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TO: Employee Benefits Security Administration
United States Department of Labor
RE: Comments to RIN 1210-AB39

INTRODUCTION

Ladies and Gentlemen:

I am a solo practitioner in Central Ohio, and my practice consists largely of the representation of claimants in ERISA benefits matters and plaintiffs in ERISA litigation. I commend the Department for addressing issues associated with the processing of employee benefit claims, and particularly claims for disability benefits.

I further appreciate that the Department is endeavoring to address what, in my experience, are the two most persistent and grievous abuses that disability benefit claims administrators visit upon claimants. Now more than ever, administrators are relying on file reviews, too often prepared by physicians who long ago stopped practicing medicine, and always prepared by physicians who are out to collect the consulting money that administrators are willing to pay. The Supreme Court cautioned long ago that one should be wary of a physician who has a vested interest in concluding that a claimant is not disabled in order to protect the physician's consulting relationship. The Department's proposal is a step in the right direction, but as my comments below reflect, it does not go far enough.

The second abuse is the claims administrators' two-faced approach to Social Security disability determinations. Administrators are, of course, eager to have clients pursue a Social Security disability claim because of the fiscal windfall that accrues to the plan following a disability award. But these administrators too frequently turn a blind eye to the same disability determination when it comes to deciding whether the claimant is disabled for purposes of their own plan.

On too many occasions, my clients have received, sometimes within days of each other, two letters from claims administrators. The first informs them that their claim has been overpaid due to the Social Security determination, demands immediate repayment, and threatens legal action if the repayment isn't promptly forthcoming. The second letter informs the client that the same claims administrator has determined that the claimant is no longer disabled and terminates their claim. The Department's proposal to address this abuse is a positive development, but it, too, does not go far enough.

The comments below are based upon more than 20 years of experience handling these claims. I appreciate the opportunity to offer them.

RIN 1210-AB39

COMMENTS

I. Comments regarding the proposed regulations.

A. Addition of paragraph (b)(7)

I support the addition of this paragraph as far as it goes, but offer the following suggestions:

- Persons employed by the administrator also should not be indirectly rewarded for denying claims. For example, a plan employee who participates in the employer's profit sharing plan or holds the employer's stock in a qualified or non-qualified plan may perceive that it is to the benefit of the employee to deny disability claims because the denial of the claims improves the profitability of the employer. The rule should be extended to address these potential indirect conflicts of interest.

- With respect to paid consultants, this rule is likely meaningless without a concomitant disclosure requirement that identifies how many times each consultant has recommended approval or denial of disability claims. In light of the fairly sophisticated computer systems that all insurers now employ, it cannot be difficult for them to track this information (or to require the vendors with whom they contract to provide this information).

- I suggest that the new rule include a further requirement regarding medical experts. Administrators should be precluded from contracting with medical experts who do not maintain an active and vigorous medical practice.

    - As an example, Ohio Rule of Evidence 601(D) requires medical experts to be actively engaged in medical practice at least half-time before they are considered competent to testify as an expert in a medical malpractice case.

    - Limiting experts to actual practicing physicians would have at least two beneficial effects. First, it would increase the likelihood that the experts consulted would be current in their understanding of relevant medical practice. Second, it would help end the consulting class that courts have observed have an incentive to find in favor of administrators in order to preserve their consulting relationships.

B. Revision to paragraph (g)(1)(v)

No comments, except to note that it makes sense to separate health claims and disability claims.

C. Addition of paragraphs (g)(1)(vii) and (viii)

I support the addition of these paragraphs, but I believe they need to be strengthened, as follows:

- With respect to opinions offered by treating physicians, the Department should adopt the "treating physician rule" that is applicable in Social Security disability case. Adoption of the treating physician rule simply recognizes that physicians who have treated a claimant over an extended period of time are in the best position to know and understand the claimant's symptoms, the diagnoses and treatment plans, and the claimant's limitations. Adopting the "treating physician rule" would also complement the Department's view that private plan determinations should more reasonably align with Social Security disability determinations.

- Subsection (A) should further be strengthened to require that a plan provide a substantive response to a Social Security (or other plan) determination of disability.

    - An administrator in a recent case that I am handling explained the basis for its disagreement with a Social Security determination simply by stating "we have received more recent medical information than was available to the Social Security Administration." Under the rule as proposed, those are the kinds of answers that administrators will provide.

    - The rule, therefore, should be strengthened to require the plan to draw a substantive distinction. For example, in a situation similar to the one just described, an administrator should be required to identify with specificity the "more recent" medical records upon which it relies and to explain why these "more recent" medical records justify a departure from the Social Security Administration's decision.

- With respect to subsection B, I recently encountered a circumstance where an administrator refused to rely on an internal protocol that I knew (from prior experience with the administrator) to exist. I did not, however, have a copy of that protocol, and since the administrator professed not to rely on it, it did not disclose the protocol to me upon my request. The rule should require the disclosure of applicable protocols, whether or not relied upon.

D. Revision of paragraphs (h)(4), (i)(3)(i) and (j)(5)

I agree with the intent of the (h)(4) revision. All too often, in my experience, administrators have obtained an opinion from a consultant, then denied the claim based upon that opinion, without providing me or my client the opportunity to respond.

There is, however, a danger in the proposal, particularly as the Department has explained how it is intended to work. Administrators will always be able to obtain another opinion from another consultant, requiring the claimant to respond yet again. Thus, the review process can be extended indefinitely - or at least until the claimant wearies of rebutting an endless series of file reviews.

Administrators and their consultants should be required to get it right the first time. *Cf. Hayden v. Martin Marietta Materials, Inc. Flexible Benefits Program*, 763 F.3d 598, 609 (6th Cir. 2014) ("Plan administrators should not be given two bites at the proverbial apple where the claimant is clearly entitled to disability benefits. They need to properly and fairly evaluate the claim the first time around; otherwise they take the risk of not getting a second chance, except in cases where the adequacy of claimant's proof is reasonably debatable.").

I suggest, therefore, that an administrator not be permitted to acquire "consultant evidence" *ad infinitum*. Thus, the rule should be, as follows. If an administrator obtains an opinion from a consultant who recommends that a claim be denied, the administrator must provide the opinion to the claimant and offer the claimant an opportunity to respond. If the claimant or his physician provides a response, the administrator then must evaluate the claim based upon the *original* consultant's opinion and the claimant's response to it. The administrator should *not* be permitted to obtain yet another opinion from another consultant.

This rule would be beneficial for two reasons. First, it would prevent round after round of reviews without a final and conclusive determination. Second, too often administrators issue decisions that simply incorporate the consultant's opinion, without making any effort to weigh the consultant's opinion against the other evidence. Putting it another way, too often administrators simply delegate the decision-making to their paid consultants. Requiring them to assess the consultant's opinion in light of the claimant's rebuttal will return the decision-making to the administrator.

E. Addition of paragraphs (j)(6) and (j)(7)

See my comments in Part C above.

F. Revision to paragraphs (l) and (m)(4)

With respect to the new rule on deemed exhaustion, I suggest the Department modify or eliminate the sentence: "This exception is not available if the violation is part of a pattern or practice of violations by the plan."

- As written, many administrators will argue, and some courts will accept the argument, that *everything is de minimus* unless the claimant can demonstrate that the violation is part of a pattern and practice. This sentence, therefore, effectively destroys the intent of the rule.

- The sentence, furthermore, is unnecessary because a violation that is part of a pattern or practice cannot, *perforce*, be for "good cause."

G. Addition of paragraphs (m)(9) and (p)

In my opinion, the addition of the definition of "claim file" creates a conflict - or at least creates the opportunity to litigate over a perceived conflict - with the definition of "relevant information? Is a "claim file" a subset of the "relevant information" that an administrator must provide. Or is a "claim file" required to contain all "relevant information?" And if it is, what other information is a "claim file" permitted (or required) to include? At a minimum, the Department should clarify the purpose of the new definition.

II. Comment regarding the statute of limitations.

I wholeheartedly support requiring claims administrators to state in unambiguous terms the date by which a claimant must pursue legal action. Many claimants are unrepresented by counsel, ERISA should not be a game of "gotcha," and with the array of computerized information at their disposal, claims administrators are in the best position to know when the statute of limitations is to run.

I appreciate the opportunity to provide comments and will be happy to provide further information upon request.

Yours very truly,

Tony C. Merry

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