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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 Federal eRulemaking Portal: http://www.regulations.gov

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:

Chisholm, Chisholm & Kilpatrick Ltd ("CCK") submits these comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. We, at CCK, use the DOL regulations frequently in our practice representing individuals in their ERISA governed benefit claims. The DOL's proposed regulations are a move in the right direction towards helping ERISA claimants access and resolve benefit disputes through ERISA's claim procedures. We provide comments, which we believe strengthen and clarify the proposed regulations.

I. STATUTE OF LIMITATIONS

The Supreme Court's decision in *Heimeshoff v. Hartford Life & Accid. Ins Co.*, 134 U.S. 604 (2013) created much uncertainty for ERISA claimants as to whether and how long they have to seek judicial review of an administrator's adverse benefit determination. Regulation on this issue is needed.

A strict reading of many plan provisions leaves open the possibility that the internal limitation period could run before the appeals process is complete (even where exhaustion is mandatory). Since *Heimeshoff*, we have encountered this problem on a regular basis. We have written to administrators explaining the issue and asking that they provide the last date upon which a law suit can be filed. Administrators responded by parroting back the plan language (which was not instructive) and/or stating that they cannot provide our client's with legal advice. On occasion,

we have been successful in reaching tolling agreements to allow sufficient time to complete the appeal process, but that was usually after protracted discussion and threats of litigation to clarify the limitation period.

The DOL can assist by creating standards for what is a reasonable plan-based limitation 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. The DOL should clarify that a limitation period that could run before the appeals process is complete 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 limitation period from the plan just as is the case with other plan terms. The administrator should also be required to advise the claimant of the date on which the limitation period will expire. Plan administrators are in a better position to know the date of the expiration of the limitations period and should not be hiding this from claimants if the plan administrator is functioning as a true fiduciary.

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 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. CLAIMANT RIGHT TO PRODUCE EVIDENCE

a. Right to respond to new evidence or rationales

We appreciate that the DOL wishes to provide recourse for claimants who are ambushed with new rationales or evidence during review on appeal. This practice, called "sandbagging", has been a persistent problem in the ERISA appeals process. Plan administrators regularly render final appeal decisions based on new rationales and evidence without allowing our client's and their doctors to respond. With few exceptions, the evidentiary record is closed in court. This leaves ERISA claimants at a significant disadvantage in court. 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 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.

The DOL should reject arguments by plan administrators that this proposed change would make the internal appeal process go on forever. In our experience, clients need their ERISA disability benefits to feed their family and pay their mortgage. These claimants have a great interest in moving through the process expeditiously. Still, the type of evidence they 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."

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.**

b. Opportunity to supplement the record

Although the EBSA has not chosen to regulate this, we recommend a rule that would require the plan administrator to accept and review evidence and treat it as part of the record, so long as it is sent in time for the administrator to consider the evidence before litigation is commenced. Many

meritorious disability claims are denied and the courts affirm these determinations because of issues regarding the scope of the record on review in the court. For instance, Social Security Disability Insurance decisions, which are the focus of some of the proposed rules, are often crucial to proving disability claims. However, the Social Security Administration ("SSA") takes time in issuing its decisions and the SSA's ruling may sometimes come after the final denial on appeal of the disability plan. This is true as well for other kinds of evidence. Even where it would not be a problem to do so, plan administrators often refuse to consider this type of evidence, choosing instead to shut the door on a meritorious claim. Meanwhile, plans will often counterclaim to recover the offset that is provided by the SSA benefit. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). There is a clear solution to this that would track the Fifth Circuit's *en banc* holding in *Vega v. National Life Ins. Serv., Inc.*, 188 F.3d 287, 300 (5th Cir. 1999), where the Court wrote:

> We hold today that the administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it. Thus, if the information in the doctors' affidavits had been presented to National Life before filing this lawsuit in time for their fair consideration, they could be treated as part of the record. Furthermore, in restricting the district court's review to evidence in the record, we are merely encouraging attorneys for claimants to make a good faith effort to resolve the claim with the administrator before filing suit in district court; we are not establishing a rule that will adversely affect the rights of claimants.

Id.

III. INDEPENDENCE AND IMPARTIALITY - AVOIDING CONFLICTS OF INTEREST

The proposed regulation appears to prohibit the plan from employing claims adjudicators or experts who are conflicted. However, the language should be clarified to prevent disagreements and 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, **vocational expert, accounting expert**, 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.

IV. DISCUSSION OF THE DECISION AND ITS RELATIONSHIP TO SSDI OR OTHER DISABILITY AWARDS

In our practice, we see plan administrators deny claimant's their plan disability benefits even though Social Security found them disabled. Plan administrators then provide a vague and often nonsensical statement that Social Security may not have reviewed the same evidence and that the plan has different rules. The regulation requiring a discussion about the difference between the plan's decision and awards made by other systems, such as Social Security, should be expanded to set forth a deferential review requirement. The regulation could utilize the same language as the regulatory settlement agreements that have been used by many state insurance commissioners in response to concerns about disability claims processes used by insurers such as UNUM. For example, in the regulatory settlement agreement UNUM was required to follow, this language was used:

> 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.

Including similar language in the proposed regulation would be helpful to assure that plans give the appropriate weight to an award made by another entity.

V. EFFECTIVE DATE OF PROPOSED REGULATION

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.

VI. NOTICE OF RIGHT TO REQUEST RELEVANT DOCUMENTS

In order to make 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] more understandable for lay persons, we suggest that the DOL 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, may not realize what rights are given here. 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.

VII. DEEMED EXHAUSTION

a. 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. 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**,

b. Deemed Exhaustion - Consequences for Plan Procedural Violations

Plan administrators should be held to meaningful and defined penalties for procedural violations. If a plan beneficiary misses an appeal deadline, the consequences are often harsh, and the beneficiary may lose the right to his/her claim. Yet, plan administrators regularly extend the 45 day deadline to decide a disability appeal to 90 days and beyond without good explanation. Meanwhile, disabled claimants are left without income trying to figure out how to pay their mortgage, feed their family and access medical care. Even if the claimant eventually wins benefits, claims for damages resulting from the administrator's wrongful delay are preempted by ERISA. We are pleased 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.

The DOL separated the consequences into two categories, i.e. for serious violations and for minor violations. We see four areas that could be improved in the proposal.

First, 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]. We 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, we 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**.

Second, the portion of the proposed regulation concerning refiled appeals requires clarification. The claimant whose appeal is refiled may need to supplement the record for the refiled appeal, since it is possible that his or her attempt to communicate with the plan was thwarted in some way. We suggest amending the regulation to require the plan to give the claimant notice of his or her right to supplement the appeal.

Third, there could be unclarity arising from how to interpret the phrase "reasonable time." It would be better to specify a period of time. Ten (10) days seems reasonable.

Finally, 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. We 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**.

VIII. DISCLOSURE OF INTERNAL GUIDELINES

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. We recently had to engage in an expensive discovery dispute in court to obtain the internal guidelines from a disability plan's third-party administrator. In this case, and many others, plan administrators argue that this information is confidential or proprietary. However, 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 *See e.g. Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111, at *10 (S.D.N.Y. Jan. 30, 2004); *Craig v. Pillsbury*, 458 F.3d 748, 754 (8th Cir. 2006)(decrying the use of "double-secret" plan terms); *Samples v. First Health Group Corp.*, 631 F. Supp. 2d 1174, 1183 (9th Cir. 2007). 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.").

Very truly yours,

J. Scott Kilpatrick
Mason J. Waring