January 19, 2016

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N–5655
U.S. Department of Labor
200 Constitution Avenue NW,
Washington, DC 20210

Attention: Claims Procedure Regulation Amendment for Plans Providing Disability Benefits - RIN 1210–AB39

Dear Sir or Madam:

My law partner, Peter Casciano and I wish to comment on "Claims Procedure for Plans Providing Disability Benefits," 80 Fed.Reg. 72014 (November 18, 2015).

The Use of IME's During The Appeal Process

I appreciate that proposed regulations will give claimants an opportunity to respond to new evidence or a newly advanced rationale during the appeal process. This is a proper and important regulation to ensure fairness to claimants. Claimants normally have the burden of proof and should have an opportunity to review new medical reviewer's reports as well as an opportunity to respond.

However, I am concerned that some Plans may take advantage of this regulation to obtain IMEs (Independent Medical Examinations) during the appeal period. In fact this already happens occasionally.

I do not think that it is fair to claimants to face an IME (Independent Medical Examination) for the first time during the appeal process and I think the regulations should prohibit that. See generally in accord *Neiheisel v. AK Steel Corporation*, 2005 U.S.Dist.LEXIS 4639 (S.D. Ohio February 17, 2005) (during the course of appeals from benefit denials, the ERISA regulations allow for "consultation" with health professionals; however, that ruling held examinations after termination are outside the bounds of the regulations). *See, e.g., Harper v. Reliance Standard Life Ins.Co.*, 2008 U.S.Dist.LEXIS 36788 (N.D.Ill. May 8, 2008) (finding a demand for an FCE and then an IME during the post-denial claim appeal was arbitrary and capricious); *Kosiba v. Merck & Co.*, 384 F.3d 58 (3d Cir. 2004).

As the regulations stand now, the Plan Administrator, or its appointee – usually an insurance company - can use a medical review to terminate or deny a claimant. Then the claimant has to put together medical and vocational evidence to rebut the conclusion of the medical reviewer for the Plan. This is a time consuming and expensive process.

The Plan can now - and under the proposed regulations - then require a claimant to undergo an IME examination during the appeal. As the regulations stand now, the claimant has no opportunity to review or respond to the IME. That was and is grossly unfair. The proposed regulations will ensure that the claimant both get to see the IME report and have an opportunity to respond.

But that still creates an unfair advantage for the Plan and an unreasonable expense and delay for a claimant if the Plan chooses to obtain an IME during the appeal process. The delay is caused by the claimant having to wait for results of the IME and then having to put together a rebuttal of the IME. The expense is the cost to the claimant of obtaining the rebuttal evidence. The unfair advantage for the Plan is that allowing the Plan to obtain an IME during the appeal process, the regulations are really allowing Plans a second bite at the apple. First a medical reviewer recommends denial of the claim and then, after the claimant has rebutted the medical reviewer, if the Plan obtains an IME, the IME may again recommend denial of the claim. That subsequent denial can be for similar or different reasons than the medical reviewer used. In either case, the claimant has the additional burden and expense of having to rebut the IME report.

If the Plan is going to set up an IME, it should have to do so during an initial review of a claimant's application or during any subsequent review. But the Plan should not be allowed to set up an IME during the appeal process. That way the claimant does not face multiple rebuttals. The process will go faster and be less expensive for claimants. It is fundamentally unfair to claimants to have to spend time and resources rebutting the medical reviewers' analyses of the claim file that led to termination of benefits, and then have the Plan order an IME during consideration of the appeal which requires the claimant to spend additional time and resources rebutting the IME..

In conclusion, the regulations should prohibit this practice. If a Plan wants to get an IME examination, it should do so during its review of the claim, and not during an appeal of the denial or termination of benefits.

In addition we have read and reviewed comments submitted earlier by attorney Mark DuBofsky. I agree with his comments and restate them as our own below.

"Full and Fair Review"

I commend the Department of Labor for issuing proposed regulations that go a long way toward closing gaps in the prior regulations, especially in relation to giving claimants an opportunity to respond to new evidence or a newly advanced rationale during the claim process. The Notice of Proposed Rulemaking cites a number of court rulings, but omitted a critical decision, *Grossmuller v. Int'l Union, United Auto. Aerospace & Agric. Implement Workers of Am., U.A.W., Local 813*, 715 F.2d 853, 858 n.5 (3d Cir. 1983), which captured the essence of the "full and fair review" requirement by finding: "[T]he persistent core requirements of review intended to be full and fair include knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his

decision."

Recissions and Limited Benefit Conditions

One glaring issue that was overlooked by the regulations is the situation where a policy limitation is invoked to limit the duration of benefit payments, such as in cases involving mental and nervous disorders or for "self-reported" illnesses. The proposed language regarding treating rescissions as adverse benefit determinations should be expanded to encompass any situation where a limitation is invoked so that the claimant can immediately appeal. Many insurers defer the right to appeal until the date the benefits end, which imposes significant economic hardship on claimants who may then be deprived of benefits for several months while appeals proceed.

Contractual Limitations Periods

The limitations problem is another issue on which there should be a regulation, especially after the confusion engendered by the Supreme Court's ruling in *Heimeshoff v. Hartford Life and Acc. Ins. Co.*, 134 S.Ct. 604 (2013). That ruling raises the specter of a limitations period expiring before the claimant can even appeal and the ruling does not allow for tolling of a limitations period during the claim appeal. A regulation may easily be issued amending 29 C.F.R. § 2560.503-1(j) to provide: *A statement that all applicable limitations periods are tolled during the claim appeal. The claim administrator must also include in its final denial notification a statement setting forth the date calculated by the claim administrator on which the relevant limitations period expires.*

The Effect of a Favorable Social Security Determination

The proposed requirement that plan administrators/insurers must address their disagreement with the treating doctor or with a Social Security determination is significant, but does not go far enough. In the multi-state regulatory settlement agreements between Unum and CIGNA and state insurance departments (and the U.S. Department of Labor), the insurance companies agreed to give deference to favorable Social Security findings. Unum, to its credit, has established an elaborate procedure for doing so and documenting a rationale explaining the basis for disagreement with the Social Security finding in situations where it has rendered a contrary decision. CIGNA, however, has not yet fully implemented procedures for meaningfully giving deference to the Social Security finding. The regulation should be expanded to explicitly set forth a deferential requirement utilizing the same language as the regulatory settlement agreements. The Unum Regulatory Settlement Agreement, for example, states: "[T]he 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."

Consulting versus Treating/Examining Physicians

The Department's concern about financial bias of medical consultants retained by benefit plans can also be more forcefully addressed by imposing a requirement that the medical consultant

certify that no more than 20% of their income is derived from reviewing files for insurance companies and/or self-funded disability benefit plans. Such a proposal would fulfill two salutary goals:

1) it would assure that the consultants are independent of the insurance companies and thus address a concern raised in *Black and Decker v. Nord,* 538 U.S. 822, 832 (2003)("Nor do we question the Court of Appeals' concern that physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers money and to preserve their own consulting arrangements." (internal quotations omitted)) that consultants may be financially beholden to the insurance companies that retain them; and

2) it would assure that the consultants be actual practitioners who are familiar with the medical conditions that they are addressing and up to date on medical testing and treatment for such conditions.

Finally, while the proposed regulations impose a requirement that insurers must furnish a rationale for disagreeing with the treating doctor or with the findings of the Social Security Administration, the Supreme Court handed the Department of Labor an opportunity to issue a more substantive regulation requiring that deference be given to treating doctor opinions. In *Black & Decker v. Nord,* 538 U.S. 822 (2003), the Supreme Court rejected an argument that plan administrators should give discretion to opinions rendered by treating doctors, much as the Social Security Administration has issued a regulation requiring such deference. 20 C.F.R. § 404.1527(d). However, the Court stated:

> If the Secretary of Labor found it meet [sic] to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference. See *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.,* 467 U.S. 837, 81 L. Ed. 2d 694, 104 S. Ct. 2778 (1984). The Secretary has not chosen that course, however, and an *amicus* brief reflecting the position of the Department of Labor opposes adoption of such a rule for disability determinations under plans covered by ERISA. See Brief for United States as *Amicus Curiae* 7-27.

538 U.S. at 832.

Hence, there is no reason why the DOL cannot adopt a rule identical to the one used in Social Security cases, 20 C.F.R. § 404.1527(c), which provides:

> (1) *Examining relationship.* Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.
> (2) *Treatment relationship.* Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the

nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability.* The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) *Consistency.* Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) *Specialization.* We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) *Other factors.* When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant

factors that we will consider in deciding the weight to give to a medical opinion.

Given the specific requirements necessary before a treating doctor's opinion is given deference according to the quoted regulation, a similar rule in disability insurance cases, which is simply a reflection of common sense, can only enhance the process.

Sincerely, ,

Elliott Andalman

Peter Casciano