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Office of Regulations and Interpretations October 19, 2015
Employee Benefits Security Administration
ATT: Claims Procedure Regulations Amendment
For Plans Providing Disability Benefits
Room N-5655
U.S. Dept. of Labor
200 Constitution Ave. N.W.
Washington, D.C.
20210

RE: Department of Labor, 2015 Notice of Proposed Rulemaking (Disability Plan claims Procedures), RIN 1210-AB39

Dear Sir/Madam:

1. Introduction

Thank you for the opportunity to comment on the DOL's November 18, 2015 Notice of Proposed Rulemaking regarding Claims Procedure Regulations Amendment For Plans Providing Disability Benefits. My comments are the by-product of a unique point of view in this field. For 15 plus years I worked as an attorney for the largest private disability insurer in the world both training and advising disability claims professionals and defending the company's denial decisions in litigation across the country. Since 2008, after leaving the disability

industry, I have represented individuals in employee benefit disputes.[1] **See Exhibit A.** It is my hope that my comments provide some value and insight to the DOL.

§ 2560.503–1 Claims procedure.

(7) In the case of a plan providing disability benefits, the plan 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. 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 that the individual will support the denial of benefits.

Comment: It will be a simple exercise to require this type of certification in either the hiring process or part of the denial letter process. I have seen perhaps two carriers adopt the practice of putting a paragraph in the initial denial letter and final appeal denial letter attesting to the examiner's independence. The biggest challenge, however, is insuring internal appeal unit independence which will go farther in assuring examiner independence. For example, aside from the attestation of an individual examiner, I think it is paramount to make sure that the manager of the appeals unit be able to work with absolute independence from the manager or head of a claims department. To this end, I would recommend certification that the appeals unit does not have an annual financial goal (defined in terms of dollars or percentages) to either uphold or deny a certain number of earlier denials. It would also be consistent with the goals of independence and transparency to require the plan to disclose:

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[1] My written opinions expressed in this letter do not reflect on any specific experiences that I had working at The Paul Revere Life Insurance Compnay/UNUM as an attorney that may be protected by the Attorney Client privilege but rather spring from my collective experience representing insureds in claim disputes with a variety of fully insured and self insured plans.

a. What was the rate of appeals upheld/reversed by the plan, the insurer or Third Party Administrator (TPA) in the previous calendar year in regards to the specific insurance product?
b. If the plan engages a third party vendor to assist in reviewing a claim/and or appeal, what is the percentage of claims that the third party upholds/agrees with the earlier denial or reverses the earlier denial?
c. Require annual certification from the General Counsel or Chief financial Officer for the employer of a self inured plan, insurer or TPA that he/she has conducted an annual audit and is satisfied that the appeals unit is entirely independent in both operation and decision making form the financial goals of the claims department.
d. Underscore the seriousness of the need for absolute independence in the claim process by crafting an appropriate criminal sanction for any party unduly influencing the decision on a claim for reasons unrelated to the merits of the underlying decision.

Given the amount of money that disability plans and insurers pay for claims adjudication services, it would be reasonable to expect that this type of information is already tracked by either the insurer or the plan which would allow for easy implementation. Moreover, this information will help engender participant and public confidence that the disability claims process is truly fair, indepedent and not overwhelmingly one sided it its results and also empower employer consumers and employers to make fully informed decisions about from whom they should purchase disability insurance.

§ 2560.503–1 Claims procedure.

(g) *** **(1)** ***
(v) In the case of an adverse benefit determination by a group health plan—
* * * * *
(vii) In the case of an adverse benefit determination with respect to disability benefits—

(A) 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;

Comment: The challenge here is that often times the internal claim file will show largely conclusory reasoning underpinning the disagreement with the insured and serving as the basis for the denial. In effect, the examiner is not saying the insured is not disabled...but that the insured has not sufficiently proven that they are disabled under the terms of the plan. A classic example that is wide spread in the industry is that often claims are denied because the nature of the medical evidence was not "objective" in the eyes of the disability claim adjudicator. The problem is two fold: (1.) the insurer fails to educate the claimant if and how one can objectify something that is subjective such as fatigue or pain and (2.) the examiner dismisses entirely the credibility of the insured and the AP. Another barrier that claims examiners often create is to, in effect... require "perfect proof " of an insured's disability as opposed to "reasonable proof." For example, medical records from a psychologist attesting a to a client's severe depression are often rejected and deemed unacceptable by disability carriers. What the carrier will ask the insured to produce is a neuropsychological evaluation...which can costs well over $5,000 and is often time not covered under an insured's health insurance assuming they have health insurance. The cost of providing "perfect proof" can be exorbitant and beyond the reach of the average claimant.

(B) 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; and

Comment:

Often times carriers will take the position that the terms of the plan language constitute "the internal rules, guidelines, protocols, etc. This contention is nonsensical. They should be required to disclose available and relevant training

materials and internal white papers on specific topics that are relevant to a disability claim.

(C) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and 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.

Comment:

The phrase "pertinent documents" is not readily understood by Joe "Sixpack" and, frankly, by most attorneys *who do not practice in this arena*. The current regulations require that when a claim or appeal is denied the carrier must advise the claimant of their right to review pertinent documents which is undefined in the denial letter. Probably 70-80% of the matters referred to me involve a situation where neither the claimant or his previous attorney obtained the claim file in order to better understand why the claim was denied. I would respectfully suggest that carriers include something along these lines in a denial letter:

Under ERISA you are entitled, upon request, to review all pertinent documents that are relevant to your denied claim. These type of documents commonly include a claim file, correspondence with you and your employer, medical records, vocational reviews, email communications between claim examiners and their managers and other materials (such as training materials, claim investigation process guidelines, department memos or white papers) that address an aspect of your disability claim. Your requesting this information may better help you in understand why your claim was denied or if it was denied in error.

Finally, carriers routinely define "claim file" narrowly. To that end, they do not produce, even upon specific request, Settlement Files, Internal Medical Review Files and Special Investigation unit Files (SIU).

(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 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; and (iii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale 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.

Comment:

This is absolutely critical to ERISA's promise of a full and fair review. Often times the denial of an appeal contains new rationale to support the original denial from new individuals. Sometimes the new individual working on a claim, i.e. a third party "independent physician, will document a discussion in the claim file with an insured's doctor that is at worst, patently false or at best, significantly out of context. Absent the ability to respond to this "new" evidence or rationale, the insured is "sandbagged" and deprived of the promise of a full and fair review. For example, a claim may be denied by a carrier initially upon the recommendation of an internal/employee nurse who simply reviews the medical records. On appeal, however, the medical reviewer for the insurance company often reaches out to the treating physicians for their input. Finally, the additional rationale for the denial needs to be specific and not conclusory and advise the insured as to why their evidence supporting disability was not credible and rejected.

Other ERISA Disability Process Issues Relevant To Your Request For Comment

Contractual Limitations Period

A disability carrier that denies an appeal should include a specific sentence or two in the denial letter that specifically tells the insured how much time they have to file a lawsuit, the date that the lawsuit must be filed by, and provide an example of how the deadline is calculated. Alternatively, require as part of the ERISA claim process that the limitations period will always run from the date a final appeal is denied.

Coverage Recissions-Adverse Benefit Determination

Group LTD disability coverage is not underwritten medically on an individual basis. I have never seena carrier attempt to rescind group LTD coverage.

Provide Greater Regulatory Guidance On what a Reasonable Investigation Is

Require disability claim examiners (DCE) to :

1. Act affirmatively in using an Authorization signed by an insured to collect necessary medical records. The purpose of the authorization is to allow the carrier to get the records which they have significant resources and experience to do. Many carriers let the Authorization sit in their file and put the entire burden of production on the insured who is the least experienced party in the claim process.

2. Act affirmatively in timely notifying an insured if it is having problems obtaining records or employment information.

3. Pay treating Doctors a reasonable fee for their time if the carrier has a need to speak with a treating Doctor. Doctors are incredibly busy and, frankly, do not enjoy working on disability forms because : (1.) they don't get paid for it by the insured's medical carrier and (2.) their conclusions are often

second guessed by a person who has never met their patient or had a chance to assess the patient's credibility.

4. If a carrier, or an "independent physician" (IME) retained by the carrier cannot speak or communicate with an insured's physician, let the insured know and ask for his assistance. Too often I see claim files where an IME leaves 2-3 voice mails for the treating Doctor, does not get a response within 24 hours, reaches a conclusion adverse to the insured's interest and the claim and/or appeal are denied event though the carrier still has more time to review the claim or appeal.
5. Provide the name and direct dial phone number of the claim and/or appeal examiner. Some carriers, Aetna comes to mind, require their insureds to navigate a minefield of voicemail and password prompts that can last several minutes before you reach the phone of the claim examiner. This is a painful and frustrating experience for anybody suffering from a psychological illness who lacks the ability to focus and concentrate on a multi step process. Make communication simpler. There is no harm or extra cost in providing a first name and direct dial number on all communication.
6. Start the appeal review/investigation sooner in the first 45 day period rather than later when the appeal is submitted . Currently, the ERISA disability claims procedures allow a carrier to extend the appeal review process an additional 45 days for "special circumstances." The clear import of the regulation is that "special circumstances" should be the exception to the rule. The reality, however, is that carriers more often than not routinely extend their review for special circumstances late in the first 45 days of review for an IME/outside medical peer review even though they know their review process calls for such a review. In short, there is nothing "special" about the extension at all since the extension is routine. Carriers want to take longer to start the process because it allows them to keep their DCE staffing levels down and they can better manage when a claim reserve will reopen if an appeal is successful. In short, 90 days is 3 months, or on a calendar basis, a single financial quarter or 90 days split between

two financial quarters. The carrier can push the "hit" of a reserve reopen into another quarter by always extending for special circumstances or abusing the "tolling" process. This technique does not require the DCE to be knowingly manipulating appeal reviews and claim reserves. Rather the DCE may be an unwitting accomplice because he/she is merely following a process established by others. If the DOL wants to investigate my point, simply ask the five largest disability carriers to tell you how often do they extend LTD appeal investigations because of special circumstances? I'd be shocked if it was less than 75% of the time. Delay in decision making is unfair to the claimant because it simply prolongs financial distress and uncertainty.

Settlement Agreements

Many disability carriers, require claimants involved in claim settlements to sign a release where by the insured promises that if he or she ever regain their health and work for another employer who is insured by the same disability carrier, that any claim they have under the new employer's LTD plan will be null and void. This is a very widespread practice and essentially asks the insured to agree to language inconsistent with a subsequent employer's disability plan language. The DOL should declare the practice as unreasonable.

Thank you for your time and consideration of my comments.

Regards

George Thompson

EXHIBIT A

GEORGE M THOMPSON
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Westborough, Massachusetts
(w) 508-366-1304

RELEVANT EMPLOYMENT:

10/08 to present — **Thompson Law Office** — Westborough, MA.

Advise and represent policyholders, individuals and businesses in disability (ERISA and Non ERISA), health, life, long term care and commercial insurance claims, disputes and litigation. Website:www.insuranceclaim-attorney.com.

3/93-8/08 — **Unum Group (formerly Paul Revere Life)** — Worcester, MA

1993 Assistant Counsel
1994 Associate Counsel
1997 Counsel
1998 Assistant Vice President and Managing Counsel
2000-2008 Vice President and Managing Counsel

Manage, evaluate and mentor a team of attorneys and paralegals responsible for: (1) providing ERISA and IDI claim coverage and claim risk analysis; (2) managing individual (ERISA and Non-ERISA) disability insurance litigation in the United States; and (3) counseling corporate clients on policy language development, product compliance and underwriting. Meet regularly with Unum officers, business unit managers and examiners to review legal issues, coverage issues, claim files and discuss claims and/or litigation strategy. Provide bi annual claim department wide training on ERISA LTD and other legal developments, i.e. bad faith, HIPPA. Partner with outside counsel to prepare and defend the company in disability insurance and punitive damage litigation. Prepare witnesses for deposition and trial. Attend and participate in trials and mediations. Prepare responses to state insurance department inquiries. Conduct due diligence reviews of insurance blocks of business offered for sale. Manage and meet regularly with UNUM TPA client AXA/Equitable to discuss legal needs and trends. Worcester legal "Point Person" for reassessment support under Regulatory Multi-State Market Conduct Settlement. Member of Worcester Steering Committee with shared leadership responsibility for overall operation of the Unum Worcester Operations Center.

1/06- 12/08 — **UMASS School of Law** — Dartmouth, MA

Adjunct Professor teaching general Insurance Law.

8/97- 8/00 — **Western New England College of Law** — Springfield, MA

Adjunct Professor of Life, Health, ERISA and Disability Insurance Law class as well as a general Insurance Law class.

9/89-3/93	**Mirick, O'Connell, DeMallie & Lougee** Litigation Associate. Admitted to State and Federal Bar in 1989. Involvement in areas of construction and commercial litigation, life and disability insurance litigation and medical malpractice litigation. Superior and District Court trial experience, argued before the Massachusetts Court of Appeals.	Worcester, MA

COMMUNITY ACTIVITIES:

5/06- 3/12 — **Westborough Board of Selectmen**
Elected member of Town's Board of Selectmen, Chairman 2008

3/00-5/06, 3/13-Present — **Westborough School Committee**
Elected member of School Committee; Vice Chairman 2001; Chairman 2005.
Oversight responsibility for a $40 million budget.

5/90-9/98 — **Westborough State Hospital**
Trustee (1990-96). Appointed by Governor Dukakis (D) of Massachusetts.
Reappointed by Governor Weld (R).
Responsible for reviewing and recommending policies affecting administration of mental health services to patients.
President of Board of Trustees (1996-98).

PRO BONO/BAR PARTICIPATION:

2008-Present — **Worcester County Bar Association** — Worcester, M A.
Insurance subcommittee, review, negotiate and recommend insurance coverage for WCBA Membership

2009-2010 — **Society of Financial Service Professionals** — Worcester, MA.

2008- 2010 — **Massachusetts Bar Association: Health Law Section** — Boston, MA.
Co-Chairman 2008

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2005- 2010 — **Health Law Advocates** — Boston, MA
Advisory Board Member.
Volunteer representing individuals/families below poverty level in obtaining health insurance coverage and social security disability benefits from the state and federal government as well as private insurers.

1993-1996 — **Worcester County Legal Aid Society**
Draft Wills and Health Care Proxies for clients with AIDS, represent indigent and elderly clients in apartment evictions.

1989-1993 — **Court Appointed Special Advocate**
Appointed by Juvenile Court to serve as a fact finder in cases of child abuse and neglect.

PRESENTATIONS:

Wellness ad The Affordable Care Act Boston, MA

November 2014 presentation to the New England Employee Benefit Council

HIPAA Boston, MA.

September 2013, produce three 1 hour webinars regarding September 2013 HIPAA Requirements.

FMLA, ADA and COBRA: The Bermuda Triangle Southborough, MA.

August 2012, present seminar to Metrowest HR Chapter regarding key legal issues and recent development in care law and regulatory enforcement.

Federal Health Care Reform, Affordable Care Act Update

Worcester, MA (Oct 2013)
Framingham, MA (June 2013)
Manchester, NH (April 2012)
Providence, RI (June 2012)

Review of current implementation and future requirements under The Affordable Care Act.

Massachusetts Bar Association Boston, MA.
June, 2009, C0-Chair Annual Health Law Conference, Health Insurance, ERISA in the First Circuit

New England Claims Conference New York, NY
September, 1999- Preparing insurance company witnesses for deposition
March, 2008- "The Year In Review" Panel Presentation on ERISA/LTD and IDI Risk Management and Litigation.

Eastern Claims Conference New York, NY
March, 1998- Organize and chair panel on Disability Insurance issues
March, 1999- Organize and chair panel on Disability Insurance issues
March, 2001- Organize and chair panel on Disability Insurance issues
March, 2005- Organize and chair panel on Disability Insurance issues
March, 2006- Panelist, Disability Insurance Roundtable

Western Claims Conference Palm Springs, CA
June, 2007- Mediation Issues preparation and strategy.

Defense Research Institute: Life, Health, and Disability Section Annual Meeting Chicago, IL
April, 2005- Punitive Damage and Insurance Claim Defense Strategies
March, 2006-The Insurer's Ongoing Duty of Good Faith During Litigation.

American Law Firm Association New York, NY
June, 2001- Punitive Damage Defense strategies and Disability Insurance Litigation
June, 2003- State Farm vs. Campbell and the impact on Insurance Litigation