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Employee Benefits Security Administration
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room M-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington DC 20210

RE: Claim Procedure Regulation for Plans Providing Disability Benefits
RAN#1210-AB39
Regulation 29 C.F.R. §2560.503-1

Dear Assistant Secretary Borzi:

I have reviewed the Federal Register, Volume 80, Number 222 and the proposed regulation changes. A period of comment has been allowed, and so I am presenting this letter to comment on the proposed regulation which is applicable to disability benefit plans.

First of all, I would like to make it clear that I am in a position to understand some of the existing unfairness and the need for changes in the regulation. I have handled claims under the Employee Retirement Income Security Act of 1974 (ERISA) since 1992. My practice has focused on that area since 2000. There is a dearth of attorneys representing claimants. In 2007 I opened my own firm focused on ERISA benefit claims and litigation. I have presented seminars on ERISA and in fact organized a seminar on ERISA litigation in conjunction with defense attorneys and a federal judge in Alabama. I have written articles on the subject, which have been published in the Alabama Lawyer and the Alabama Addendum. I principally assist clients that reside in the states of Alabam and Mississippi, although I have handled cases for claimants out to California and up to New York and many states in between.

In my practice I have found that claimants are taken by surprise by the gross unfairness that can occur in connection with long term disability claims and the reluctance of courts to remedy the unfairness. I believe that changes in the proposed regulations would require courts to give deference to the interpretation of the Department of Labor as to the ERISA statute and appropriately follow the guidance provided in the regulations. While every unfairness under the ERISA statute is not addressed by the proposed regulations, I do believe that the Department of

Labor has addressed some key issues. There are a few other issues that are of concern in my opinion. The issues I am most concerned about are as follows:

1. Limitation of action provisions in plan documents;

2. The right of claimants to review and respond to new information before a final decision;

3. Deemed exhaustion; and

4. Venue selection plan provisions.

I. The Limitation of Action Provision

One of the underlying themes for ERISA is that there is to be a more uniform approach across the states as to the handling of employee benefits. While that has been accomplished in some respects, that is far from the case when it comes to limitation of action provisions and statutes of limitations. The best approach probably would be to have an actual statute of limitation in the ERISA statute, but that is beyond the scope of matters here. At the very least, the regulation should take a step toward a more uniform approach in the handling of a limitation of action provision in the plan document.

The United States Supreme Court has noted in the case Heimeshoff v. Hartford Life & Accid. Ins Co., 134 U.S. 604 (2013) that such limitation of action terms are enforceable. The problem is that under certain factual scenarios they are confusing and difficult to interpret consistently. This is unfair to claimants.

For example in a case that I have recently filed (and which has since settled) called Bowman v. Life Insurance Company of North America case 7:15-cv-01834, in the United States District Court of the Northern District of Alabama (Western Division), the plan stated that no action could be brought more than three years after the time satisfactory proof of loss was required to be furnished. There is no definition of "satisfactory proof of loss" in the plan and so it left it to the subjective determination of LINA as to when satisfactory proof of loss occurred. Further, it is difficult to ascertain whether "the time for the loss for which claim is made" referred to a month to month claim or the initial claim. These matters are detailed in the complaint which was filed and is a public record on PACER.

The problem is that Mr. Bowman was disabled going back to August 2011 and proof of loss was shortly provided after that time frame. However, knowing when it was "satisfactory" to LINA is difficult. The claim was paid initially, so apparently it was satisfactory in some respects. It was paid into 2014. However, it was later denied without evidence of improvement or change in Mr. Bowman's condition. The denial in essence conveyed that LINA should never have paid the claim. Arguably then, the limitation of action provision meant that suit had to be filed prior to sometime in the fall of 2014. The problem is that Mr. Bowman's claim was on appeal and was still being considered by LINA at that time, as it had been paid and then denied and then paid again and denied again. The claim was not finally decided until July of 2015. So

there was a question as to whether the limitation of action provision barred Mr. Bowman's claim while it was under review. Was he required to file a lawsuit during LINA's review in 2014 and thus violate the 11th Circuit's requirement of exhaustion of "administrative remedies"? What if the claim was paid into 2015, would he be required to file suit in 2014 while the claim was paid? Such limitation provisions are nonsense. You can't know where you stand.

To make matters more frustrating, repeated requests were made on LINA to provide the date it considered the limitation of action provision would bar the claim. LINA refused and claimed that this would be providing legal advice to Mr. Bowman. Accordingly, I asked for LINA to provide the date that "satisfactory proof of loss" was last furnished. LINA likewise refused to do that and claimed that this too would be legal advice. Again, all these matters are detailed in the lawsuit and are a matter of public record.

In order to meet the Heimeshoff requirement, suit was filed by October 19, 2015, shortly after the claim record was received. The claim record was requested immediately after the claim was denied, but unfortunately LINA took until October 8, 2015 to produce the claim file, thus necessitating a very fast review of a claim record of over 2,200 pages and then preparation of a lawsuit. Claimants should not be placed in this posture. The unfairness of this is noteworthy in that courts in many cases have strictly construed the limitation of action language to bar a claimant's lawsuit when it would not be able to literally do so if the claim was paid past the date established.

The problem always arises when a claim is paid for some time and then terminated. For example, if a claimant is on claim for ten years and then the insurer decides to terminate benefits, how does one interpret the limitation of action provision that relates back six or seven years earlier? Claims can't be barred before there is a breach. The Supreme Court's remedy of filing suit "as soon as reasonably practicable" gives no assurance to a claimant, as no one knows what is "as soon as reasonably practicable". That is patently unfair and seems to assume that counsel can be located, retained, and the claim file received within a short amount of time. Given counsel does not know what a court will believe is "reasonable", it may be hard to find a willing attorney. Such terms are contrary to the spirit or intent of ERISA.

Accordingly, in my view it should be required of the claims administrator or plan administrator to state exactly when the limitation of action provision will bar the claim in any given case and that interpretation should be consistently applied to all claims. It would be appropriate to simply require the state law statute of limitation to be applicable, notwithstanding that that it will vary from state to state. At least it would be somewhat logical and rational to run the limitation of action provision from the date the claim was last denied as an ordinary breach of contract claim. A lack of a consistent interpretation of the limitation of action provision in a plan document is by definition the lack of a full and fair review (i.e. it runs at a certain time in some instances and as soon as reasonably practicable in other instances).

One court has required notice of the date of the expiration of limitations of action provision. Most courts, including those in the 11th and 5th Circuit, have not. To my knowledge only one court has done so. Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis,

No. 4:12CV53 HEA, 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." This is only one court, but at least the unfairness is recognized. The DOL should amend the regulation to remove any doubt and establish fairness requirements on this.

I have reviewed comments of others who represent claimants, and I agree with comments that the claims administrator must notify the claimant of the date of the expiration of any plan based limitations period. There should be at least a one-year period after the completion of the plan's appeals process in which a claimant can file suit. In particular, I agree with the following proposal:

29 C.F.R. 2560.503-1 (j)(6)(7),(8) [proposed regulation – bold is added recommended changes.]

> 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.
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> **(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).

II. The Right to Comment on New Evidence Considered in Connection With a Final Appeal Decision.

In nearly every long term disability benefit lawsuit that our firm files there is an issue as to new evidence or new reasoning or rationales being utilized in connection with the final decision. As a routine matter our firm usually sends a demand to the insurance company or claims administrator, submitting further information to rebut the new information considered. Almost uniformly the insurer or claims administrator will refuse to consider the information. Some return the same to our office. In fact, in litigation the routine argument asserted in opposition to our request for the court to consider the new information is that the "administrative record" is closed and was closed with the final decision. That of course is unfair, and, in my opinion, a denial of procedural due process rights. No court would permit this advantage for one side in a case in litigation. But the unfairness is carried through into litigation by permitting this when compiling the record.

Courts have called this "sandbagging", but the remedy for this is usually insufficient. At best, a remand is often required for the participant to be required to go back through the claim process to again present the information that should have been considered when presented. The insured is the one who has been without benefits for an extended period of time, so it is very difficult to see how this is fair. If the insured has already attempted to present the information to the insurer or claims administrator, should a "second bite at the apple" be allowed? Again, courts do not permit a "second bite" to either side in other litigation. Why is it allowed under ERISA?

My view is that no new rationales or evidence or reasons to deny the claim should be permitted to be generated by the insurer in connection with an appeal. If the process is to truly be considered "administrative" then <u>all reasons</u> as to the claim denial should be asserted. Then the claimant should be allowed to comment and rebut those reasons. The insurer should merely be in the position of reviewing the record as it exists at that point in time. If the insurer or claims administrator believes there is additional information that should be considered, my view is that the appropriate approach here is for the insurer to pay the claim up to that point and then assert that there appears to be other reasons that have been overlooked and the insurer can then conduct another review. The insurer should send the case back for initial review and then explain why it may change its position if it is denied. An appeal on those reasons would be allowed.

The proposed changes to the regulation are a legitimate and good first step in the direction of making the process more fair. I still remain concerned over there being an endless appeal if the claims administrator or plan administrator decides to continue to "purchase" more peer review opinions every time a rebuttal is submitted.

I have seen suggestions from others who work in this field on the claimant's side regarding some changes to the language of the proposed regulation which I think are reasonable. I am in agreement with this until further steps toward fairness can be taken.

2560.503-1(h)(4)(ii) [proposed regulations new language indicated by bolding]

(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.**

I still believe that requiring a complete initial decision is a better approach, but I can agree with this.

III. Deemed Exhaustion and Failure to Exercise Discretion

When there are significant defects in providing a full and fair review, the claimant should be entitled to file suit, and a *de novo* review conducted by the court. Presently many courts have resorted to merely remanding the entire case back to the claims administrator or insurer let it "get it right". This is unfair to the claimant, as it requires the claimant to go through an extended ordeal. In effect, this disregards the timeframes in which decisions were due to be made.

The timeframes are critical to most claimants. Many are in need of the benefit to survive. In essence, if a remand is the only recourse, there is no reason for an insurer or claims administrator to make a solid, timely decision in the first place. If there is a problem, it will receive a remand. The only downside to that "gamesmanship" would be if the court ordered payment of attorney's fees. Courts have been slow to award attorney's fees in such circumstances and it only benefits the attorney usually.

Accordingly, the proposed regulation change as to deemed exhaustion and which reflects that there was no discretion exercised is much more appropriate. It is a step in the right direction. That provides the incentive necessary to get a timely decision right in the first place rather than sandbagging or refusing to honor the claims procedure regulation to force the claimant's hand to file suit. We have seen this occur in the case Ronnell Oliver v. AIG filed in the Southern District

of Mississippi. Procedural violations asserted in a lawsuit caused a remand back to the plan administrator or claims administrator to correct. This does not correct the delay in receipt of benefits. In practice it merely allows more time to deny the claim again.

IV. Venue Clause Provisions

There is one other area of unfairness and that is the assertion of venue provisions in plan documents. I believe the DOL has taken a very solid position on this in its *amicus* briefs, but courts continue to enforce plans allowing as much. Accordingly, claimants in Alabama can be forced to litigate in Missouri, or even Alaska, which causes an undue burden and expense upon the claimant. The claimant's residence on the date they were last covered under the plan should be the first choice or preference for venue. The requirement to force a claimant to litigate out of state should be a denial of a full and fair review.

V. Conclusion

There are many other issues concerning unfairness, but I appreciate the DOL's focus on rectifying the unfairness as it relates to the above issues. Thank you very much for the opportunity to comment and thank you very much for the good steps taken toward more fairness in connection with the claim process for long term disability claimants.

Very Sincerely,

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