ROSENFELD & RAFIK & SULLIVAN

January 19, 2016

**BY ELECTRONIC MAIL AND FIRST CLASS 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:

We are writing to offer comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. Our firm has been representing individuals who are chronically ill and disabled for 20 years under ERISA-governed employee welfare benefit plans. Our work has primarily been focused on the representation of individuals in short- and long-term disability claims, as well as health, life, long-term care and accidental death and disability claims. We have handled thousands of applications for benefits, represented clients in the internal appeals process, and litigated these cases in federal court. Our firm handled *McDonough v. Aetna Life Insurance Company of America*, 783 F. 3d 374(1st Cir. 2015), cited in the proposed regulations. The proposed changes to the regulations would have avoided the five years of litigation Mr. McDonough endured to prove that the termination of his benefits without a thorough vocational evaluation, was required by ERISA.

It has been over fifteen years since the procedures regarding the administration of claims have been updated. Since that time, there have been substantive changes in jurisprudence, which have limited our clients' access to the benefits to which they are entitled. The proposed regulations address a number of the issues our clients face every day in our practice, most significantly, new rationales for benefit denials posed for the first time on appeal with no opportunity to respond, the right to obtain all relevant information forming the basis of the decision to deny coverage and including internal guidelines. In addition, we are particularly heartened by the Department of Labor's ("DOL") request for commentary on the applicable statute of limitations, as this is an issue that has, in the last few years, caused unnecessary

litigation for our clients because the accrual date of the contractual limitations period is uncertain.

Our comments are organized as follows. First, we address the most important substantive issues for the DOL to address as it finalizes the proposed regulations. Second, we have set out what we see as the most important technical issues in the proposed regulations. These are matters that do not change the substance of a proposed regulation but request language changes for purposes of greater clarity or conformity with other regulations. Avoiding ambiguity in the regulations will result in reduced litigation for ERISA claimants in the future.

## I. Comments on Substantive Matters in the Proposed Regulations.

### A. 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 & Acc. Ins Co.*, 134 U.S. 604 (2013). This is a critical area for regulation as the *Heimeshoff* decision has resulted in significant litigation regarding confusion around the accrual date of the contractual limitations period contained in plans. In particular, since *Heimeshoff* was issued, our firm has regularly filed lawsuits while the internal appeals process is pending because the accrual date for the contractual limitations period is unclear and insurers refuse to provide guidance regarding the applicable deadlines. Not only does this increase the cost of pursuing claims for our clients, it unnecessarily clogs the courts' dockets with cases that need to be stayed pending the conclusion of the internal appeals process.

To be clear, prior to filing litigation, our firm writes the insurance company in each case asking for clarification regarding the application of the contractual limitations provision, including the date the provision accrues and the date by which the insurer believes litigation must be filed. With the exception of one insurance company, every disability insurer we have written refuses to provide a substantive response to our inquiries. This failure to advise an ERISA claimant as to the date their claim accrues causes needless stress, and requires us to file preemptive litigation to preserve our clients' rights. This problem is easily resolved by the creation of standards for 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. 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 the full and fair review required by 29 U.S.C. §1133.

In addition, because contractual limitations periods are plan terms, the DOL should require insurers to provide notice regarding the limitations period in the plan just as it requires with respect to the application of other plan terms to an individual's claim. As the DOL aptly points out in the preamble to these proposed regulations, plan and claims administrators are in a

better position to know the date of the expiration of the limitations period. They should not be permitted to hide the ball from claimants if they are functioning as a true fiduciary.

Our request is not without precedent. At least one court since *Heimeshoff* has interpreted the existing regulations to require notice of the expiration of a limitations period. *See 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)). Yet another court has upheld a 45-day timeframe for filing litigation. See Davidson v. Walmart Associates Health and Welfare Plan, 305 F.Supp.2d 1059 (S.D.Iowa 2004). Prior to Heimeshoff, the federal courts looked to the most analogous state statute of limitations to apply to ERISA benefit claim actions. The DOL should explicitly prohibit the modification of this rule – which is in effect, the modification of the state statute of limitations through the use of plan language.

In light of the above, 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]. 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 the accrual date. Such an alteration resolves the different courts' views on when claims "accrue" in that it makes clear that no limitations period may begin to run before the internal claim and appeals process is complete. The amended language 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. Such a rule would reduce litigation devoted to the threshold issue of the running of the limitations period, and provide clarity in an otherwise ambiguous situation. In addition, it may well lead to a standardization of internal limitations periods that would benefit both claimants and plan administrators.

Accordingly, we 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).

**B. Comment on Timing of Right to Respond to New Evidence or Rationales.**

The proposed regulations aim to resolve one of the most unfair aspects of the current internal appeals process: claimants being sandbagged with new rationales or evidence in response to their appeal, without an opportunity to respond. This is a persistent problem in the ERISA appeals process. Unfortunately, the courts, without any regulatory guidance, have neither found this to a violation of law, nor 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 a plaintiff in litigation, 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.

In every internal appeal handled by our office, we request from the insurer the opportunity to respond to any medical or vocational reviews conducted on appeal in order to allow a fair exchange of information. These requests are routinely denied. Claims decisions are then ultimately made on the basis of new medical reviews conducted of our clients' records that they are foreclosed from responding to, even if based on erroneous information. In one case, the insurer relied upon surveillance of the wrong person to deny our client's benefits. Because the record was closed, the insurer refused our attempts to respond to this error, and we were forced to file suit. If the goal is getting to the truth of a plan participant's disability, then allowing him or her the opportunity to respond to new information or rationales for denials on appeal is not only necessary, but should be required by law.

There is certainly a countervailing concern that allowing plan participants the opportunity to respond to appellate reviews would make the internal appeals processes last indefinitely. This argument is out of touch with the reality of being an ERISA disability benefits claimant. ERISA claimants, in our 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 may require hiring an expert such as another physician, psychologist, or vocational consultant. In our experience, obtaining medical and vocational responses on appeal takes at least sixty days. As a result, it is our opinion that participants should be permitted at least sixty 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" for denying coverage or constitutes new "evidence."

Accordingly, we 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.**

In our experience, when an insurance company does allow treatment providers or our client's experts to respond to medical or vocational reviews conducted by the insurer on appeal, denials are often overturned because the meaningful dialogue contemplated by the regulations results in a better understanding of our client's disability. This is the essence of the full and fair review contemplated by the regulations.

### C. Independence and Impartiality - Avoiding Conflicts of Interest.

#### a. Alternative A.

The proposed regulation regarding the impartiality of claims personnel is essential. 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 retained to review our client's claims.

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), which is then 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, we suggest that the proposed regulation language 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 <u>and its agents, contractors, or vendors (such as any entities who supply consulting experts to plans)</u>** 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 **<u>or who are consulted in the process of making the decision</u>.** Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, (such as a claims adjudicator, **<u>vocational expert, accounting expert,</u>** or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

For our clients, where the abuse of discretion standard allows an insurance company to hire or employ any expert (medical or vocational) and generally rely solely on that opinion rather than that of the treating physicians or experts submitted by the claimant, it is critically important to ensure impartiality. If an insurance company is employing the very person who has the final say as to whether that insurance company is going to pay the claimant, the process lacks the specter of neutrality contemplated by ERISA. For clients who have worked their entire lives and find themselves in circumstances they never expected, it would be unfortunate to allow bias to prevent them from receiving benefits they have not only paid premiums for, but also deserve, solely due to the hiring practices of an insurance company or third party vendor. The inherent conflict of interest that exists in the claim process can be mitigated by changes to the proposed regulations.

**b. Alternative B.**

The proposed regulation appears to prohibit the plan from employing claims adjudicators or experts who are conflicted. However, the regulation requires more clarity to prevent needless litigation over mixed motives for using these individuals. 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. In light of these concerns, we suggest that the proposed regulation language be amended as follows (added language is bolded and underlined):

29 C.F.R. §2560.503-1(b)(7) [proposed regulation]

Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator 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.

**D. Opportunity to Supplement the Record.**

In our practice we have found that few insurers will consider evidence submitted after a final appeal denial, but prior to litigation. However, in our experience, when such information is allowed to be submitted, it can avoid litigation all together. It is therefore imperative that a claimant be allowed to supplement the record. This is true for both Social Security Disability Insurance ("SSDI") decisions, as well for other kinds of evidence. The problem becomes that if the door is shut by the insurer, litigation becomes necessary for new, relevant, and potentially dispositive evidence to be reviewed, regardless of the merits of our clients' claims. We have had several cases where the insurer has refused to consider a SSDI decision that, while filed contemporaneously with the claim for disability benefits, is rendered after the conclusion of the internal appeals process. In each case, the insurer has refused to consider the SSDI decision. However, they often file a counterclaim to recover the offset that is provided by the SSDI benefit. *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008).

Similarly, many of our clients are correctly diagnosed only after the internal appeals process has concluded. The failure to obtain a correct diagnosis in a timely manner is not the fault of our clients, who often see innumerable specialists before a diagnosis is made and treatment initiated. In such situations, we often submit updated medical records to the insurer explaining the basis for our client's limitations, but to no avail, as the record was closed with the final denial. Accordingly, we recommend a rule that would require the plan administrator to accept and review evidence and treat it as part of the record, as long as it is sent in time for the administrator to consider the evidence before litigation is commenced.

Time and again, information we have sought to submit after the close of the internal appeals process would have made a critical difference in proving our client's case. The goal of the decision-making process should be to discover the truth, not to use the regulations as a shield to turn a blind eye to information that directly bears on our clients' eligibility for benefits.

**E. Discussion of the Decision and Its Relationship to SSDI or other Disability Awards.**

Similarly, unnecessary litigation could be avoided if the regulation requiring a discussion about the difference between the plan's decision and awards made by the Social Security Administration ("SSA"), or other systems, were expanded to set forth a deferential review requirement. Many state insurance commissioners found language to discuss this very issue in response to concerns regarding Unum and other disability insurers. The regulatory settlement

agreement with Unum provides language that requires a full explanation of the insurer's decision and how it varies from the Social Security Administration:

> 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.

A similar rule would be avoid those situations where our clients have been approved for SSDI benefits on the basis of the same information provided to the insurer for review, but disability benefits denied without explanation. The SSA is an independent agency, unfettered by conflict. Insurers should be required to deal directly with the decision of the SSA, and if deciding the reject the decision, explain why. This is neither burdensome nor difficult. It is what insurers are required to do every day with respect to the medical information in the record.

## II. Comments on Technical Matters in the Proposed Regulations.

### A. Effective Date of Proposed Regulations.

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

> **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), 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.

### B. Notice of Right to Request Relevant Documents.

The regulation concerning notice of the right to request relevant documents contained in 29 C.F.R. §2560.503-1(g)(1)(vii)(C) [proposed regulation] is an improvement since it was formerly missing from the regulation. However, it would be significantly more helpful to claimants to use the words "claim file," which is plain language and is consistent with the amendment at 29 C.F.R. §2560.503-1(h)(4)(i) [proposed regulation]. Attorneys understand the language of (g)(1)(vii)(C), but lay persons, who are the actual participants and often not represented by counsel, may not realize what rights are given by the proposed regulation.

Accordingly, we suggest the following amendment to the proposed regulation (added language is underlined and bolded):

> 29 C.F.R. §2560.503-1(g)(1)(vii)(C)[proposed regulation]
>
> A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to **the claimant's claim file, including** copies of all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

**C. 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 may seek review regardless of whether the claim is in the "claim" or the "appeal" stage. We 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**,

**D. Right to the Claim File and Meaning of Testimony.**

There is a lack of clarity in the proposed regulations 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 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 regulations in that the preamble specifies "written testimony" whereas the proposed regulations simply states "testimony." We anticipate this leading to costly disagreements in litigation over whether the regulation contemplates actual live testimony, *i.e.* a hearing.

Furthermore, under the current regulations, claimants often submit "testimony" in the form of an audio or video CD. This is particularly useful in cases where, due to physical, cognitive, or mental disability, the claimant cannot read or write so that a written statement is impossible. We have also found visual presentations of our clients' lives speak volumes regarding their limitations. 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 evidence." 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.

Further, the proposed regulation's verbiage, *i.e.* "evidence and testimony" could be interpreted to impose courtroom evidentiary standards for claimants submitting proof of their claim – something that is not normally applied in the ERISA context. Plans are in a position to observe rules of evidence as they have in-house counsel and other legal resources to rely upon to assure compliance with the rules of evidence. But claimants, who are often representing themselves, are not equipped to understand, much less apply, the usual evidentiary standards suggested by the phrase "evidence and testimony." The DOL needs to make clear that it is not curtailing or narrowing the types of information that claimants may submit to the administrator.

## III. Other Issues of Concern with the Regulations.

### A. Disclosure of Internal Rules etc.

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. 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. In fact, we are often placed in the position of having to file costly discovery motions to obtain the internal guidelines required to be disclosed by the current regulations. These internal guidelines often make the difference between winning or losing for our clients. *See e.g. Glista v. Unum Life Ins. Co. of Am.*, 378 F.3d 113 (1st Cir. 2004). 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

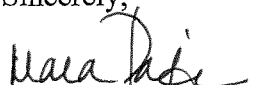
the dialogue between claimant and plan that ERISA contemplates. *Booten v. Lockheed Med. Ben Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997)("in simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries.").

**B. Notice of Right to Retain Counsel for Appeal.**

ERISA claimants who have been wrongly denied disability benefits or whose benefits have been terminated are often unaware of the process required to appeal the decision or that they are able to retain counsel to assist with process. In fact, a significant number of our clients were told by claims representatives to simply send the insurer a letter stating that they appeal the adverse decision. Claimants do so, the denial is upheld, and an incomplete record exists that makes prevailing in litigation virtually impossible. These individuals, debilitated by their illness, with families overwhelmed by the loss of income and caring for a sick family member, neither appreciate the type and nature of the evidence that needs to be submitted during the internal appeals process, or the ramifications of failing to do so. As a result, we propose that the DOL adopt a regulation that ERISA administrators must advise claimants of their right to hire an attorney to represent them during the internal appeals process. The Social Security Administration does this. There is no reason to hide this right from claimants.

Thank you for the opportunity to submit a response to the proposed regulations. Please do not hesitate to contact us with any questions or concerns.

Sincerely,



Mala M. Rafik
On behalf of Rosenfeld Rafik & Sullivan, P.C.