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BY U.S. MAIL & EMAIL TO: 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

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:

Thank you for the opportunity to comment on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. The protection of workers who become disabled is an important concern and we appreciate the Department of Labor's ("DOL") decision to further develop and improve upon the current procedural protections in place under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA").

Our practice is primarily focused upon the representation of individuals in ERISA-governed benefit disputes, including in large part, disability benefits. We have represented hundreds (thousands?) of claimants and feel that we are particularly well-suited to inform on the practical realities that disability benefit claimants face in the system as it is presently established. As such, we are deeply interested in the content of these regulations.

Our comments are organized as follows. First, we address the DOL's Request for Comments on statutes of limitations in ERISA after the Supreme Court's decision in *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S.Ct. 604 (2013). Second, we address the proposed regulations and their strengths and shortcomings as presently drafted. Third, we have additional recommendations that are not presently covered by the regulations as proposed.

I. STATUTES OF LIMITATIONS AFTER *HEIMESHOFF V. HARTFORD LIFE & ACCIDENT INSURANCE COMPANY.*

The Supreme Court's decision in *Heimeshoff* is based largely upon esoteric, if technically correct, principles of trust and fiduciary law, but it fails to realistically consider the actual, real-world consequences these interpretations can have upon ERISA claimants. As such, this is a crucial area for regulation by the DOL. Indeed, *Heimeshoff* permits an ERISA plan to prescribe not only the length of the limitations period (as opposed to applying the closest analogous state law contractual limitations period), but also when that period commences. The result is that a plan's terms can actually start the statute of limitations running long before the claimant ever has the right to file suit. Such a result can and has had drastic consequences on claimants' ability to pursue their disability benefit claims in spite of the otherwise substantive viability of the claims. While the Supreme Court acknowledged that typically Congress does not intend for statutes of limitations to commence until their associated causes of actions accrue, it nevertheless allowed this result because the parties have agreed by contract to do so. The Court relied on this supposed contractual privity despite the fact that ERISA plan participants are rarely, if ever, given any say in negotiating the terms of their employer's ERISA plan, much less given the chance to agree by contract to any specific provisions. By implementing the three recommendations submitted below, however, the DOL is in the position to mitigate the oppressive results imposed by *Heimeshoff* and provide a fuller and fairer system of disability claim processing as intended by Congress in enacting ERISA.

First, in *Heimeshoff*, the plan required participants to file suit for benefit claims within three years after "proof of loss" is due, which occurred in December, 2005. The claimant went through the Plan's administrative process, as is required, and a final denial was issued in November, 2007. As a result, almost two years of the claimant's three-year statute of limitations had run before she ever had the right to file suit in the first place. A result that allows the time period within which one has the right to obtain legal redress of a wrong to be running against them before they have even been legally wronged is totally incompatible with our legal system. This is the case in any legal setting, but it is particularly so in the ERISA context, where the claimant is required -- by penalty of dismissal with prejudice -- to fully exhaust the plan's administrative procedures controlled by the adversarial party (taken to the extreme, *Heimeshoff* leaves open the possibility that an internal limitations period could run before the appeals process is complete even where exhaustion is mandatory[1]). The Fourth Circuit has long recognized this problem and has held that the statute of limitations is tolled until the claimant has fully exhausted administrative remedies under the Plan and a final administrative decision has been issued. *White*

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[1] While the Supreme Court suggested that in situations where the statute of limitations would run during the claim appeal process, courts have applied equitable doctrines to prevent the limitations period from being invoked, including the doctrine of equitable tolling (citing *Irwin* v. *Dep't of Veterans Affairs*, 498 U.S. 89, 95, 111 S. Ct. 453, 112 L. Ed. 2d 435 (1990) (limitations defenses "in lawsuits between private litigants are customarily subject to 'equitable tolling'")), this is difficult to reconcile with *U.S. Airways, Inc. v. McCutchen,* 133 S. Ct. 1537 (2013), which rejected equitable defenses that undermined plan terms. Under *McCutchen,* a benefit plan sponsor could draft terms that would strictly enforce the contractual limitations period and exclude equitable defenses such as equitable tolling.

v. Sun Life Assurance Co. of Canada, 488 F.3d 240, 245-46 (4th Cir. 2007). This rule was equitable and in line with ERISA's stated purpose of protecting workers and their benefit claims. As such, the DOL is in an excellent position to clarify that the approach now permitted by *Heimeshoff* violates the full and fair review required by 29 U.S.C. §1133 and to adopt a rule that is similar to the reasoning of the Fourth Circuit in tolling all applicable statute of limitations periods until the claimant's receipt of the final benefit determination.[2] Such an alteration will make it clear that no limitations period can start before the internal claim and appeals process is complete and provide more meaningful access for disabled workers. Having clarity here would not only be equitable for the claimant, but it would also substantially cut down on litigation devoted to the threshold issue of the limitations period and may well lead to a standardization of internal limitations periods that would be salutary for both claimants and plan administrators.

Second, because contractual limitations periods are plan terms, the claimant should receive notice about the limitations period from the plan just as is the case with other plan terms. As the DOL aptly points out in the preamble to these proposed regulations, "[i]nasmuch as plans are responsible for implementing contractual limitations provisions, plans may be in a better position than claimants to understand and to explain what those provisions mean." Instead, plans, who are supposed to be functioning as fiduciaries, are able to enforce time limitations that can be utterly incomprehensible to practitioners, much less lay disability claimants, who are nevertheless purposed with figuring it out on their own.

Indeed, many plans are set up as sadistic scavenger hunts with the applicable limitations period as the final destination, if you can make it. For example,[3] a plan may state that the applicable statute of limitations is three years from the earlier of when the insurer receives the Proof of Claim (or Proof of Loss), which is a defined term in a separate part of the plan, or when Proof of Claim is required to be given. Thus, to determine which occurred earlier, the claimant's first step will be to determine both dates -- when the insurer received the Proof of Claim (not when it was submitted, which is potentially within the knowledge of the claimant, but when the insurer deems it to have been received) and when Proof of Claim is required to be given by the plan. Proof of Claim is often required to be given within a set number of days starting from the end of the Elimination Period, which is yet another defined term in yet another part of the plan. The Elimination Period may begin on the first day of Disability, another defined term (which the plan is charged with determining), and be satisfied by a set number of days, or upon the conclusion of short-term disability payments, or when the required number of days is accumulated within a period which does not exceed two times the Elimination Period, with the exception of any statutory disability benefits, accumulated sick time, or salary continuation program sponsored by the Employer. All of this also assumes that the Proof, another defined

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2 Such a regulation would also be consistent with statutes passed by many states that toll the running of limitations periods between the submission of proof of loss under an insurance policy and the communication of the final claim determination. *See, e.g.*, 215 ILCS 143.1 ("Whenever any policy or contract for insurance, except life, accident and health, fidelity and surety, and ocean marine policies, contains a provision limiting the period within which the insured may bring suit, the running of such period is tolled from the date proof of loss is filed, in whatever form is required by the policy, until the date the claim is denied in whole or in part.").

3 All of which have been pulled from actual disability policies.

term in yet another part of the plan, that was submitted to trigger these calculation dates was deemed to be adequate in the first place, as the Proof is generally required by the plan to be satisfactory to the insurer.

This can readily be resolved, however, by placing that burden where it belongs, on the plan administrators who crafted these limitations and who are in a far better position to know the date of the expiration of their own limitations period. There is no reason to allow fiduciaries to continue to hide the ball. Thus, we 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]), wherein the claims administrator is required to notify the claimant of the exact date of the expiration of any applicable plan-based limitations period.

Finally, the DOL should regulate to prevent plans from contracting around applicable state statutes of limitations, which typically range between one and three years, to unreasonably shorten the time period in which claimants have to pursue their legal remedies. Since *Heimeshoff*, at least four courts have upheld six-month limitations periods as reasonable,[4] and two more have upheld nine-month limitations periods.[5] In cases decided prior to *Heimeshoff*, courts have upheld 45, 60, 71, 90, and 120 day limitation periods.[6] The Seventh Circuit has even suggested that 30 days may be reasonable. *See Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869 (7th Cir. 1997).

Together, these three requirements would be minimally invasive to plans and their administrators, but they would be extraordinary in their potential to make a meaningful impact on the fairness of a process that is, by all accounts, intended to be fair.

II. COMMENTS ON THE REGULATIONS AS PROPOSED.

The proposed amendments to the disability claim regulations are a welcome and considerable step forward in clarifying and protecting the rights of claimants, as well as in providing more accountability to plan administrators. We believe there are certain areas where further modifications could be made to improve the process.

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[4] *Claeys v. Aetna Life Ins. Co.*, 548 Fed. Appx. 344 (6th Cir. 2013); *Santana-Diaz v. Metro. Life Ins.*, 2015 U.S. Dist. LEXIS 8755 (D.P.R. Jan. 23, 2015); *Lundsten v. Creative Cmty. Living Servs.*, 2015 U.S. Dist. LEXIS 31238, 2015 WL 1143114 (E.D. Wis. March 13, 2015), *reversed on other grounds*, 2015 U.S. Dist. LEXIS 111052 (E.D. Wis. Aug. 20, 2015); *Mahan v. Unum Life Ins. Co. of Am.*, 2015 U.S. Dist. LEXIS 82230 (N.D. Cal. June 24, 2015).

[5] *Tuminello v. Aetna Life Ins. Co.*, 2014 U.S. Dist. LEXIS 20964 (S.D.N.Y. Feb. 14, 2014); *Barriero v. NJ BAC Health Fund*, 2013 U.S. Dist. LEXIS 181277 (D.N.J. Dec. 27, 2013).

[6] *Davidson v. Wal-Mart Assocs. Health & Welfare Plan*, 305 F. Supp. 2d 1059 (S.D. Iowa 2004); *Delosky v. Penn State Geisinger Health Plan*, 2002 U.S. Dist. LEXIS 17188 (M.D. Pa. 2002); *White v. Worthington Indus.*, 266 F.R.D. 178 (S.D. Ohio 2010); *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Emple. Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998); *Dye v. Assocs. First Capital Corp. Long-Term Disability Plan 504*, 243 Fed. Appx. 808 (5th Cir. 2007).

1. 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. We request these items in every appeal, but we almost never receive them, nor are they produced in the ensuing litigation absent a protracted discovery dispute. As is true in the healthcare context, plans sometimes argue that internal criteria are confidential or proprietary. But keeping the rules that are used to administer a plan a 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 Disab. Plan*, 2004 U.S. Dist. LEXIS 1259, at *56-57, 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). The regulations should therefore emphasize that if the plan relies on an internal rule, it cannot maintain it is confidential. Given that the regulations require adverse benefit determinations to include the reasons for the denial and the applicable plan terms, this additional requirement should not be onerous and would promote the dialogue between claimant and plan that ERISA contemplates. *Booten v. Lockheed Med. Benefit 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."). As with the limitations provisions, there is no reason for a fiduciary not to be forthcoming with the information upon which it relied. Moreover, making the details of the plan and the rules by which they are playing more accessible to the average, unsophisticated claimant is undeniably a positive step in the advancement of the rights of the disabled.

2. Rescission.

The proposed language regarding treating rescissions of coverage as adverse benefit determinations should be expanded to encompass any situation where a limitation is invoked so that the claimant can immediately appeal. For instance, a plan may approve benefits but may invoke a temporal limitation that exists in the plan, such as for mental and nervous disorders or for "self-reported" illnesses or the disability definition change from "own occupation" to "any occupation." Many insurers defer the right to appeal until the date that benefits end, which imposes significant economic hardship on claimants who may then be deprived of benefits for several months while appeals proceed. The claimant should have the option to immediately appeal that determination to avoid the economic hardship in the future.

3. Deemed Exhausted.

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. We suggest adding the following bold and underlined clarifying language to 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**, the claimant is deemed to have exhausted the administrative remedies available under the plan …"

4. Disagreement with Other Decisions.

The regulation requiring a discussion about the difference between the plan's decision and awards made by treating doctors or other systems, such as Social Security, should be expanded to set forth a deferential review requirement. Indeed, the Supreme Court handed the DOL an opportunity to issue a more substantive regulation requiring that deference be given to the opinions of treating doctors. In *Black & Decker v. Nord,* 538 U.S. 822 (2003), the Supreme Court rejected an argument that plan administrators should give discretion to opinions rendered by treating doctors, much as the Social Security Administration has issued a regulation requiring such deference. 20 C.F.R. § 404.1527(d). However, the Court stated:

> If the Secretary of Labor found it meet [sic] to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference. *See Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.,* 467 U.S. 837, 81 L. Ed. 2d 694, 104 S. Ct. 2778 (1984). The Secretary has not chosen that course, however, and an *amicus* brief reflecting the position of the Department of Labor opposes adoption of such a rule for disability determinations under plans covered by ERISA. *See* Brief for United States as *Amicus Curiae* 7-27.

Black & Decker, 538 U.S. at 832. With respect to other systems such as Social Security, the regulations should require plans to give significant weight to evidence of an award of Social Security disability benefits as supporting a finding of disability, unless there is compelling evidence that the decision was founded on an error of law or an abuse of discretion, inconsistent with the applicable medical evidence, or substantively inconsistent with the definition of disability contained in the applicable insurance policy.

5. Meaning of "Testimony."

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" (emphasis added). But the actual proposed regulation states that a claimant may "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] (emphasis added). 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. More importantly, under the current regulation, claimants can submit testimony in the form of an audio or video CD. This is useful in cases where the claimant cannot read or write so that a written statement is impossible. It is also particularly helpful in those cases where actually seeing and hearing the claimant might be important. As such, we are concerned that the reference to "written testimony" in the preamble might give plans the ammunition to disallow any audio or video submissions on the grounds that these forms of evidence do not represent "written testimony." If this were the interpretation given to the language in the proposed regulation, it would actually put claimants in a worse position than they face at present.

6. Independence and Impartiality.

The proposed regulation regarding the impartiality of claims personnel is essential and we 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 who, in turn, employ the experts. Second, clarification is needed concerning which individuals are "involved." 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 not only claims adjudicators and consulting physicians must be impartial. Vocational experts and accountants are also frequently used in the claims process and should be included in the scope of the impartiality requirement.

III. ADDITIONAL RECOMMENDATIONS.

As stated above, the proposed amendments are a significant improvement to the current ERISA disability landscape. However, we now respectfully recommend certain additional changes that have not been address in the proposed regulations:

1. Notice of Right to Retain Counsel for Appeal.

Often ERISA claimants who have been denied disability benefits do not realize that they have the right to be represented in the administrative appeal process. In fact, many times we have been told by prospective clients that their internal claims reviewer presented as assisting or advocating for the claimant to get their claim completed and approved or even so far as to tell the claimant that they do not need an attorney. Additionally, many attorneys will not take a

claimant's case when the claimant has appealed on their own and failed to put the appropriate evidence into the record. We therefore 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. The Social Security Administration already does this. There is no reason to hide this right from claimants.

2. Notice of Evidentiary Record Closure.

In our experience, most claimants, even sophisticated ones, believe that ERISA benefit claims are no different from other legal claims, i.e., that they will have the right to produce and present their evidence and have their day in court. But not knowing that they will be limited 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. Indeed, we have seen so-called administrative records wherein the claimant simply faxed a one sentence letter of appeal to the insurer that merely stated, "I appeal." As such, the regulations should require plans to include a statement that in most scenarios, the claims record closes when the claimant receives the final claims denial, that if the claimant chooses to file a lawsuit, the court will not typically consider any additional evidence, and that any evidence the claimant has to submit, must be submitted during the appeal process.

3. Recoupment of Overpayments.

When participants are informed that they have received an overpayment of their benefits, the letter does not inform them that they may challenge this determination through the plan's internal benefits claim process. Rather, the letters threaten additional action and collection processes. Nor do these overpayment notices typically provide the reasoning and basis for seeking the overpayment, nor do they provide the claimant with their ERISA Rights notices. However, such actions by the plan affect a substantial right of the claimant and therefore the regulations should make clear that recoupments of disability benefit payments are subject to the plan's internal benefits claims process. There is no persuasive reason to allow plans to seek sometimes large sums of money from the pockets of disabled claimants without first requiring exhaustion and the same procedural protections that are in place for typical benefits claims.

Additionally, there are presently no limits to how much of a claimant's monthly disability benefit that insurers can offset while recouping overpayments. Thus, plans can and do offset 100% of the claimant's monthly disability benefit for years at a time if there is a sizeable overpayment. In order to prevent the unnecessary hardship caused by the forced repayment of, for example, Social Security benefits to private insurers, the regulations should set a maximum percentage of the monthly benefit that the insurer can offset while recouping the overpayment. In that way, plans are repaid and disabled claimants retain some level of income to meet their basic needs. Insurers are in a far better position to spread out this repayment than a disabled claimant.

4. Venue Selection.

The regulations should make clear that ERISA's broad venue provision cannot be thwarted by contrary plan or policy provisions. Some courts have permitted plans to draft around ERISA's venue requirements. At a minimum, the present state of the law means that there will continue to be litigation on this question before the merits of a dispute can even be reached. Venue selection clauses are mostly used to disadvantage ERISA claimants in litigation or create barriers to their statutory right to sue. *McQuennie v. Carpenters Local Union* 429, 2015 U.S. Dist. LEXIS 151470, at *12, 2015 WL 6872444, at *5 (D. Conn. Nov. 9, 2015) (*pro se* litigant allowed to sue in home state of Connecticut because he could not afford to travel to California); *but see*, *Turner v. Sedgwick Claims Mgmt. Servs.*, 2014 U.S. Dist. LEXIS 180506 (N.D. Ala. Dec. 19, 2014), *adopted by* 2015 U.S. Dist. LEXIS 5289, 2015 WL 225495 (N.D. Ala. Jan. 16, 2015). In *Turner,* the court encouraged the agency to regulate in this area as opposed to filing amicus briefs in some cases and not others. *Id.* at 58 ("Also underwhelming is that the Secretary has expressed his view only rarely, through the ad hoc, highly informal means of amicus briefs in private litigation, rather than in a regulation, an enforcement setting, or even in a published statement of policy or guidance."). By requiring claimants to litigate in a forum far away from their residence, plans are stripping rights explicitly afforded to individuals by ERISA. As such, the regulations should prohibit venue and forum selection provisions that are contrary to 29 U.S.C. § 1132(e)(2) (actions under ERISA "may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found…").

5. Opportunity 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. This is true as well for other kinds of evidence. Even where it would not be a problem to do so, plan administrators often refuse to consider this type of evidence, choosing instead to shut the door on a meritorious claim. Meanwhile, plans will often counterclaim to recover the offset that is provided by the SSA benefit. *Metro. Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008). Sometimes a claims administrator may rush an appeal decision through simply to avoid the claimant being awarded SSDI and having that evidence in the claims file. There is a clear solution to this that would track the Fifth Circuit's *en banc* holding in *Vega v. National. Life Insurance Service, Inc.,* 188 F.3d 287, 300 (5th Cir. 1999), where the Court wrote:

> We hold today that the administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it. Thus, if the information in the doctors' affidavits had been presented to National Life before filing this lawsuit in time for their fair consideration, they could be

> treated as part of the record. Furthermore, in restricting the district court's review to evidence in the record, we are merely encouraging attorneys for claimants to make a good faith effort to resolve the claim with the administrator before filing suit in district court; we are not establishing a rule that will adversely affect the rights of claimants.

Id. In light of this holding from *Vega,* we recommend a rule that would require the plan administrator to accept and review evidence and treat it as part of the record, so long as it is sent in time for the administrator to consider the evidence before litigation is commenced. This will not result in extending the claims process to a degree not intended by ERISA as most claimants are highly incentivized to move quickly as their mortgage payment may depend on it.

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In closing, we think that the proposed regulations, together with our recommendations submitted herein, go a long way towards strengthening, improving, and updating the rules that are applicable to plans providing disability benefits under ERISA. As such, we believe that the regulations should be implemented and clarify that they apply to all claims that are pending on or arise after the date that the regulations go into effect.

We thank you for the opportunity to comment on the proposed regulations and to participate in this process.

If you have any questions, please do not hesitate to contact us at (704) 377-4300.

Sincerely yours,

Edward G. Connette

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