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January 19, 2016

Re: Claims Procedure Regulations for Plans Providing Disability Benefits
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503-1

Dear Secretary Borzi:

I have been representing claimants in ERISA benefit matters both in the internal appeal process and in litigation for the past seventeen years. The majority of my clients are seeking to reverse denials of disability claims. Most of these matters involve full and fair review in some form. Over the years disability claims administrators have become more adept and aggressive in denying claims and upholding the denial of benefits in the appeal process. The requirements of full and fair review need to be revitalized to prevent further erosion of claimants' rights to disability benefits and to prevent the promised disability benefits from becoming illusory.

When Congress enacted ERISA, Congress created a strict fiduciary standard for those individuals and entities involved in the administration or management of employee benefit plans or their assets, a standard that requires those persons or entities to make decisions solely in the interests of the plan's participants and their beneficiaries. Over time this has not what has occurred. ERISA is a shield for those involved in administrating these benefits and insulating them from unfair conduct, while a sword at the same time against the claimant.

COMMENT I: What Time Limits Should Apply to the Claimant's Right to Respond to New Evidence or Rationales?

A common problem with ERISA disability benefit claims is that a claims administrator reviewing an appeal can come up with new support to deny a claim and then close the process to the claimant by refusing to offer an opportunity to respond. It is the claimant who has the greatest interest in the speedy resolution of the appeal, since it is the claimant who is going without benefits, and often times enduring significant financial hardship. Moreover, the number of claimants who will realistically be able to participate in what the plan administrators predict will be an endless process is limited by the out-of-pocket costs of doing so by the claimant.

a) **Right to Respond** -. A very common scenario occurs where the insurer denies the appeal based on quotes from a medical report created by a well seasoned player in the industry as well as a report of a vocational consultant who opines that the claimant can work at some jobs and can

earn a small fraction of the former wages. The claimant is informed that the opportunity to appeal has been exhausted and the matter is ripe for suit. However, when the final claim is produced, claimant discovers that the insurer's medical review contains falsehoods and inaccuracies and it is clear the reviewer was not supplied with critical information about some of the conditions. Additionally, the medical reviewer claims to have spoken with treating doctors, who agreed that he was capable of working. The claim file also reveals that the vocational consultant was not applying the proper wage threshold to her claim; her plan says that she is disabled if she is unable to earn more than 60% of her former wage. She writes to the insurer explaining that her doctor denies any such conversation with the company's reviewer and explains that the reviewer missed key facts. She adds that the jobs they think she can perform don't pay very much. The insurer explains that the appeal process is closed. Faced with the distortions and falsehoods that a judge might accept as true under the abuse of discretion standard of review, and the possibility that the lengthy litigation process would only result in a remand back to the plan that would elongate the process further, she settles with the insurer for 30 cents on the dollar.

There is nothing special about this fact pattern; it is so common as to be generic. This is how a meritorious claim can be whittled down through sandbagging. Although there is supposedly a right to judicial review, that right is entirely undermined where the claims administrator refuses to entertain any rebuttals and the claimant is facing a lawsuit that is based on a record entirely engineered by the claims administrator. The opportunity to respond to new evidence or rationales before the final decision is crucial.

b) Timing - The claimant needs sufficient time to counter reports and rationales that the claims administrator has generated on appeal. Claims administrators often employ different types of consultants. In order to effectively rebut these reports, a claimant must sometimes find her own experts. Sometimes these professionals are busy. Even the claimant's own physicians are busy and may not be immediately available to formulate a response. For this reason, I believe that a claimant should be provided at least 90 days. This is fair, given that the plans usually take at least this long to make their determinations on appeal. If the claimant does not need this amount of time, he should be able to submit his response and expect a final determination within the period of time left over by the claims administrator.

COMMENT II: Should a Plan be Required to Notify The Claimant of an Internal Limitations Period?

a) Notification of the Internal Limitations Period - First, full and fair review should minimize the possibility that ERISA claims will be buried for reasons that have nothing to do with their merit. Notification of the plan's time limits for filing suit protects the claimant from the loss of benefits because of a mere technicality. This is a particular hazard to the unrepresented claimant in this regard. ERISA contemplates a process that claimants can participate in without legal representation.

b) Reasonable Limitations Period - The agency should intervene and set a standard for reasonableness, keeping in mind the goal of minimizing the number of claims that are lost due to technicalities. The agency has created other minimum time limits, so the agency is well versed in this type of rule.

Of course, it would be beyond the imagination of any claimant that the internal limitations period could run before he had completed an appeal process, but there is still confusion around this absurd possibility. Accordingly, I am recommending 2 fixes.

First, the limitations period should not be able to run before the appeal process is complete.

Second, an internal limitations period that is shorter than 3 years after the final appeal denial should be deemed to violate full and fair review.

COMMENT III: Ensuring Independence and Impartiality of Persons Involved with Making the Decision.

I am pleased that the agency is interested in addressing the widespread problem of ERISA disability benefit plans' use of conflicted employees or consultants. However, the regulation could use some refinement in the form of greater specificity.

a) **Independence and Impartiality of All Agents in All Fields** - The regulation needs to make clear that contractors, agents, outside vendors, and their employees are all covered by the regulation. The disability plans do not directly employ or hire many of the people on whom they rely to deny claims, but all of the people and entities and individuals need to be free of bias or conflict.

A typical example is a disability claim in which surveillance is used against the claimant. The claims administrator will have a contract with a surveillance company who will hire an investigator. Another individual, perhaps, will write the report describing the video. This video and report may be sent to yet another vendor who will contract with a medical reviewer to opine on what the surveillance shows. This process is fraught with bias and conflict.

b) Clarification of "involved." - The agency needs to make clear that what it means to be "involved with making the decision." Insurers and plans regularly take the position that medical and other experts they rely upon are not *making* the decisions but are simply rendering opinions within their expertise so that claims handlers or other committees, who are the delegated decision-makers, can make the decisions. The industry makes this assertion in affidavits and depositions too numerous to count. In my experience, however, these assertions are disingenuous. A medical or vocational expert will make or break the claim, and the claims handler often adopts these opinions without question. This comes out in depositions of the claims handlers. In addition, because of how disability departments are structured there is often a supervisor, who may not make a decision, but may give final approval to that decision. Does this supervisor fall under the regulation? I would expect and argument that she does not.

Given this quandary about who truly makes disability decisions, the agency needs to clarify that independence and impartiality applies to everyone who decides claims or appeals, approves or signs off on those decisions, or renders any opinion that is relied upon in the decision-making process, i.e. anyone who is consulted in the process is considered to be "involved" and is subject to the same standard of objectivity.

COMMENT IV: Explaining Why the Administrator Does not Agree with Other Payers of Disability Benefits

Perhaps the most astounding practice by claims administrators is to entirely discount a favorable Social Security decision in disability benefit denials. The claims administrators doggedly pursue Social Security benefits on behalf of the ERISA claimants, since most ERISA disability benefits are reduced by the amount of these benefits. In many cases plans hire representatives to advocate for claimants before the Social Security Administration, which advocacy entails taking that the position that the claimant is disabled in a way that more severe than almost any LTD plan would require. Once the money-saving Social Security award is obtained (and the plan has perhaps recouped the benefits), the LTD claim is then denied and the plan does an about face on the disability question. (This inconsistency was described and criticized in *Metropolitan Life v. Glenn*, although the decision does not appear to have changed claims practices very much.)

The explanation for rejecting or ignoring the favorable Social Security decision, if one is attempted, is often boilerplate and goes something like, *"[w]e realize that you obtained a favorable ruling from the Social Security Administration. The SSA's decision is not binding on us. The difference between our decision and SSA's may be driven by the regulations that govern the Social Security system."* There is no explanation that is pertinent to the specific claim at hand. If the proposed regulation intends to render such an explanation insufficient to satisfy the rule, the agency should clarify this by including language as follows: (A) A discussion of the decision**, that is pertinent to the specific claim or appeal under consideration, . . ."**

To require this level of analysis from plan is to require nothing more than a "deliberate, principled reasoning process," which a plan fiduciary is already obligated to provide. *Glenn v. MetLife*, 461 F.3d 660, 666 (6th Cir. 2006) aff'd sub nom. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008).

COMMENT V: Effective Date of the Final Regulations

The previous revision of the ERISA claims regulations applied to new claims filed on or after January 1, 2002. Since then there have been cases decided on the "old regs" and other on the "new regs." Insurers and plans have applied one set of standards to some claims and another set to others. This is not ideal. It leads to confusion in the case law and unfairness, especially where the regulations could be seen as clarifications instead of amendments. For example, see *Abram v. Cargill*, 395 F.3d. 882 (8th Cir. 2005) as compared to *Midgett Washington Group Int'l LTD Plan*, 561 F.3d 887, 894-96 (8th Cir. 2009).

I suggest that the agency minimize this patchwork effect by making the final rules apply to all claims "pending on or after" the effective date.

COMMENT VI: Deemed Exhaustion Procedure

I commend the agency's effort to set out a procedure for deemed denied claims for those claimants needing to by-pass claims administrators who are committing serious procedural violations. However, some additional clarification is necessary.

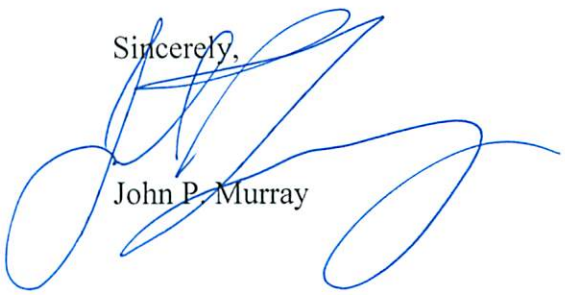
a) **Clarifying De Novo Review** - The regulation indicates that a deemed exhausted claim will be decided by the court "without the exercise of discretion by an appropriate fiduciary." The agency should clarify that the court "shall not defer to the decision in any way but shall apply de novo review to all questions whether factual or interpretive." I believe that this added language is needed because some courts applying de novo review will still defer to the claims administrators' factual determinations. This variant of de novo review should not be applied where the claim lands in court due to the fault of the claims administrator. I believe this small change will help to carry out what the agency is intending with its regulation.

b) **Supplementing the Record Before the Tribunal -** Where a claim is accepted for review by the court, it is important to remember that the procedural irregularities may have prevented the claimant from including his best evidence in the record. The agency should add some language to the regulation providing that a claimant can supplement the record under this scenario. While some courts applying de novo review might permit this, many would not. Without this addition, a deemed exhausted plaintiff may be worse off than he was before.

c) **Supplementing the Record Re-filed on Remand** – Likewise, the regulations should provide for supplementation of the record on remand. As I understand it, where the court determines that the violation the claimant complained of was *de minimis*, the claim is remanded to the plan as if it were an appeal. However, a claim that is re-filed with the claims administrator may not have been fully developed and the claimant should be given an opportunity to supplement the record so that the claims administrator has enough evidence on which to decide the merits of the claim. The claims administrator's notice to the claimant should therefore include notice of the right to submit additional information before the claim is re-reviewed.

Please feel free to contact me should DOL need any further information or input on these very important matters.

Sincerely,



John P. Murray