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VIA EMAIL (e-ORI@dol.gov)

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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:

The following comments relate to the Employee Benefits Security Administration's proposed amendments to 29 C.F.R. §2560.503-1 applicable to disability benefit plans. I base my comments on my last 15 years of law practice, which have focused on representing disability claimants under ERISA. My practice includes representing claimants in the administrative appeal process, Arizona District Court, the United States Court of Appeals for the Ninth Circuit, and recently successfully opposing a petition for certiorari to the United States Supreme Court.

Plans should be required to inform participants of all deadlines.

Plans should be required to inform participants of contractual limitation periods when informing them of adverse benefit decisions. The Supreme Court's decision in *Heimeshoff v. Hartford Life & Accid. Ins Co.*, 134 U.S. 604 (2013) has caused confusion and precipitated much litigation. *Heimeshoff* left open the possibility that a contractual limitations period could expire before a claimant exhausts the administrative appeals process, even where exhaustion is mandatory. This would require filing a lawsuit to preserve the right to do so before the plan makes an adverse benefit decision, *i.e.,* before the participant suffers any damages and a claim has accrued for purposes of federal jurisdiction or state statutes of limitations.

Plans are already required to inform participants of regulatory deadlines effecting the administrative appeal process and of the right to file a lawsuit following an adverse decision on appeal. Requiring plans to inform participants of a contractual limitation period is no more burden than the plan already bears. Given ERISA's lack of a statutory limitation period most claimants (and, in my experience, many lawyers) are unaware of how to determine the statute of limitations under ERISA. But even if a claimant knew to look to the applicable state law, the claimant cannot be expected to ask for copies of plan

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documents to search for a contractual limitation period. A contractual limitation period shorter than the state limit is a trap for the unwary.

ERISA provides a right to bring a lawsuit. That right would be meaningless if the statute of limitations expired before the plan advised the claimant of an adverse decision or if the contract contained an undisclosed unreasonably short period. The Congressional purpose of ERISA, embodied in 29 U.S.C. § 1001(b), is to promote the interests of employees. *See Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 101 (1989). Requiring a plan to inform a claimant of any limitation on the rights provided under ERISA is consistent with that purpose. That a plan's fiduciary duty would not require the plan to inform a claimant of terms of the plan that limit the claimant's rights is unlikely.[1]

A clear statement of the statute of limitations is imperative. Just in the District of Arizona, under the existing regulation, judges have applied different statutes of limitations depending on which state statute the judge determines is most analogous. *See, e.g., Felton v. Unisource Corp.*, 739 F. Supp. 1388, 1392, 1990 WL 84396 (D. Ariz. 1990) *aff'd in part, rev'd in part,* 940 F.2d 503 (9th Cir. 1991) (applying one-year statute of limitations applicable to statutory claims); *Lemberg v. Scottsdale Healthcare Corp. Health Plan*, 2:11-CV-00271-REJ, 2011 WL 6049873, at *2 (D. Ariz. Dec. 6, 2011) (noting the Ninth Circuit has instructed to apply the statute of limitations for written contracts, which is six years in Arizona) (citing *Wetzel v. Lou Ehlers Cadillac,* 222 F.3d 643, 648 (9th Cir. 2000); A.R.S. § 12-548); *Blood Sys., Inc. v. Roesler*, 972 F. Supp. 2d 1150, 1156 (D. Ariz. 2013) (applying one-year statute of limitations applicable to written employment agreements). The statute of limitations should not depend on the analogy drawn by the judge assigned to the case. A definite limitation period benefits plans and claimants by reducing litigation devoted to the determination of the statute of limitations.

The proposed regulations should require: plans to inform claimants of statutory and contractual limitations periods; that any contractual limitations period does not commence until the administrative process is exhausted; and a minimum one-year limitation period.

Plans should not be permitted to offer new rationales for evidence after a claimant has appealed to support affirming an adverse benefit determination.

I support the Department of Labor's ("DOL's") goal of preventing plans from affirming adverse benefits decisions based on reasons or evidence to which the claimant has had no opportunity to respond. Relying on post-hoc rationales or new evidence has never been consistent with the regulations. *See Gabriel v. Alaska Elec. Pension Fund,*

[1] Although it is the minority view, some courts have interpreted the existing regulations to require notice of the statute of limitations. *See, e.g., 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." 29 C.F.R. § 2560.503–1(g)(iv)).

773 F.3d 945, 963, 14 (9th Cir. 2014) (quoting *Abatie v. Alta Health & Life Ins. Co.,* 458 F.3d 955, 974 (9th Cir.2006)). Despite this, I have had to litigate the issue often. It appears necessary for the DOL to state what seems obvious – a review cannot be "full and fair" if the claimant never had an opportunity to address the ultimate reason or evidence supporting an adverse benefit decision. The review process is designed to resolve, as often as possible, claims in the administrative process. That design fails, if a claimant's first opportunity to address a rationale or evidence is in the district court. Post-hoc rationales force the district court to allow a claimant to present new evidence in the district court, remand the case to the plan administrator, or consider a case that has not been properly developed. None of these is consistent with an expeditious, efficient, or cost-effective claim's administration.

Plans often obtain and offer the opinions of new medical reviewers, cite new or different evidence, or rely on different plan terms when affirming an adverse benefit determination. If these were included in the original decision, a claimant would have a minimum of 180 days to address them. The current regulation provides no opportunity to do so at the administrative level if a plan changes the basis for an adverse benefits decision after the claimant appeals. Although a claimant, who has been wrongfully denied benefits, bears what is often a devastating financial burden during the appeal process, no reason exists that the regulations should allow less time to address the real reason for the adverse benefit determination than the original reason, which the plan administrator often abandons on appeal. When the plan administrator abandons the original reason that should be a victory for the claimant. And, it would be except for the ability of plan administrators to change the reason for the denial of benefits after the claimant has appealed.

The DOL should amend the regulations to allow a minimum of 180 days to appeal an adverse benefit decision from the date the plan presents its last new piece of evidence or rationale. The amendment should provide that if a plan denies a claimant the opportunity to address the new or rationale, the claim is deemed denied and subject to *de novo* review in the district court.

Claims decisions should not be tainted by conflicts of interest.

Minimizing the effect of bias in the claim review process is a laudable goal. But as the Supreme Court noted in *MetLife v. Glenn,* 544 U.S. 105, 113 (2013), when finding an inherent conflict in the insurer making the benefit determination, even the employer's "selection of an insurance company to administer is plan," may be tainted by the employer's own conflict. It follows that the plan's or the plan's insurer's selection of personnel, outside consultants, vocational experts, financial experts, or medical professionals to review claims will always be tainted by self-interest. Although the conflict cannot be eliminated, the regulation can be amended to minimize it.

The DOL should amend the regulation to require plans to ensure that any agent, contractor, expert, or vendor, hired or consulted during the claim process is independent and impartial and not selected based on the likelihood that the person will support the denial of benefits.

A plan should have to explain rejection of a treating physician's opinion or a Social Security Administration's disability determination.

The norm is for plans to require claimants to apply for Social Security disability benefits. If claimants fail to do so, a plan will offset its benefit payment by the amount it estimates the Social Security benefit would have been if the claimant applied and the Social Security Administration approved the claim. Many plans will even hire companies to assist the claimant in obtaining Social Security disability benefits only to terminate the plan's benefits pending the Social Security determination or, in some case, after the award of Social Security disability benefits. Except in the context of mental versus physical disability, I have never been able to understand how a plan can represent to the Social Security Administration that a claimant meets the Social Security Administration's definition of disability and simultaneously find the claimant does not meet the plan's definition. I have never seen a plan's definition of disability that is more stringent than the Social Security Administration's definition. Thus, either the plan is misrepresenting the claimant's disability to the Social Security Administration or wrongfully terminating the plan's benefit payments. Plans profit from a favorable Social Security Administration determination, then ignore that determination and terminates its payment of benefits without explanation. Requiring a plan to explain its rejection of a Social Security determination (especially where the plan has advocated for the claimant in order to obtain the Social Security benefit) is consistent with the existing requirement of a full and fair review.

An argument plans offer is that the Social Security Administration is bound by the "treating-physician rule," but plans are not. While this explanation rationalizes a plan's acceptance of the benefit of a Social Security disability award while rejecting the analysis supporting it, it side steps the issue of why the plan is rejecting the treating physician's opinion. The treating physician rule is premised on treating physicians likely being the medical professionals most able to provide a detailed, longitudinal picture of the claimant's disability and bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations. The treating-physician rule only allows an administrative law judge to reject the treating physician's opinion in the face of substantial contrary evidence.

While adopting the treating-physician rule would be best for ERISA disability claimants, plans should *at least* have to explain in detail its reason for rejecting a treating physician's opinion. In my experience, when a rationale has been offered, it is usually

that the plan found someone to review the medical records, who does not agree with the treating physician. To find this "someone" is always possible.

This ties into the issue of the plan's conflict of interest and incentive to hire experts and reviewers who support the denial of benefits. My view may be cynical, but anyone familiar with expert witnesses in litigation knows every party can find an expert with an opinion to support that party. While trial experts are subject to qualification under state and federal rules and case law, plan administrators have unfettered discretion in seeking opinions. Coupling the requirement that plans not select reviewers who will support denials of benefits with the requirement that plans provide cogent explanations for rejecting a treating physician's opinion moves the process closer to a full and fair review. As the administrative process approaches a full and fair review, the burden on courts lessens by reducing the number of cases that can be litigated and reducing the issues to litigate in the cases that make it to court.

A court should be permitted to review any relevant evidence a claimant makes available to a plan before litigation commences.

Limiting review in district court to the evidence available to the claims administrator at the time of an adverse decision provides an incentive to claims administrators to process claims before a claimant obtains evidence to support a claim. For example, the claim process for Social Security disability benefits is notoriously slow. Often a favorable Social Security decision issues after a claim administrator terminates plan benefits. This is true even in cases where the plan continues to assist the claimant to obtain the Social Security disability benefits. This was the case in *Bilyeu v. Morgan Stanley Long Term Dis. Plan,* 683 F.3d 1083 (9th Cir. 2012) *cert. denied* 133 S.Ct. 1242 (2013). In *Bilyeu,* even after the plan's insurer, Unum, terminated Bilyeu's benefits, Unum continued to use its wholly owned subsidiary, Genex, to assist Bilyeu in obtaining Social Security disability benefits. Genex was successful. But when Bilyeu challenged the termination of plan benefits, Unum countersued for reimbursement for the overpayment created by the retroactive award of Social Security benefits that overlapped with the period Unum paid benefits. Unum did not have to explain its rejection of the administrative law judge's decision because it was not part of the administrative record at the time Unum denied benefits. Thus, the district court could consider the Social Security disability award with respect to Unum's counterclaim, but not necessarily with respect to Bilyeu's claim for benefits. That seems absurd. Permitting the court to consider any evidence available to the plan before litigation remedies the situation. This is the view taken by the Fifth Circuit in *Vega v. National Life Ins. Serv., Inc.,* 188 F.3d 287, 300 (5th Cir. 1999).

Another example is a claimant not having enough time to obtain additional treatment during the appeal process. In some cases, a disability requires treatment by a specialist, who is out-of-state, in high demand, or to whom a claimant has limited access because of limited medical insurance. Waiting six months for an appointment is not

unusual. But when the appeal process is 180 days, six months is not soon enough. Which leads me to another issue. The current regulations [29 C.F.R. §2560.503-1(h)(3)(i) and (4)] allow a *minimum* of 180 days for a claimant to submit an appeal. In the last year have I seem two claim files in which the same insurer has told the claimant that the regulations permit a *maximum* of 180 days to appeal.

The DOL should amend the regulation to permit claimants to add the administrative record at any time prior to commencing litigation. And, the regulation should require plans to extend the time to appeal beyond the minimum absent a showing a prejudice to the plan.

Notice of the right to obtain relevant documents should include the definition of relevant documents.

Requiring plans to provide claimants notice of the right to request "relevant documents" is important to insure a claimant receives a full and fair review. But a claimant is unlikely to know what "relevant documents" means. A claimant is much more likely to be familiar with the term "claim file." The amendment to the regulation should require that plans provide notice to claimants that they may request their "claim file." In the alternative, plans should not only be required to inform claimant of their right to request "relevant documents," but also provide the definition of "relevant documents" contained in 29 C.F.R. § 2560.503-1(m)(8).

The amendment needs to be clarified that "deemed exhausted" also applies to the appeal process.

The proposed amendment is clear that a plan must adhere to the regulations or the claim process is deemed exhausted. But many view the claim process and the appeal process as distinct. The proposed amendment should clarify that the appeal process is part of the claim process and that a claimant is deemed to have exhausted the claim process if a plan fails to adhere to the regulations in either the initial claim process or the appeal process.

The proposed amendment should also clarify that the standard of review in the district court when a claim is deemed exhausted is *de novo,* which is consistent with the case law interpreting the current regulation. *See, e.g., Abatie v. Alta Health & Life Ins. Co.* 458 F.3d 955, 963 (9th Cir. 2006); *Gilbertson v. Allied Signal, Inc.,* 328 F.3d 625, 631 (10th Cir. 2003) (citing *Firestone,* 489 U.S. at 111). The preamble to the proposed regulation is clear that review is *de novo* when special deference is not given to the plan's decision. But, the regulation states "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." That is not as clear a statement as the preamble. To avoid a potential ambiguity the DOL should amend the regulation to state that review is *de novo* when a claim or appeal is deemed denied.

Plans should be required to disclose internal rules, protocols, guidelines, etc.

I support the proposed amendment requiring plans to state in adverse benefit determinations the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon or state that they do not exist. To the extent they exist they would all within the definition of "relevant documents" that a claimant could request. But requiring disclosure will protect the unwary and unsophisticated claimant against plans creating and applying hidden terms or conditions. Perhaps most important is the requirement to disclose the non-existence of this category of documents. Rudderless claims handling cannot be consistent with a plan administrator's fiduciary duties. Benefits must be administered "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104. The regulations already require adverse benefit determinations to include the reasons for the denial and the applicable plan terms. The proposed amendment would not be onerous and would promote "a meaningful dialogue between ERISA plan administrators and their beneficiaries" as ERISA contemplates. *Booten v. Lockheed Med. Ben Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Not requiring plans to identify the basis of an adverse benefit decision is antithetical to a full and fair review.

Plans should notify claimants of their right to retain counsel for appeal.

Plans promote the notion that the administrative appeal process is an informal process and do not convey the importance of the process. Because the current regulations limit what a claimant may present in the district court to evidence presented during the appeal process, the appeal process is crucial. In my experience, frequently claimants do not seek counsel until after the plan denies the administrative appeal, and then it is too late to present evidence and limits review in the district court. Although some of the proposals above address the current limitations on the content of the administrative record, in the absence of such changes, many of the issues now litigated would be avoided if a claimant had the advice of counsel during the appeal process. The DOL should amend the regulations to require plans to inform claimants of their right to an attorney during the appeal process. This is consistent with a plan administrator's fiduciary duties to claimants and the goal of a full and fair review.

I hope that these comments are clear and helpful

Sincerely,

Kevin Koelbel

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