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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
VIA EMAIL

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.

Although I have been a practicing law for only four years, I am well poised to comment because I have represented over one hundred individuals in lawsuits and/or pre-suit appeals for disability benefits under the ERISA statute. Most recently, I helped litigate *Fontaine v. Metro. Life Ins. Co.*, 800 F.3d 883 (7th Cir. 2015), upholding the validity of Illinois's ban on discretionary language in group policies of health disability insurance. We were fortunate to have the DOL provide *amicus* support in that case. In addition, I have drafted *amicus* briefs in support of the plan participants in *Montanile v. Bd. of Trustees of the Nat'l Elevator Indus. Health Benefit Plan*, No. 14-723 (U.S. cert granted Mar. 30, 2015) and *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364 (6th Cir. 2015) (en banc), and I am a frequent speaker on disability benefit claims at conferences of the American Bar Association Employee Benefits Committee.

Whether by design or through decades of judicial interpretation, the ERISA statute presently provides fewer protections to disability claimants than they enjoy under state law. Participants in disability plans subject to ERISA are denied jury trials, compensatory and punitive damages, and discovery outside the so-called "administrative record." Very often, plan participants are confronted with a standard of review that gives deference to the decision of the plan administrator, as though the plan administrator is a neutral government agency and not a self-interested private actor. *See Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 112 (2008)

(acknowledging that an ERISA plan administrator that both evaluates and pays claims operates under a structural conflict of interest).

The only protection ERISA disability claimants enjoy over participants in non-ERISA plans is ERISA's requirement of a "full and fair review" and the regulations interpreting that requirement. *See* 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1. Although I doubt ERISA's drafters intended to require exhaustion of appeals prior to filing suit, disability claimants undoubtedly benefit from the opportunity to review their claim file and have their appeal reviewed by a new person not involved in the prior claim determination. Plan participants and administrators alike benefit from the reduction in litigation, as many claims that would otherwise result in litigation can be resolved in pre-suit appeals.[1] I commend the DOL for seeking to strengthen the ERISA claims regulations. I believe any additional administrative burden to plan administrators is substantially outweighed by the benefit to plan participants in terms of increased transparency and due process – which, in turn, will result in less litigation.

I. Statute of Limitations

The DOL has invited comment regarding 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.

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

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[1] In addition to demographic factors cited in the preamble to the proposed regulations, I submit that the rise in disability benefits litigation is attributable to the lack of any meaningful deterrent under the ERISA statute to the denial by plan administrators of meritorious claims. As *Rochow v. Life Insurance Company of North America* made clear, insurance companies can earn sizeable returns on wrongfully withheld benefits, in excess of typical prejudgment interest, even if the decision to deny or terminate benefits is ultimately reversed. 737 F.3d 415 (6th Cir. 2013), *reversed by* 780 F.3d 364 (6th Cir. 2015) (en banc).

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.

(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).

II. Responding to New Evidence or Rationales During the Appeal Proceedings

One frustration I repeatedly encounter in my practice is when a plan procures a new medical or vocational report during the course of the appeals proceedings but refuses to disclose that report to the claimant until the conclusion of the appeal. Another less frequent but equally frustrating occurrence is when the plan administrator relies on a new rationale to deny benefits in the appeal determination.[2] This "sandbagging" of claimants is highly prejudicial in view of the fact that claimants often may not supplement the record in litigation. The DOL's proposed change offers some assurance that a claimant can contribute his or her relevant evidence to the record that the court will review.

Plans have voiced the concern that the appeals proceedings will drag on unnecessarily, thus unduly burdening the plan, but those concerns are unfounded. Claimants have mortgages to pay and families to feed; they are not interested in unnecessarily prolonging appeals proceedings. At the same time, the type of evidence claimants 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

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[2] In the Seventh Circuit, such "post hoc" rationalizations are prohibited unless the claimant is provided an opportunity for further review. *See Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 696 (7th Cir. 1992) ("A post hoc attempt to furnish a rationale for a denial of . . . benefits in order to avoid reversal on appeal, and thus meaningful review" is not acceptable.) However, this additional round of appeals is inefficient and unnecessarily prolongs the proceedings.

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.**

III. Notice of Right to Counsel

Although the EBSA has not chosen to regulate about this, it should do so. Very often I am approached by prospective clients about pursuing litigation after they have exhausted their pre-suit appeals without the assistance of counsel. These claimants frequently do not request their claim files prior to submitting their appeal and often do not submit new evidence in support of their appeal, not realizing that they may not have the opportunity to supplement the record in litigation. When I ask, "Why didn't you hire an attorney?", they often respond, "It didn't occur to me," or "The insurance company told me I didn't need one." I then ask, "Would you go to a Social Security hearing without an attorney?" to which they always respond, "No."

I 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 does this. *(See* POMS Manual DI 32594.035, https://secure.ssa.gov/apps10/poms.nsf/lnx/0432594035). There is no reason to hide this right from claimants, particularly if plan administrators are to enjoy the same deference on review as administrative law judges.

Thank you for your consideration.

Very Truly Yours,

Martina B. Sherman