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Via E-Mail (e-ORI@dol.gov) and U.S. First Class 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 represent many claimants in ERISA-governed disability benefit disputes. I submit the following comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. I have seen dozens of claimants who have been denied needed benefits, merely because they have not mastered the technicalities and gamesmanship often encountered in the administration of disability benefit plans, particularly those underwritten and administered by insurance companies. I offer my comments from the perspective of plan participants.

My comments are not exhaustive, and I have limited them to those that I believe are the most important issues for the DOL to address as it finalizes the proposed regulations.

Notice for Applicable Statute of Limitations

The DOL has invited comment on the statute of limitations issues that have developed since the Supreme Court's decision in *Heimeshoff v. Hartford Life & Accid. Ins Co.*, 134 U.S. 604 (2013). This area is a crucial one for regulation; since *Heimeshoff,* I have heard claims administrators offer confusing interpretations of plan-based limitations provisions that are themselves ambiguous, such as those that accrue when "proof of claim is required." The DOL can assist by creating standards for what is a reasonable plan-based limitations provision, in the same way that the DOL used its regulatory power to create timing deadlines for the claims process in prior versions of the regulations. To the extent that *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 is in a good position to clarify that such an approach would violate full and fair review required by 29 U.S.C. §1133.

Contractual limitations periods are plan terms, and the claimant should be entitled to receive notice about the limitations period from the plan, as is the case with other plan terms. As the DOL aptly points out in the preamble to these proposed regulations, plan administrators are in a better position to know the date of the expiration of the limitations period and should not be hiding the ball from claimants, if the plan administrator is functioning as a true fiduciary.

Several courts have interpreted the existing regulations to require notice of the expiration of a limitations period. *See Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 2014 WL 562557, at *4 (E.D. Mo. Feb. 13, 2014), *aff'd sub nom. Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 790 F.3d 799 (8th Cir. 2015)("[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of [ERISA] following an adverse benefit determination on review." 29 C.F.R. § 2560.503–1(g)(iv)). *See also Mirza v. Ins. Admin. of Am., Inc.*, 800 F.3d 129, 133-136 (3d Cir. 2015); *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282, 1295 (9th Cir. 2014); *Moyer v. Metro. Life Ins. Co.,* 762 F.3d 503, 505-7 (6th Cir. 2014); *Ortega Candelaria v. Orthobiologics LLC*, 661 F3d 675, 680 (1st Cir. 2011). Here, the DOL should do more than interpret its own rules; it should re-write them to remove any ambiguity.

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 and should include a definition of what is a reasonable limitations period. This amendment would eliminate litigation on when claims "accrue" and preclude a limitations period that starts before the internal claim and appeals process is complete. The amendment also should require there will be at least a one-year period after the completion of the plan's appeals process in which a claimant can file suit. These amendments could well lead to a standardization of internal limitations periods that would be salutary for both claimants and plan administrators and eliminate one area of litigation.

Accordingly, I propose amending the proposed regulation by adding a section as follows and renumbering accordingly (added language bolded and italicized):

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.

(8) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (p) of this section).

Timing of Right to Respond to New Evidence or Rationales

The DOL clearly wishes to address a problem described by the court in *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005):

> [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. at 886. In other words, claimants should not be ambushed with new rationales or evidence during the administrative without any opportunity to respond. I wholly endorse the proposed changes which offer some assurance that a claimant can contribute his or her relevant evidence to the record that the court will review. 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 effectively provides the claimant the right of rebuttal in litigation.

While this extra opportunity to submit proof might extend the time without benefit payments, the reality is that ERISA disability benefits claimants have every incentive to conclude the administrative process as expeditiously as possible, because they need their benefits to meet their day to day living expenses and are unlikely to prolong the process unnecessarily. To address this concern, claimants should have at least 60 days to respond to new evidence or rationales provided by the plan on appeal. Any shorter period will not provide a claimant with sufficient time to hire experts, such as physicians, psychologists or vocational consultants, to develop the evidence needed to respond to new evidence or rationales by the plan. A claimant who can submit responsive evidence in a shorter time frame should be able to notify the plan that the response is complete and that the review may continue.

Moreover, the period for the decision on review to be completed should be tolled during this 60-day period. 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."

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

> 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.***

Opportunity to Supplement the Record

The regulations should be amended to permit claimants to supplement the record. Many meritorious disability claims are denied, and the courts affirm these determinations, because of issues regarding the scope of the record on review in the court. For instance, Social Security Disability Insurance decisions, which are the focus of some of the proposed rules, are often crucial to proving disability claims. However, the Social Security Administration ("SSA") takes time in issuing its decisions, and the SSA's ruling may sometimes come after the final denial on appeal of the disability plan. Plan administrators often refuse to consider this type of evidence, choosing instead to shut the door on a meritorious claim, even though, if litigation is filed, the plan will seek to recover the offset that is provided by the SSA benefit. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). A claims administrator may rush an appeal decision through simply to avoid having to consider that the claimant has been awarded SSDI and having that evidence in the claims file.

The DOL should adopt a regulation that includes in the administrative record relevant information made available to the plan administrator in sufficient time to give the administrator a fair opportunity to consider it. *See Vega v. National Life Ins. Serv.*, Inc., 188 F.3d 287, 300 (5th Cir. 1999). Such a regulation will encourage attorneys representing claimants to make a good faith effort to resolve the issue before filing suit in district court. I have represented claimants who are too sick to submit relevant medical information before the end of an appeal period; when the plan has accepted and considered such evidence, the deserving claimant has been able to resume needed benefits without burdening the courts.

The Relationship Between the Decision and SSDI

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. An easy to implement regulation, such as that proposed, would also likely reduce litigation on this issue.

Notice of Right to Request Relevant Documents

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 clarifies a right formerly missing from the regulation. It would be helpful to claimants, who are plan participants and not represented by counsel, however, to use the more understandable word "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].

The following suggested amendment to the proposed regulation (added language bolded and italicized) addresses this concern:

> 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.

Deemed Exhaustion Drafting Issue

This regulation should be edited to clarify that the "deemed exhausted" provision applies to both claims and appeals, not just "claims." Presumably, if there is a violation of the regulations, the claimant can seek review regardless of whether the claim is in the "claim" or the "appeal" stage. I suggest the following clarifying language (added language bolded and italicized):

29 C.F.R. §2560.503-1(l)(2)(i)[proposed regulation]

In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim **or appeal**,

Deemed Exhaustion of Claims and Appeals Processes

The DOL properly has undertaken to clarify the consequences resulting from the plan's failure to comply with the procedural requirements of the regulations, separating the consequences into two categories, i.e. for serious violations and for minor violations. Some areas of improvement follow.

First, the regulations should be clarified to explicitly state that when the fiduciary administering the plan violates the regulations, the standard of judicial review should be *de novo*, and a court should not give special deference to the plan's decision. To avoid a potential ambiguity on this point, I suggest the following amendment to the proposed regulation (added language bolded and italicized):

29 C.F.R. 2560.503-1(l)(2)(i)[proposed regulation]

if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary, ***and the reviewing tribunal should not give special deference to the plan's decision, but rather shall review the dispute de novo***.

Second, the proposed regulation should be clarified to require the plan to give the claimant notice of his or her right to supplement the appeal.

Third, to avoid any confusion regarding how to interpret the phrase "reasonable time," the regulation should specify a reasonable time, such as ten (10) days.

Finally, for the reasons described above regarding the appropriate standard of judicial review, it would be beneficial to specify the standard of judicial review is *de novo* when the court does not remand. I suggest the following amendment (added language bolded and italicized, deleted language is stricken):

29 C.F.R. 2560-503-1(l)(2)(ii)[proposed regulation]

If a court rejects the claimant's request for immediate review under paragraph (l)(2)(i) of this section on the basis that the plan met the standards for the exception under this paragraph (l)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within ~~a reasonable time~~ ***ten (10) days*** after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission ***and notify the claimant of the right to supplement the appeal if she chooses. If the court accepts the claimant's request for immediate review, the court will retain jurisdiction and decide the case applying de novo review.***

Disclosure of Internal Rules

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. Plans sometimes argue that internal criteria are confidential or proprietary. But keeping the rules that are used to administer a plan 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 would 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.").

Notice of Right to Retain Counsel for Appeal

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, a practice followed by the Social Security Administration. There is no reason to hide this right from claimants.

In conclusion, the amendments to the claims regulations should make the "full and fair" review mandated by ERISA § 503 accessible to the average plan participant, who should have an opportunity to provide all information relevant to his or her claim without having to resort to litigation to recover promised benefits. The proposed amendments to the claims procedure regulations applicable to disability benefit plans is certainly a positive step in the right direction, and I urge the adoption of the proposed regulations, with some modifications described above.

Thank you for the opportunity to comment on the proposed regulations.

Sincerely,

Tybe Ann Brett

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