O'RYAN
LAW FIRM

January 19, 2016

By Email and regular 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 am an attorney in Indianapolis, Indiana, and for approximately fifteen years I have been representing claimants in ERISA-governed disability claims both in the appeal process and in litigation. Prior to this, I worked for an administrative agency, was in-house counsel to a large insurance company and also was employed at an insurance defense firm. I point this out because at the time I began taking on disability benefit claims governed by ERISA, I had significant experience in administrative law, insurance law and civil litigation. I was absolutely astounded at the gross inequity for claimants/plaintiffs who had disability benefits subject to ERISA jurisprudence. The law has been horribly tilted in favor of the insurance companies and plan administrators. The claimants have lost their constitutional right to a jury trial, their cases are decided on summary judgment thereby eliminating their right to any trial, they are allowed little discovery, and they are mostly subjected to an abuse of discretion standard which has been interpreted by the 7th Circuit on occasion to require the plaintiff to establish that the defendant was "downright unreasonable." With this as the backdrop, I am very grateful and relieved to see the DOL tilting the playing field a little more in favor of the claimants, which makes sense given that Congress passed ERISA to protect plan participants and beneficiaries.

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

I appreciate the DOL's efforts to improve the process 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. I have had numerous cases wherein new evidence is not disclosed to my office or my client until the final denial letter has been issued effectively closing the door on any possibility for my client to rebut or respond to the newly developed evidence by the insurer or claims administrator. In fact, it is not uncommon for the initial denial letter to be paltry in comparison to the final denial letter. I recently litigated a case with Standard Insurance wherein the initial denial letter was only 5 pages and the final denial letter, on the appeal, was 25 pages. This practice certainly thwarts the claimants' rights to a full and fair review of their claim. It is especially egregious because the courts do not allow the claimants to submit additional evidence during litigation or to conduct discovery regarding the question of whether the claimant is disabled. The proposed change offers

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

oryanlawfirm.com

O'RYAN
LAW FIRM

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. To the contrary, my clients' greatest wish is to expedite the claims process in order to obtain their benefits as quickly as possible. More and more of my clients are facing foreclosure, losing their vehicles and lagging behind on their bills because of the delay in the payment of the disability benefits. My clients want to conclude the appeal process as quickly as possible as long as they are able to receive a full and fair review of their claim.

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 may require hiring 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**

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

O'RYAN
LAW FIRM

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.

Independence and Impartiality - Avoiding Conflicts of Interest

The proposed regulation regarding the impartiality of claims personnel is essential and I am grateful for the DOL's effort to minimize the effect that biased individuals have on the claims and appeals process. In fact, in one of our most recent cases, *Maiden v. Aetna Life Ins. Co., et al.*, 2016 WL 81489 (N.D. Ind. Jan. 16, 2016), the court specifically commented on the lack of objectivity of the two record reviewing physicians hired by Aetna and noted:

> In response, Aetna provided Maiden's file to two "independent" consultants. (*See* DE 27-3 at 87–92, 95–99.) I put quotations marks around the word "independent" because one might reasonably wonder just how independent the reviewers—Dr. Malcolm McPhee and Dr. Leonard Schnur—really are. Their bread has been buttered by Aetna before; each of them has been hired by Aetna multiple times to conduct these kinds of disability reviews. *See, e.g.*, *Pearson-Rhoads v. Aetna Life Ins. Co.*, 2011 WL 5116633, at *9 (E.D. Penn. Oct. 28, 2011); *Flatt v. Aetna Life Ins. Co.*, 2015 WL 5944365, at *10–11 (W.D. Tenn. Oct. 13, 2015); *see also Aschermann v. Aetna Life Ins. Co.*, 2011 WL 6888840, at *10 (S.D. Ind. Dec. 30, 2011); *Barrett v. Aetna Life Ins. Co.*, 2012 WL 2577505, at *3 (W.D. Ky. July 3, 2012); *Wiggin v. Aetna Life Ins. Co.*, 2013 WL 6198181, at *6 (D. Maine Nov. 27, 2013); *Hulst v. Aetna Life Ins. Co.*, 2014 WL 4594528, at *7 n. 4 (E.D. Ky. Sept. 15, 2014); *Rall v. Aetna Life Ins. Co.*, 565 Fed. App'x 753, 756 (10th Cir. 2014); *Hammonds v. Aetna Life Ins. Co.*, 2015 WL 1299515, at *8 (S.D. Ohio Mar. 23, 2015); *Carrier v. Aetna Life Ins. Co.*, 2015 WL 4511620, at * 7 (C.D. Cal. July 24, 2015); *Jalowiec v. Aetna Life Ins. Co.*, 2015 WL 9294269, at *10 (D. Minn. Dec. 21, 2015).

I have reviewed thousands of disability claim files and see the same record reviewing physicians over and over contending that my clients are not impaired, and able to work, contrary to the reports of the treating physicians. I have seen statistics showing that these same physicians oftentimes are paid hundreds of thousands of dollars per year to review more than 1,000 claims for one insurance company. As the DOL is aware, disability claims are mostly denied on the basis of reports manufactured by record reviewing physicians. Without impartiality, the claims process is greatly tainted by the record reviewing physicians' interest in maintaining their contract with the insurance company. Accordingly, the DOL's efforts to insure impartiality in the claims process is greatly needed in this area, more than any other area.

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

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

O'RYAN
LAW FIRM

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.

In light of these concerns, I suggest that the proposed regulation language be amended as follows (added language is bolded and underlined):

29 .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.

Comments on Technical Matters in the Proposed Regulations

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 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**,

---

Deemed Exhaustion of Claims and Appeals Processes

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

oryanlawfirm.com

O'RYAN
LAW FIRM

I am grateful that the DOL has undertaken to clarify the consequences that will result when the plan does not comply with the procedural requirements of the regulations. I submit that 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**.

Additionally, 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**.

I am also concerned about the lack of a concrete deadline for plans to issue determinations on appeals. I am currently briefing this issue in a case wherein the insurer issued the determination on the appeal more than 30 days after the 90 day deadline. The current regulations seem clear that the decision on the appeal must be issued within 45 days unless special circumstances warrant an extension of 45 days but a final decision is mandated by the 90th day. I appreciate the clarity of the current

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

oryanlawfirm.com

O'RYAN
LAW FIRM

regulation in part because it has become routine for insurers to surpass the 90th day without any explanation. Regardless, it provides my client with great comfort to know that the determination on the appeal must be received on the 90th day or the claimant is allowed to pursue a lawsuit in federal court. This is significant for our clients, not only by providing a concrete deadline, but it is one of the few ways we are able to argue that that my clients are subject to *de novo* review rather than the more oppressive arbitrary and capricious standard of review. The current state of law provides that if the insurance company or plan administrator fails to issue a decision on the appeal by the 90th day, the claim is deemed exhausted and the claim is subject to *de novo* review. This can make a significant impact on the outcome of the case and encourages plan administrators to stick to the regulatory deadlines. I therefore am not in favor of providing the plans with excuses and arguments that most likely will lead to unmitigated delays in issuing appeal determinations and substantial litigation over whether the plan's failure to issue a timely decision on the appeal was *de minimis* and non-prejudicial to the claimant. These arguments do not protect the plan participants, do not provide concrete deadlines for an appeal determination and are very likely to result in substantial litigation. I would request that the DOL eliminate section (ii) of the promulgated regulations and thereby provide more certainty in the appeals process by providing concrete deadlines and avoid substantial litigation over whether the plan administrator's violations of the regulations were *de minimis*.

Comment on Notice for Applicable Statute of Limitations

The DOL has invited comment in the statute of limitations issues that have developed since the Supreme Court's 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 much litigation. The DOL can assist by creating standards for what is a reasonable plan-based limitations provision in the same way that the DOL used its regulatory power to create timing deadlines for the claims process in prior versions of the regulations. Since *Heimeshoff* left open the possibility that an internal limitations period could run before the appeals process is complete (even where exhaustion is mandatory), the DOL is in a good position to clarify that such an approach would violate full and fair review required by 29 U.S.C. §1133. Additionally, 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, plan administrators are in a better position to know the date of the expiration of the limitations period and should not be hiding the ball from claimants if the plan administrator is functioning as a true fiduciary.

One court has interpreted the existing regulations to require notice of the expiration of a limitations period. *Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis, No.* 4:12CV53 HEA, 2014 WL 562557, at *4 (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)("[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." 29 C.F.R. § 2560.503–1(g)(iv)). This is a minority perspective. Here, the DOL should do more than interpret its own rules; it should re-write them to remove any ambiguity.

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

O'RYAN
LAW FIRM

I 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]. The amended language should require the claims administrator to notify the claimant of the date of the expiration of any plan based limitations period and should include a definition of what is a reasonable limitations period. Such an alteration takes care of the different courts' views on when claims "accrue" in that it makes clear that no limitations period can start before the internal claim and appeals process is complete. It also makes clear that there will be at least a 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 limitations periods that would be salutary for both claimants and plan administrators.

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.

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

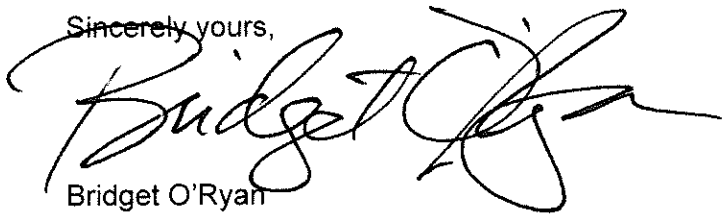
oryanlawfirm.com

O'RYAN
LAW FIRM

(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 greatly appreciate all of the efforts on the part of the DOL to strengthen and clarify the rights of plan participants who have been denied disability benefits.

Sincerely yours,



Bridget O'Ryan

Toll Free (855) 778-5055
Tel (317) 255-1000
Fax (317) 255-1006

1901 Broad Ripple Avenue
Indianapolis, IN 46220

oryanlawfirm.com