Law Office of
Katherine L. MacKinnon P.L.L.C.

Katherine L. MacKinnon
katemackinnon-atty@msn.com

Sarah J. Demers
sarah@katemackinnon.com

January 18, 2016

Via email only
e-ORI@dol.gov.

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
e-ORI@dol.gov.

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 am an attorney in a two-person law firm in St. Paul, Minnesota. The majority of our practice is focused on representing claimants/participants or beneficiaries (hereafter "claimants") in ERISA-governed benefit disputes. Last year this firm worked on 52 matters involving employee benefit disputes under ERISA. Over the preceding years, we have handled many more such cases -- including several that were resolved by judicial action.[1] The vast majority of the ERISA disputes we have been involved with have concerned disability benefit issues. As such, the DOL's proposed regulations in this area are of great interest to the clients we represent. Accordingly, I write to offer comments on some of the proposed regulations.

I have organized my comments as follows. First, I will address the most important substantive issues for the DOL to address as it finalizes the proposed regulations. Second, I have set out what I see as the most important technical issues in the proposed regulations, *i.e.*, requests for changes in the proposed language for purposes of greater clarity or conformity with other regulations.

---

[1] *Alliant TechSystems, Inc. v. Marks*, 465 F.3d 864 (8th Cir. 2006);
Abram v. Cargill, 395 F.3d 882 (8th Cir. 2005);
Wenzel v. Blue Cross and Blue Shield of Minnesota, 2015 U.S. Dist. LEXIS 146815 (D. Minn. 10/28/15);
Lanpher v. Metropolitan Life Ins. Co., 50 F. Supp. 3d 1122 (D. Minn. 2014);
UNUM Life Ins. Co. v. Zaun, 2014 U. S. Dist. LEXIS 100425 (D. Minn. 5/29/14);
Brandt v. ALLINA Health Systems LTD Benefits Plan, 2010 U. S. Dist. LEXIS 58967 (D. Minn. 6/15/10);
Gordon v. Northwest Airlines, Inc. LTD Income Plan, 606 F. Supp. 2d 1017 (D. Minn. 2009);
Groska v. Northern States Power Co. Pension Plan, 2007 U.S. Dist. LEXIS 71081 (D. Minn. 2007); and
Wolfe v. 3M Short-Term Disability Plan, 176 F. Supp. 2d 911 (D. Minn. 2001).

Part One: Comments on Substantive Matters in the Proposed Regulations

I. Comments on Issues with Periods of Limitation for Suit.

The DOL has invited comment on the period of limitations issues that have developed since the decision in *Heimeshoff v. Hartford Life & Accid. Ins Co.*, 134 U.S. 604 (2013). I agree that this is a crucial area for regulation as the *Heimeshoff* decision has created confusion and litigation. Even before *Heimeshoff* was decided, issues surrounding the applicable period of limitations, coupled with the obligation to exhaust administrative remedies, have posed real headaches for lawyers/clients in this area. Indeed, I have been in the position of facing a potential malpractice claim when a long-term disability claim I was pursuing for a client was defended on the basis of missing the statute of limitations while the parties were engaged in administrative exhaustion. (Fortunately, that case was resolved satisfactorily).

The DOL could offer significant assistance to plans, claimants and courts by doing two things: (1) creating standards for what is a reasonable plan-based period of limitations provision, *i.e.* a reasonable standard for time limits for suit specified within the plan; and (2) creating notification standards for plans that would include the duty to inform claimants of the date when the period of limitations will elapse, whether that time is based on a plan-imposed period of limitations or a legal statute of limitations.

Reasonable Standard for Plan-Based Periods of Limitation: To begin with, it would be very helpful if the DOL were to establish by regulation a reasonable plan-based period of limitations. The DOL certainly has the authority to do so as it acted similarly when it promulgated the 180-day period by which a claimant must file an appeal from an adverse benefit determination. Since the *Heimeshoff* decision has left open the possibility that a plan-based period of limitations could run before the administrative appeals process is concluded which would frustrate the idea of administrative exhaustion, the DOL is in the best position to clarify that such an approach would violate the full and fair review required by 29 U.S.C. §1133. Thus, as it did when it mandated the 180-day appeal period, I suggest that the DOL adopt standards for what is a reasonable plan-based limitations period. For that reason I suggest that a reasonable period is any period that runs our no sooner than one (1) year after final determination.

Such an amendment will have the beneficial effect of addressing the different courts' views on when claims "accrue" in that it will clarify that no limitations period can start before the internal claim and appeals process is complete. It also will explain that there will be at least a (1) one-year period after the completion of the plan's appeals process in which a claimant can file suit.

The justification for this rule is that it would cut down on litigation devoted to the threshold issue of the running of the limitations period. In addition, it may well lead to a standardization of internal plan limitations periods a salutary goal for both claimants and plan administrators.

Notice Regarding the Expiration Date of the Applicable Limitations Period: Additionally, whether the plan relies on a plan-based limitations period or a legal statute of limitations,

because the time by which suit must be brought is essentially a crucial term of the plan, I believe that the regulations should mandate that the claimant receive notice about the date when the plan-based or legal limitations period will run. That is, the DOL should regulate to require the plan to advise the claimant of when the applicable limitations period (whether plan-based or statutory) will expire.

Such a requirement would be consistent with the general obligation on a plan to inform a claimant about important plan terms. As the DOL aptly points out in the preamble to the proposed regulations, plan administrators are in a better position to know the date of the expiration of the applicable limitations period. Advising claimants when that date will occur is vital information that a plan fiduciary should be disclosing.

There is precedent for such an approach. *See e.g. Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis, No.* 4:12CV53 HEA, 2014 WL 562557 at *12-13 (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)(observing that the plan should disclose to a claimant "[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."). Unfortunately, the *Kienstra* decision appears to be a minority perspective. However, with the amendment of the regulations, the DOL could adopt the approach from *Kienstra* and require a plan to divulge the specific date when the plan-based limitations period will run out.

In light of these two concerns, I recommend amendment to the regulations governing the manner and content of notification of benefit determinations on review which is found at 29 C.F.R. §2560.503-1(j) [proposed regulation]. The amended language should do two things. First, it should include a definition of what is a reasonable limitations period to include in a plan-based limitations period. Second, the amendment should require the plan to notify the claimant of the date when any plan-based limitations period will expire. Accordingly, 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.

(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. Comments on Timing of Right to Respond to New Evidence or Rationales

The DOL's proposals clearly attempt to improve the situation for claimants who are trapped by new rationales or evidence developed by the plan during its review of an appeal submitted by a claimant. I commend this effort. "*Sandbagging*"[2] has been a persistent problem in the ERISA appeals process and some courts have not appreciated how prejudicial this is to claimants. In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), a case which I handled on behalf of Ms. Abram, 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 [in its appeal determination], Abram could not meaningfully participate in the appeals process. . . This type of "gamesmanship" is inconsistent with full and fair review.*

Id. Given that: (1) once the claimant has submitted his/her appeal there is no chance to respond to anything new raised by the plan in its review determination; and (2) it is often very hard to supplement the record in litigation, the DOL's proposed change offers some assurance that a claimant can contribute his/her relevant evidence to the record that the court will review. Where

---

[2] *Marolt v. Alliant Techsystems*, 146 F.3d 617, 620 (8th Cir. 1998)(observing that ERISA does not permit claimants to be "sandbagged" by rationales not presented by the plan during the administrative review process).

the claimant, as plaintiff in the litigation, has the burden of proof on most issues,[3] this only makes sense. That is, 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/plaintiff the right of rebuttal in litigation.

There is, however, a countervailing concern that while this extra opportunity to submit proof to the plan exists, claimants will be going longer without disability benefit payments. This is a problem that already exists and could be exacerbated. Plans will urge that giving claimants the last word will make the internal appeals processes unending. This argument is out of touch with the reality of being an ERISA disability benefits claimant. Claimants, in my experience, would not continue the process endlessly while not receiving disability benefits. Claimants are customarily highly motivated to get a resolution that will allow them to pay their mortgages and feed their families. In short, the risk of an unending to and fro between plan and claimant is not a realistic concern.

The following suggestion places reasonable limits on both claimants and plans and responds to the concern that claimants will have to wait too long for determinations on review. While claimants will want to act quickly in providing their responses (because they are usually without income during this process), the type of evidence they often need to respond to new evidence or rationales from the plan may require hiring an expert such as another physician, psychologist, or vocational consultant. These professionals are not readily available for quick turn-arounds and, depending on the new information needed, such experts may need weeks to evaluate the new information.

For this reason, claimants should have at least sixth (60) days to respond to new evidence or rationales provided by the plan on appeal. Moreover, the period for completing the decision on review 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 regardless of whether the new information considered by the plan is a new "rationale" or new "evidence." 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)

---

[3] *See Schaffer v. West,* 546 U.S. 49, 56 (2005), in which the Court commented:
"The ordinary default rule [is] that plaintiffs bear the risk of failing to prove their claims. McCormick § 337, at 412 ("The burdens of pleading and proof with regard to most facts have been and should be assigned to the plaintiff who generally seeks to change the present state of affairs and who therefore naturally should be expected to bear the risk of failure of proof or persuasion"); C. Mueller & L. Kirkpatrick, Evidence § 3.1, p 104 (3d ed. 2003) ("Perhaps the broadest and most accepted idea is that the person who seeks court action should justify the request, which means that the plaintiffs bear the burdens on the elements in their claims").

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 the 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.**

III. Independence and Impartiality - Avoiding Conflicts of Interest

The proposed regulation regarding the impartiality of claims personnel is essential and I applaud the DOL's effort to minimize the effect that biased individuals have on the claims and appeals process. However, 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 and the vendors, in turn, employ the experts.

Second, clarification is needed concerning what is meant by the reference in the proposed regulation to individuals "involved" in the process. 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 it applies to not only claims adjudicators and consulting physicians but also to other experts such as vocational consultants or accountants. Such experts are 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 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.

Part Two: Comments on Technical Matters in the Proposed Regulations

I. Effective Date of Proposed Regulation

To avoid the application of the previous regulations to disability claims that are already in process before the effective date, I suggest the following text be added to the amended regulations:

> **The regulations shall apply to all claims pending with the plan fiduciary on or after the date that the regulations go into effect.**

The holding in *Abram v. Cargill*, 395 F.3d 882 (8th Cir. 2005), my client's case, was seriously undermined when the Eighth Circuit later concluded that its decision in *Abram* was grounded in the pre-2000 version of the claims regulations and would not apply to cases decided under the post-2000 claims regulations. *See Midgett Washington Group Int'l LTD Plan*, 561 F.3d 887, 894-96 (8th Cir. 2009). To avoid this sort of problem occurring again, the above suggested language should be added to the proposed regulations.

II. 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 serious violation of the regulations, the claimant can seek judicial review regardless of whether the claim is in the "claim" or the "appeal" stage. I suggest the following clarifying language (added language is bolded and underlined):

> **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.**

III. Right to Claim File and Meaning of "Testimony"

There is confusion in the proposed language concerning what manner of "testimony" is contemplated by the new regulations.

In the preamble to the proposed regulations, the DOL has stated: "the proposal would also grant the claimant a right to respond to the new information by explicitly providing claimants the right to present evidence and written testimony as part of the claims and appeals process." Note that the underscored language refers to "*written testimony*." But the actual proposed regulation uses this phrasing: "[the processes for disability claims must] allow a claimant to review the claim file and to present evidence and testimony as part of the disability benefit claims and appeals process." 29 C.F.R. §2560.503-1(h)(4)(i)[proposed regulation]. Here the regulation refers to "testimony" without limiting the type of testimony to "written" testimony.

By comparison, the current regulation uses the following language: "[the process must] provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits." 29 C.F.R. 2560.503-1(h)(ii)(2)[current regulation].

Hence, there is an inconsistency between the preamble and the proposed regulation in that the preamble specifies "written testimony" whereas the proposed regulation just says "testimony." This could lead to costly disagreements over whether the regulation contemplates actual live testimony, *i.e.* a hearing.

Furthermore, under the current regulation often my clients submit testimony in the form of an audio or video CD. This is particularly useful in cases where the client cannot read or write so that a written statement is impossible. One case that I handled was made workable by using a video CD interview of the claimant. He was a middle-aged gentleman who had not completed high school (in part because he was really unable to read) and had worked all of his life as a mechanic. When he developed a neurological condition that impaired his ability to have steady hands, he was disabled. I could not send in a written statement for this claimant as he could not read it. Furthermore, he would not have been able to write down his story himself both because of his illiteracy and his neurological tremble. The video statement was, therefore, critical to showing the plan administrator how he was disabled.

As such, I am concerned that the reference to "written testimony" in the preamble might give plans ammunition to disallow any audio or video submissions on the grounds that these forms of evidence do not represent "written evidence." If this were the interpretation given to the proposed regulation, it would actually put claimants, like my client described above, in a worse position than they face at present.

Further, the proposed regulation's verbiage, *i.e.* "evidence and testimony" could be interpreted to impose courtroom evidentiary standards for submitting proof of a claim. That is words like "evidence and testimony" carry an aura of litigation. I fear that plans could use such language to argue that only evidence that meets the standards of admissibility in a court proceeding will be considered. Such a threshold would pose a considerable hurdle for claimants who are often unrepresented. While plans may well be able to observe the rules of evidence by employing counsel and other legal resources, claimants are often not equipped to do so.

Additionally, adding a requirement of a courtroom-level of evidentiary admissibility to the administrative claims process by regulation will seriously erode the idea of a "meaningful dialogue" [4] between plan and claimant. This is the very essence of the administrative review process. Hence, I would ask the DOL to make explicit that the proposed amendment is not intended to curtail or narrow the types of information that claimants may submit to the plan in support of their claims. More particularly, I would ask for clarification that the phrase "written evidence" does not mean that only narrative evidence written down will be accepted and also that the standards of evidence used in a courtroom do not apply to what may be submitted by a claimant in support of his/her claim or appeal.

---

[4] *See Booten v. Lockheed Medical Benefit Plan,* 110 F.3d 1461, 1463 (9th Cir. 1997)

IV. 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 by counsel in the administrative appeal process. Not only that, but I have had prospective clients advise me that they inquired of plan representatives as to whether they should hire a lawyer for the appeal and were actually encouraged not to do so.

When this happens and the claimant does not get assistance with the appeal, he/she often squanders his/her best chance for reversing the benefit denial. I have had several potential clients come to me seeking representation for litigation had not retained counsel for the administrative appeal process. Many of those potential clients had claims that were effectively lost before they even came in the door of my office because the administrative record was so inadequate that the claimant would not be able to win in federal court –even if the claim was actually quite meritorious. That is by not having legal advice that the administrative review process is the gatekeeping step by which evidence is considered later in court, these claimants were effectively unable to get judicial review.

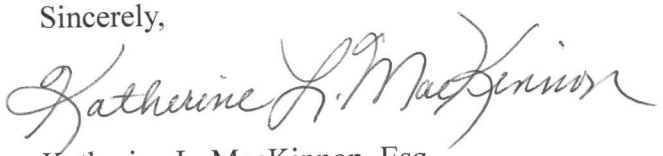
Obviously having a lawyer does not guaranty that claimants will be fully able to optimize their claims during the administrative review process, but legal assistance would surely decrease the instances in which a claimant does not offer adequate evidence to the plan during the administrative process. Hence, a regulation requiring plans to advise claimants of their right to retain counsel for the appeal may well prevent claimants from foregoing their last and best opportunity for reversing a benefit denial.

Accordingly, I propose that the DOL adopt a regulation that benefit denial letters must advise claimants of their right to hire an attorney to represent them in the appeal phase of the claims process. The Social Security Administration does this. There is no reason to hide this right from claimants.

CONCLUSION

On behalf of the claimants I represent now and those that I may represent in the future, I sincerely thank the DOL for undertaking this effort to amend the disability claims regulations. I am heartened that the agency has taken these steps to level a playing field that is decidedly uneven. The measures that have been proposed as well as other parts of the proposed regulations will very likely make it possible to resolve claims without litigation. They will be a boon for claimants, plans and the court system. Thank you for these efforts.

Sincerely,



Katherine L. MacKinnon, Esq.

KLM/klm