a court order compelling them to do so. Simply put, the regulations should require each company to provide these materials so that we can determine if their procedures align the ERISA regulations and if the company is in compliance.

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. Booton *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.").

I have several disability cases where my clients were pursued through invasive surveillance based on a medical consultant for the insurer suggesting an "exploratory" credibility investigation, despite no evidence that the claimant is overstating their disability in any way. The company's internal rules state that there must be a bona fide reason to hire surveillance. The courts have suggested that violating internal rules is tantamount to procedural irregularities, supporting a conflict of interest and arbitrary and capricious behavior. Having the insurer's own internal guidelines was critical to this analysis.

e. <u>The right to retain counsel to assist them with the appeal.</u>

Comment: Often ERISA claimants who have been wrongly denied disability benefits do not realize that they have the right to be represented in the administrative appeal process. Not knowing what evidence would have proven their claim to the plan administrator, and limited by the administrator or the court in submitting any new evidence in support of their claims in later litigation, they have often squandered their last, best opportunity to prove a meritorious claim. I propose that the DOL adopt a regulation that benefit denials must advise claimants of their right to hire an attorney to represent them in the appeal phase. The Social Security Administration does this. There is no reason to hide this right from claimants.

f. <u>Advise as the deadline to submit the appeal, and the deadline for filing a lawsuit if the appeal should fail.</u>

Comment: Litigation Deadline Should Be Explicitly Stated and Be No Less Than One Year After the Final Denial Decision- When we submit an administrative appeal of the denial of a claim, we should not have to wonder how long we have to file a litigation for our client. Since ERISA does not establish a statute of limitations, which is left up to the plan, plans have haphazardly established arbitrary deadlines, which in some cases forces the time clock to be running during the time period that the insurer is deciding the appeal. The plan is in the best position to determine what the expiration of the limitations period is, since they wrote the plan and have the document. However, when a claim is denied on appeal, there is no insurer that automatically instructs the claimant of the deadline for litigation in the final letter. There is no just reason for the plan to withhold this information to use as a defense to the eventual filing. This is not

supposed to be an adversarial process. There are many opportunities for prompt filing of the litigation lost by claimants uninformed.

In my practice, there are only a few insurers who will respond when I write to them and ask what the exact deadline is. Aetna and Metlife will instruct us of the exact deadline for filing a lawsuit. Others, including Prudential intentionally withhold this information from us, noting recently following our request for this information,

"the policy language provides you can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required unless otherwise provided under federal law."

We of course, are aware of the aforesaid language, but do not know what the plan considers the "time proof of loss is required" on a case that has been paid for years. Does that mean from the date the original proof of loss was filed, e.g. 2010? If so, based on the denial of the claim that occurred in 2014 and the appeal decision rendered in 2015, what is the litigation deadline?

The impact of this anomaly is that the insured is left without a clear deadline by which to file suit. He does not know if he has weeks, months or years following the denial of the appeal to secure an attorney to file federal litigation. Unfortunately, this flaw in the law has deprived many disabled people of their day in court. That cannot be the goal of Congress in enacting ERISA, whose purpose is to improve the procedural protections for workers who become disabled.

Furthermore some plans enforce a limitations period that comes too soon after the final denial. No attorney should be faced with the situation of having to file a lawsuit in federal court before having a reasonable time to review the final administrative claim file of the claimant, and determining together whether litigation is warranted. Having to rush to file litigation right after an appeal denial deprives the claimant of a reasonable review time. This has resulted in several problems; attorneys like me will not take a case for litigation if I do not have the entire claim file well in advance, so claimants are deprived of the chance to litigate their case, or cases are abruptly filed in court, which should never be placed in the judicial system. This wastes judicial time.

Heimeshoff v. Hartford Life & Accid. Ins Co., 134 U.S. 604 (2013) exemplifies the problems in the system, since Mr. Heimshoff lost his right to litigation due to the litigation deadline running during his appeal review. There was not enough time for his counsel to review the matter before the litigation deadline; by the time he filed the complaint, Hartford successfully defended the case based on a statute of limitations defense. Since *Heimeshoff* left open the possibility that an internal limitations period could run before the appeals process is complete (even where exhaustion is mandatory),

the DOL also should clarify that such an approach would violate full and fair review required by 29 U.S.C. §1133.

My Recommendations:
I recommend an amendment to the regulations governing the manner and content of notification of benefit determinations on review. 29 C.F.R. §2560.503-1(j) [proposed regulation]. The amended language should require the claims administrator to notify the claimant of the date of the expiration of any plan based limitations period.

I propose amending the proposed regulation by adding a section as follows and renumbering accordingly (added language is indicated by bolding and underlining):

29 C.F.R. 2560.503-1 (j)(6) [proposed regulation]

In the case of an adverse benefit decision with respect to disability benefits— (i) A discussion of the decision, including, to the extent that the plan did not follow or agree with the views presented by the claimant to the plan of health care professionals treating a claimant or the decisions presented by the claimant to the plan of other payers of benefits who granted a claimant's similar claims (including disability benefit determinations by the Social Security Administration), the basis for disagreeing with their views or decisions; and (ii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

(7) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, a statement of the date by which a claimant must bring suit under 502(a) of the Act. However, where the plan includes its own contractual limitations period, the contractual limitations period will not be reasonable unless:

a. it begins to run no earlier than the date of the claimant's receipt of the final benefit determination on review including any voluntary appeals that are taken;

b. it expires no earlier than 1 year after the date of the claimant's receipt of the final benefit determination on review including any voluntary appeals that are taken;

c. the administrator provides notice to the claimant of the date that the contractual limitations period will run; and

d. the contractual limitations period will not abridge any existing state limitations period that provides for a period longer than one year.

Claimant Should Be Entitled to Respond to New Evidence or Rationales Developed After the Appeal is Filed

It is commonplace for insurers who have denied LTD claims with shoddy evidence to buttress their review of our appeals with new evidence they create. This often includes reviews by hired physicians who come up with new theories to support a denial. Once the final denial is issued, then and only then is the claimant provided with the new evidence relied upon to support the decision. If the claimant submits a rebuttal to the new evidence, companies habitually return the evidence and advise that the claim is closed and no new evidence will be accepted. The plan has a distinct advantage in litigation because the court will have only their views on the appeal, without any rebuttal on the merits of the case permitted under the law. In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), the court articulated the problem as follows:

> [w]ithout knowing what "inconsistencies" the Plan was attempting to resolve or having access to the report the Plan relied on, Abram could not meaningfully participate in the appeals process. . . This type of "gamesmanship" is inconsistent with full and fair review.

Id. the proposed change offers some assurance that a claimant can contribute his or her relevant evidence to the record that the court will review.

Plans have protested that giving the claimant the last word will require them to respond which may invite the claimant to again rebut, creating a cycle without a distinct end. Yet, this concept is disconnected from reality. Where the claimant, as plaintiff, has the burden of proof on most issues, this only makes sense. In most litigation contexts, the party with the burden of proof is given the last word. Here, giving the last word to the claimant during the claims appeal process is, in effect, giving claimant the right of rebuttal in litigation. In litigation matters, the moving party sets out his argument, the respondent submits a reply brief, and the moving party has the right to submit a rebuttal, related solely to the new evidence included in the reply.

The following suggestion places reasonable limits on both claimants and plan administrators. Claimants should have at least 60 days to respond to new evidence or rationales provided by the plan on appeal. During this time, the period for the decision on review to be completed should be tolled. When the claimant has responded, the plan administrator should be allowed whatever time was left under the existing regulations or

30 days, whichever is longer, to issue its determination on review. This rule should apply whether the new information is a new "rationale" or new "evidence."

My Recommendations:
Accordingly, I suggest the following amendment to the proposed regulation (new language indicated by bolding and underlining):

2560.503-1(h)(4)(ii) [proposed regulations]

(ii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date. **Such new evidence or rationale must be provided to claimant before the decision on appeal is issued and the claimant must be afforded up to 60 days to respond. The time to render a determination on review will be suspended while the claimant responds to the new evidence or rationale. After receiving the claimant's response to the new evidence or rationale or notification that the claimant will not be providing any response, the plan will have whatever time was left on the original appeal resolution time period or 30 days, whichever is greater, in which to issue its final decision.**

Impartiality of Claims Personnel

There is a clear pattern and practice of insurers and their vendors using the same medical consultants over and over again. My office has assembled copies of medical reports from some doctors and their reports are recycled, identical to one another and lacking any rationale to discount the contrary opinions of the treating doctors. Records show that certain doctors never appreciate the disabling features of diseases, like fibromyalgia, for example, asserting that people with fibromyalgia should simply exercise more and get back to work. It is astounding the millions of dollars earned by the vendors such as MLS for working for certain insurers. Court filed documents show that this medical vendor company earns over $3.5 million for providing peer review services for Liberty Mutual alone. Apparently they cannot afford to be neutral, since every time they send over a report supporting denial, Liberty saves money. The regulations need to provide some control of this system that has destroyed any chance of independence. The proposed regulation needs clarification in three areas.

First, the proposed regulation should make clear that impartiality is ensured, even where the plan, itself, is not directly responsible for hiring or compensating the individuals involved in deciding a claim. This clarification is necessary because, as a practical matter, plans frequently delegate the selection of experts to third-party vendors who, in turn, employ the experts.

Second, clarification is needed concerning which individuals are "involved." Claims administrators often protest that physicians, or other consulting experts, are not "involved in making the decision" but merely supply information (such as an opinion on physical restrictions and limitations) that is considered by the claims adjudicator. Under this logic, plans may argue that consulting experts are not affected by the impartiality regulation.

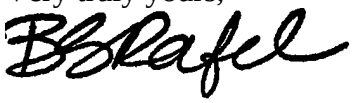
Finally, the proposed regulation should make clear that not only claims adjudicators and consulting physicians must be impartial. Vocational experts and accountants are also frequently used in the claims process and should be included in the scope of the impartiality requirement.

In light of these concerns, I suggest that the proposed regulation language be amended as follows (added language is bolded and underlined):

29 C.F.R. §2560.503-1(b)(7) [proposed regulation]

In the case of a plan providing disability benefits, the **plan and its agents, contractors, or vendors (such as any entities who supply consulting experts to plans)** must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision **or who are consulted in the process of making the decision.** Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, (such as a claims adjudicator, **vocational expert, accounting expert**, or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

Very truly yours,



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