GISELE M. NADEAU
ATTORNEY

55 PLEASANT AVE.
PORTLAND, ME 04103
207-671-0327
NADEAU@NADEAUERISADISABILITY.COM

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:

I write to offer comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. I am interested in the content of these regulations because I am an attorney whose practice is focused on the representation of claimants in ERISA-governed disability benefit disputes. I am well poised to comment because I have engaged in this practice exclusively for many years and have seen first hand how claimants are most frequently denied the benefits they deserve or are paid benefits in a grossly unfair amount on account of the fact the procedures and resulting substantive law are stacked against them.

There are many proposed changes which will go some distance to cure the current inequities. I will not address each of them here but urge you to adopt such proposed changes. I want to address two issues and will expect my colleagues, other claimants' attorneys will make cogent arguments in favor of each of the others. In particular, I want to urge you to 1. require that the letter denying benefits states clearly what is at stake in the appeal and encourage claimants' to seek the advice of counsel and 2. allow claimants' to have the "last word" in the appeals process

> 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.

(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).

I would require the following language be contained in the benefits denial letter:

The Appeal is the last meaningful chance you have to present your case. Once the Appeal is decided, you cannot add any evidence of your disability through additional medical, vocational or other evidence except in the rarest of cases. If you go to court you will not have a trial except in the rarest of cases and will not even be able to present anything new to the judge. Accordingly, we recommend you engage the services of an attorney, knowledgeable in this area, most of whom will not require fees unless you prevail. Your attorney may supplement your record with additional evidence which may well serve to overturn our decision. It is strongly advised that you do not attempt to pursue your Appeal on your own.

The Social Security Administration provides this warning. There is no reason why insurance companies should not be held to the same standard and allowed to hide the ball, hoping a claimant will helplessly fail in the appeal process.

Comment on Timing of Right to Respond to New Evidence or Rationales

The DOL clearly wishes to improve things for claimants who are ambushed with new rationales or evidence during review on appeal. I commend this effort, since sandbagging 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), 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, Abram could not meaningfully participate in the appeals process. . . This type of "gamesmanship" is inconsistent with full and fair review.

Id. Given that it is often very hard to supplement the record in litigation, the proposed change offers some assurance that a claimant can contribute his or her relevant evidence to the record that the court will review. Where the claimant, as plaintiff, has the burden of proof on most issues, this only makes sense. 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 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 extending their time without benefit payments. This is a problem that already exists and could be exacerbated. Plans have protested that giving the claimant the last word will make the internal appeals processes go on forever. This argument is out of touch with the reality of being an ERISA disability benefits claimant. These claimants, in my experience, would not continue the process *ad nauseum* while they are unable to pay their mortgages and feed their families.

The following suggestion places reasonable limits on both claimants and plan administrators and responds to the concern that claimants will have to wait too long for determinations on review. While claimants will want to make fast work of 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 by the plan may require hiring an expert such as another physician, psychologist, or vocational consultant. These professionals are not always readily available for quick turn-arounds and, depending on the new information such experts are responding to, they may need weeks to evaluate the new information. For this reason, claimants should have at least 60 days to respond to new evidence or rationales provided by the plan on appeal. Moreover, the period for the decision on review to be completed 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 whether the new information 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) 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 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.**

I commend the efforts of the Department of Labor to insert equity into the ERISA disability claims process which is now so unfairly stacked against claimants and look forward to positive changes on behalf of my clients.

Sincerely,