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By Mail: 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:

As a practitioner in the field of ERISA disability claims, I submit the following comments on the proposed regulations. My practice is focused almost entirely on the representation of claimants in ERISA-governed disability benefit disputes. Over the past 25 years, I have represented over 500 disabled claimants. I am the author of the book, "An Attorney's Guide to ERISA Disability Claims," James Publishing, Costa Mesa, CA, 2014.

I strongly support the proposed regulations which will significantly improve the processing of claims at insurance companies, and will make the process more full, fair and accountable.

I believe that the three most important changes that the Department could make to improve the lives of ERISA disability claimants are as follows:

1. Adding a New Section Permitting Claimants the Opportunity to Reopen Claims Under Certain Circumstances
2. Clarifying the meaning of "persons involved" and "based upon the likelihood" in (b)(7)
3. Granting Deference to Social Security Disability Awards

In addition, there are three technical changes that should be made in order to avoid possible misinterpretations in the future.

A. Substantive Changes

1. Adding a New Section Permitting Claimants the Opportunity to Reopen Claims Under Certain Circumstances

The Department should add a new section to the proposed regulations that gives claimants the opportunity to reopen administrative remedies prior to a lawsuit being filed under certain circumstances. I recommend a rule that permits a claimant to reopen administrative remedies in a manner similar to Federal Rules 59(e) and/or 60(b)(2),. The Department could put a time restriction on it, such that a claimant can reopen the appeal within 180 days of the close of administrative remedies as a matter of right, and then thereafter, could reopen administrative remedies if he or she has newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move to reopen administrative remedies within the initial 180 day period. The Department could make clear that reopening of administrative remedies pursuant to this right does not enlarge or otherwise stay the statute of limitations.

Such a right would alleviate the need for a lot of litigation, and would assure that insurance company determinations are more fair. Often relevant information is simply not available during the timeframes established by the current regulations. Moreover, the savings from avoiding needless litigation would more than offset any additional cost that insurers must bear in order to reopen administrative remedies.

Such a right would be consistent with the Fifth Circuit's *en banc* holding in *Vega v. National Life Ins. Serv., 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.

Such a right would help two classes of clients who I see on a regular basis.

The first are those who obtain medical or other documentation that was not available until after administrative remedies have been exhausted. Currently, there is no mechanism available for the claimant to petition the insurer to reopen the claim. One example is an individual who was granted Social Security disability benefits only after administrative remedies already have been exhausted. Another example is a client of mine, who is now the party in a federal court

litigation, *Rodriguez v. Standard Life Ins. Co. of New York*, 14 CV 09380 (SDNY). During the claims process, she had symptoms that were not readily explained, but after the administrative remedies were exhausted, it was discovered that she had a malfunctioning intracranial shunt—an objectively verifiable cause of her disability. As of the writing of this letter, the case is still in briefing, but to date the insurer has resisted introduction of the new evidence that was not available at the time of the claim process (through no fault of plaintiff). It would be manifestly unfair if her case is decided without consideration of this determinative evidence.

The second are those who come to me after they ineffectively did their own appeal. Some of these individuals suffer from mental illnesses or are otherwise unsophisticated. Being in disbelief that their claim was denied, they often just send a short letter to the insurer asserting that the insurer was incorrect. The insurer then denies the appeal and closes the record. Because these individuals did not create an adequate administrative record, their claim has very little chance of success in court. This result is extremely unfair, particularly when there is no requirement that the insurer even warn the claimant that he/she has the right to obtain an attorney and/or that if information is not sent to the insurer during the appeal, a court will not consider it later.

2. Clarifying the meaning of "persons involved" and "based upon the likelihood" in (b)(7)

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, I propose the following changes to subsection (b)(7)(added language is bolded and underlined) to clarify which persons are "involved" with the decision and to clarify what is meant by "based upon the likelihood":

> 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, in **whole or in part**, that the individual will support the denial of benefits.

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 almost always delegate the selection of experts to third-party vendors who, in turn, employ reviewing doctors and other experts.

TPC's, such as MES, MLS, UDC, NMR, MAG, MCMC, Psybar (to name a few), derive substantial income from the insurance companies, often in the millions per year. These TPC's are in a competitive industry, where insurance companies switch TPC's every few years. In this

environment, the TPC's have an incentive to keep the insurance company happy, and thereby have a tendency to hire doctors who are biased in favor of the insurer.

The TPC's use the same doctors over and over. Therefore, many of the doctors derive a substantial portion of their income from their contract with the TPC, and through the TPC with the insurance company. The facts learned during discovery in the following cases are illustrative of the need explicitly to cover TPCs and doctors:

- In *Jacoby v. Hartford Life and Accident Ins. Co*., 07 CV 4677 (SDNY), it was learned that in 2006, UDC arranged 1,774 medical file reviews for Hartford, and was paid $2,515,168 by Hartford.
- In *Bendik v. Hartford Life Ins. Co.*, 03 CV 8138 (SDNY), it was learned that a single file reviewer on behalf of Hartford, a Dr. William Sniger, performed during the same time period as *Jacoby* (from 2005-2007) over 200 reviews a year for Hartford, and earned approximately $100,000 per year performing those reviews. At his deposition he admitted that the bulk of his experience is consultation work and that he only sees "an occasional patient." If you compare the number of reviews conducted by Dr. Sniger and the total performed for Hartford in 2006, it is clear that he performed a very significant percentage of all the reviews for Hartford.

Given his financial dependence on UDC and Hartford, Dr. Sniger could not be viewed as "independent." However, as written, Hartford arguably satisfies the requirements of the proposed regulations because Hartford had no direct role in selecting or paying Dr. Sniger. The insurer should not be able to evade the protections of the regulation by outsourcing the selection process to a TPC, who might itself have an incentive to hire biased doctors for the insurer. Bringing TPC's within the purview of this regulation will help prevent this.

Second, the regulation should make clear that if the conflict plays any part in the decision to retain, hire, or compensate the claims handler or other expert, the decision would violate the regulations. As currently drafted, the regulation could lead to added litigation over whether instances of "mixed-motive" are prohibited.

3. <u>Granting Deference to Social Security Disability Awards</u>

The proposed regulation as drafted, requiring a claims administrator to meaningfully distinguish the views of treating physicians or other entities that are paying benefits, will be helpful.

I recommend, however, that in addition to a requirement to meaningfully distinguish the SSA award, the insurer be required to grant the SSA determination a level of deference. I fear that with the proposed regulations as written sophisticated insurers will just develop detailed boilerplate language designed to give the appearance of compliance, but ignore the spirit of the proposed regulations. This is what most insurers now do to satisfy *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 118 (2008)(criticizing the insurer for ignoring the SSA's findings). A typical denial letter will state that the insurer considered the SSA determination, but discounted it because the SSA standard is different from the standard in the policy and/or it was decided on a different record. Of course, what is omitted from the denial letter is the fact that the SSA

standard is more difficult to satisfy (unable to do any gainful employment), than the policy definition of being unable to perform the duties of the claimant's regular occupation.

The regulation should utilize the same language as the regulatory settlement agreements that have been used by many state insurance commissioners in response to concerns about disability claims processes used by insurers such as UNUM. For example, in the regulatory settlement agreement UNUM was required to follow, this language was used:

> The Companies must give significant weight to evidence of an award of Social Security disability benefits as supporting a finding of disability, unless the Companies have compelling evidence that the decision of the Social Security Administration was (i) founded on an error of law or an abuse of discretion, (ii) inconsistent with the applicable medical evidence, or (iii) inconsistent with the definition of disability contained in the applicable insurance policy.

Including similar language in the proposed regulation would be helpful to assure that plans give the appropriate weight to an award made by the SSA.

B. Technical Changes

1. Effective Date of Proposed Regulation

Following the issuance of the final regulations, litigation could develop over the effective date of the regulation. To avoid this litigation, I suggest the following text be added, making it clear that the regulation applies to claims that already were initiated prior to the issuance of the regulations:

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

There was litigation of this kind following the enactment of the claims regulations in 2002. For instance, the holding in *Abram v. Cargill*, 395 F.3d 882 (8th Cir. 2005), 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.

2. Deemed Exhaustion Drafting Issue

The proposed 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. 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**,

3. **Deemed Exhaustion of Claims and Appeals Processes**

First, the standard of judicial review that will apply requires clarification because there is a potential conflict between language in the preamble and the proposed regulation. The preamble says: "in those situations when the minor errors exception does not apply, the proposal clarifies that the reviewing tribunal should not give special deference to the plan's decision, but rather should review the dispute de novo." The underscored language clearly contemplates that a court should exercise *de novo* review. However, the regulation itself says: "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." 29 C.F.R. §2560.503-1(l)(2)(i) [proposed regulation]. I anticipate that plans will argue that this underscored language does not go far enough to require a court to exercise *de novo* review. For example, this language could mean simply that the plan did not make a decision and another plan review would be ordered rather than *de novo* judicial review. To avoid a potential ambiguity on this point, I suggest the following amendment to the proposed regulation (added language is bolded and underlined):

29 C.F.R. 2560.503-1(l)(2)(i) [proposed regulation]

> 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, **and the reviewing tribunal should not give special deference to the plan's decision, but rather shall review the dispute de novo.**

Second, for the same reasons as described above with regard to the appropriate standard of judicial review, it would be beneficial to specify the standard of judicial review is *de novo* when the court does not remand. I suggest the following amendment (added language is bolded and underlined, deleted language shown by strikeout):

29 C.F.R. 2560-503-1(l)(2)(ii) [proposed regulation]

> If a court rejects the claimant's request for immediate review under paragraph (l)(2)(i) of this section on the basis that the plan met the standards for the exception under this paragraph (l)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within ~~a reasonable time~~ **ten (10) days** after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission **and notify the claimant of the right to supplement the appeal if she chooses. If the court accepts the claimant's request for immediate review, the court will retain jurisdiction and decide the case applying de novo review**.

CONCLUSION

I strongly support the updating of the claims regulations to make the claim process more transparent and to ensure that claimants are provided with a full and fair review of their claim as required under ERISA §503.

Very Truly Yours,

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