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Sent Via E-mail: e-ORI@dol.gov
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room M-5655
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

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

Dear Assistant Secretary Borzi:

We submit these comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. We are attorneys who represent individual claimants/plaintiffs in ERISA-governed disability benefit disputes. With nearly four decades of experience between us in handling ERISA disability benefit claims, we have represented hundreds of individual claimants, and have witnessed the significant inequities they face in the claims process. Our comments address both important substantive and technical issues that we have identified that we believe should be addressed as the Department of Labor ("DOL") finalizes the proposed regulations ("PR").

A. Notice of the Applicable Statute of Limitations – PR 29 C.F.R. § 2560.503-1 (j)(6)

The DOL has invited comment on 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). Given the confusion that has resulted following the *Heimeshoff* decision, we agree that regulation in this area is imperative. *Heimeshoff* left open the possibility that an internal limitations period could run before the appeals process is complete (even where exhaustion is mandatory), and the DOL is able to clarify that such an approach would violate full and fair review required by 29 U.S.C. §1133. 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 can create standards for what is a reasonable plan-based limitations provision. Additionally, similar to other plan terms, administrators should be required to provide claimants with sufficient notice about contractual limitations period just as is the case with other plan terms. As the DOL acknowledged in the preamble to the proposed regulations, plan administrators are in a much

better position than claimants to know the date of the expiration of the limitations period and should be required, as fiduciaries, to provide this information to beneficiaries.

Only one court has interpreted the existing regulations to require notice of the expiration of a limitations period. *See Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis, No*. 4:12CV53 HEA, 2014 WL 562557, at *4 (E.D. Mo. Feb. 13, 2014), *aff'd sub nom. Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 790 F.3d 799 (8th Cir. 2015) (finding that "[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of [ERISA] following an adverse benefit determination on review." 29 C.F.R. § 2560.503–1(g)(iv)). However, this is a minority perspective. As such, the DOL should re-write the regulations to remove any ambiguity.

We recommend an amendment to the regulations governing the manner and content of notification of benefit determinations to include a requirement that claims administrators provide notification to claimants of the date of the expiration of any plan based limitations period and provide a definition of what is a reasonable limitations period. We recommend an amendment to add a section following proposed regulation 29 C.F.R. § 2560.503-1 (j)(6) and to renumber accordingly (added language is indicated in bold/italics):

> 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).

This would eliminate confusion among the courts as to when claims "accrue," as it makes clear that no limitations period can start before the internal 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. This will cut down on litigation devoted to the threshold issue of the running of the limitations period and likely lead to a standardization of internal limitations periods that would benefit both claimants and plan administrators.

B. Timing of Right to Respond to New Evidence or Rationales – PR 29 C.F.R. § 2560.503-1(h)(4)(ii)

We applaud the DOL's efforts to prevent claimants from being ambushed with new evidence or adverse benefit determination rationales during review on appeal. Many times an administrator will issue a denial of benefits based on a single, incomplete paper records review by a physician. Once the claimant has submitted an appeal addressing the single paper records review report, the administrator obtains multiple paper review reports, each providing much more detail than its initial paper records review report, without permitting the claimant and his/her treating physician(s) an opportunity to address the new evidence. ERISA claimants have the burden of proof on most issues in litigation, which is made substantially harder when claimants are stripped of the right to submit rebuttal evidence. *See, e.g., Glazer v. Reliance Standard Life Ins. Co.*, 524 F.3d 1241 (11th Cir. 2008).

Moreover, very often, when a court does determine that a claimant should have been afforded an opportunity to respond to the new evidence or rationales obtained by the administrator, courts will simply remand the case to the administrator to provide the claimant with an opportunity to submit rebuttal evidence and the administrative process starts over. This needlessly prolongs the process for often already financially devastated claimants. We have had a number of clients whose claims were remanded under similar circumstances and their administrators subsequently offered to buy out their claims and policies. Faced with a second administrative appeals process and possibly a second lawsuit, some of our clients, out of

financial desperation, ultimately agreed to settle their claims for less than the claims were likely worth.

Here, giving the last word to the claimant during the claims appeal process is, in effect, giving claimant the right of rebuttal in litigation and removes the incentive for administrators to engage in sandbagging claimants with evidence to obtain an advantage in litigation.

Plans have protested that giving the claimant the last word will make the internal appeals processes a never ending cycle. However, as the above discussion establishes, this argument is out of touch with the reality of being an ERISA disability benefits claimant. In our experience, claimants would not needlessly continue the process.

Claimants have the incentive to bring the process to an end as soon as reasonably possible, because they are usually without income during this process. However, the type of evidence often needed 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 immediately available 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, we suggest the following amendment to proposed regulation 29 C.F.R. § 2560.503-1(h)(4)(ii) (new language is indicated in bold/italics):

> (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.***

C. Independence and Impartiality; Avoiding Conflicts of Interest – PR 29 C.F.R. § 2560.503-1(b)(7)

We further commend the DOL for its effort to minimize the effect that biased individuals have on the claims and appeals process. The proposed regulation regarding the impartiality of claims personnel is vital to promoting a full and fair review of ERISA benefit claims. This fact is best illustrated by examining what occurred in one of our client's claims. We had a client who was determined to be disabled from all occupations by the Social Security Administration due to the devastating symptoms of Multiple Scoliosis ("MS"), including severe tremors in his hands. It took our client almost a year to accept and emotionally come to terms with his diagnosis. However, after eleven separate physicians confirmed the diagnosis of MS and his limitations and restrictions left him unable to work in any occupation, our client could not deny the facts any longer. Despite overwhelming evidence of his severe symptoms and disability, the Plan denied our client's disability insurance claim based solely on the report of a paper reviewer that asserted that the diagnosis of MS was not supported, that he likely suffered merely from carpal tunnel syndrome, and that he could return to work in his past occupation. The insurance company administrator previously denied the claims of three of our other clients based on reports by this same physician, each time claiming that the evidence did not support our clients' diagnoses. After Good Morning America began investigating our client's claim, the administrator quickly overturned its denial and asserted that it would no longer retain the services of the physician involved in the claim decision. Following the airing of the Good Morning America episode, multiple claimants and attorneys came forward with tellingly similar stories involving the same physician and insurance company administrator.

Accordingly, ensuring the impartiality of those involved in the claims process is essential. However, we suggest clarification of the proposed regulation as follows.

First, the proposed regulation should make clear that impartiality is ensured, even where the plan, itself, is not directly responsible for hiring or compensating the individuals involved in deciding a claim or preparing a consultation report. As a practical matter, plans frequently delegate the selection of experts to third-party vendors who, in turn, employ the experts.

Second, clarification is needed concerning which individuals are "involved." Claims administrators often assert that physicians, or other consulting experts, are not "involved in making the decision" but merely supply information (such as an opinion on physical restrictions and limitations) that is considered by the claims adjudicator. Thus, plans may argue that consulting experts are not affected by the impartiality regulation.

Third, the proposed regulation should make clear that not only claims adjudicators and consulting physicians must be impartial, but all individuals "involved" in the claim decision. Vocational experts and accountants are also frequently used in the claims process and should be included in the scope of the impartiality requirement.

Fourth, the proposed regulation appears to prohibit the plan from employing claims adjudicators or experts who are conflicted. However, the regulation could use some more teeth 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 proposed regulation 29 C.F.R. § 2560.503-1(b)(7) be amended as follows (added language is indicated in bold/italics):

> In the case of a plan providing disability benefits, the plan ***and its agents, contractors, or vendors (such as any entities who supply consulting experts to plans)*** 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 ***or who are consulted in the process of making the decision.*** 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.

Further, Plans are not likely to document that they hire, compensate, terminate, promote, or other similar matters with respect to any individual, (such as a claims adjudicator, vocational expert, accounting expert, or medical expert) based upon the likelihood, in whole or in part, that the individual will support the denial of benefits. Accordingly, we suggest that the DOL add a requirement that Plans establish appropriate procedures and safeguards to ensure the impartiality of the individuals involved in the claim decision, including audit procedures to evaluate whether said individuals produce reports that support claim denials or render adverse claim decisions at statistically high rates. Moreover, administrators must require any third party vendor hired by a Plan to secure a consultation report to have similar procedures and safeguards in place to ensure the impartiality of the individuals involved in the claim decision, including audit procedures to evaluate whether said individuals produce reports that support claim denials or render adverse claim decisions at statistically high rates.

D. Opportunity to Supplement the Record

Although the Employee Benefits Security Administration ("EBSA") has not specifically included in its proposed regulations that claimants should be given the opportunity to supplement the administrative record prior to the filing of a lawsuit; we feel strongly that this should be included in the regulations. Meritorious disability claims are regularly denied and courts affirm those wrongful denials because of limitations imposed by the scope of the record on review in court. Under the current regulations, once the plan administrator has issued its final denial, the claimant is prevented from supplementing the claim file with evidence that was either sought but not obtained prior to the final denial or is relevant to any new review or rationale identified by the carrier after the final. Of particular concern is the inability of many claimants to include

Social Security Disability Insurance decisions that were rendered after the final denial, but were clearly pursued, often at the plan administrator's insistence, almost immediately after a claim for disability benefits was filed. Social Security Disability Insurance (SSDI) decisions are often critical to proving disability claims. However, the Social Security Administration (SSA) frequently takes an extensive amount of time to review a claim and make an initial determination; set an appeal hearing; and reach a final determination. As such, the SSA's ruling sometimes comes after the final denial on appeal of the disability plan but prior to litigation being commenced. Even where it would not be a problem to do so and where inclusion of an SSDI decision after the final denial would not prejudice the insurance company, plan administrators often refuse to consider this evidence, choosing instead to shut the door on a meritorious claim and compelling evidence supporting disability. This is particularly frustrating in light of the fact that in many of these cases the plan administrator required that the claimant file for SSDI benefits, citing to specific plan provisions obligating the claimant to do so. Moreover, very often despite its refusal to consider the post appeal SSDI decision, the plan will counterclaim to recover the offset that is provided by the SSA benefit. *See Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105 (2008). Our firm has handled many claims in which the claims administrator rushed to obtain an appeal decision in order to avoid having the claimant submit their SSDI award as evidence in the claim file. In fact we are currently dealing with this situation in an ERISA claim administered by Sun Life Insurance Company, as discussed in more detail below.

The above-noted problems are not unusual and we have seen numerous claimants railroaded by this issue. In the Sun Life case referenced above (which represents the typical scenario for many of our clients), our client was paid benefits for two years under the *own occupation* definition of her plan. During that time, she was instructed to apply for SSDI benefits by the plan administrator who cited to the plan's requirements under the *Other Income Benefits* provision of the plan. Additionally, the plan administrator put her in touch with a company specializing in social security representation to handle the filing of her SSDI claim. Our client agreed to use the recommended company and applied for SSDI benefits. Her initial application was denied; however pursuant to her contractual obligation to appeal that denial, she used the plan administrator's recommended social security representative to handle her appeal. Meanwhile, she was advised by the plan that she no longer qualified for disability benefits due to the change of definition form *own occupation* to *any occupation* that applied after disability benefits had been paid for 24 months and her benefits were terminated. In other words, although the plan administrator agreed that her injuries prevented her from performing the duties of her *own occupation*, a registered nurse, they felt that she did not qualify for benefits under the plan's *any occupation* definition because there was a lack of evidence proving that she could not perform with reasonable continuity the duties of a gainful occupation for which she is reasonably qualified for by education, training or experience. Our client appealed the denial of benefits and was ultimately issued a final denial. Not long after sending our client the final denial letter, the plan was advised by the social security representative that our client had been approved for SSDI benefits and that a retroactive benefit payment had been sent to her. Despite the plan's refusal to include the SSDI decision in its claim file or as part of the administrative record for litigation purposes, it has been demanding that she reimburse them for the overpayment due to the plan

under the plan's terms. The fact that a plan administrator can advise a claimant that he or she may qualify for SSDI benefits, urge them to submit an application to the SSA with the assistance of a company they recommend, and insist that the claimant appeal a denial to the highest level possible, strongly suggests that the plan administrators place a great deal of importance on the SSDI decision. Therefore, a plan's strategic decision to ignore a favorable SSDI decision, yet aggressively seek reimbursement for an overpayment needs to be addressed and changed. Our client subsequently obtained our Firm, but under the current state of the law, a reviewing Court may never consider this persuasive evidence of disability.

Just as frustrating is the not uncommon instance where the plan administrator is advised, either right before a final denial is issued or prior to the claimant's filing of a complaint, that medical information such as test that could shed light on the claimant's diagnosis, a neuropsychological test, or other relevant information that would provide the plan with proof of disability is being obtained or has been performed (but the resulting report is not yet available) and will be submitted immediately upon receipt. Despite being fully aware that such information is forthcoming, or perhaps knowing that such information will be available, administrators sometimes rush to render a final denial or refuse to supplement the administrative record prior to the filing of a lawsuit. The effect of this is to restrict a court's review of relevant evidence in the record or provide both the claimant and the administrator from making an effort to resolve the claim.

As a solution, the regulations should 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' review of evidence in the record, we are merely encouraging attorneys for claimant 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. In light of this holding from *Vega*, 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.

Additionally, the importance of SSDI or other Disability Awards should be specifically addressed in the regulation. 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 reasons 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 plan.

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

E. Effective Date of Proposed Regulations

To avoid application of the old regulations to disability claims already pending before the effective date of the proposed new regulations, we suggest the following be added to the proposed new regulations:

> ***The regulations shall apply to all claims pending with the plan fiduciary on or after the date that the regulations go into effect.***

To illustrate the problem if such language (or similarly worded language) is not included, consider the decisions by the Eighth Circuit Court of Appeals first in *Abram v. Cargill*, 395 F.3d 882 (8th Cir. 2005) and then in *Midgett Washington Group Int'l LTD Plan*, 561 F.3d 887, 894-96 (8th Cir. 2009). The Eighth Circuit concluded in *Midgett* that its seminal holding in *Abram* was grounded in the pre-2000 version of the claims regulations and thus that *Abram* would simply not apply to cases decided under the post-2000 claims regulations. This seriously undermined the true meaning and holding behind the *Abram* decision. The above suggested language should be added to the proposed new regulations to avoid this problem from occurring again, and to ensure that all rightful claimants are afforded any additional protections and rights that the new regulations provide.

F. Notice of Right to Receive Relevant Documents Upon Request – PR 29 C.F.R. §2560.503-1(g)(1)(vii)(C)

The provision concerning notice of the right to request relevant documents contained in proposed regulation 29 C.F.R. §2560.503-1(g)(1)(vii)(C) is hugely important. However, we believe it would be better understood by lay person claimants if it included the words "claim file," which is plain language and consistent with the amendment at 29 C.F.R. §2560.503-1(h)(4)(i) [proposed regulation]. Lay person claimants are often not represented by attorneys, and may not realize what rights are being given under this significant provision.

Thus, we suggest that the following bolded/italicized language be added to proposed regulation 29 C.F.R. §2560.503-1(g)(1)(vii)(C):

> 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.

Too often we speak with claimants facing denied or terminated ERISA benefits that are unaware of the meaning of a request for all "relevant" information, but understand the concept of "claim file." Likewise, insurance company claims and appeals representatives understand the concept of "claim file," and what it entails.

G. Deemed Exhaustion Clarifying Language – PR 29 C.F.R. §2560.503-1(l)(2)(i)

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/italicized) to proposed regulation 29 C.F.R. §2560.503-1(l)(2)(i):

> 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***,

This clarifying language allows for any ambiguity to be removed, to ensure that a claimant's right to pursue a lawsuit is protected at either the claim or appeal stage when a deemed exhaustion situation occurs, without uncertainty of facing a motion to dismiss for failure to exhaust administrative remedies simply because she was at the appeal stage of the benefits claim. This is also allows the regulations to remain consistent, as throughout both the claim and appeal stages are carefully addressed and incorporated.

H. Deemed Exhaustion of Claims and Appeals Processes – PR 29 C.F.R. 2560.503-1(l)(2)(i)-(ii)

We applaud the DOL for undertaking the task of clarifying the consequences that will result when the plan does not comply with the procedural requirements of the proposed new regulations. We further believe it is prudent that the DOL has separated the consequences according to serious and minor violations. However, after giving the proposed regulations much thought, we believe they could be greatly improved by incorporating the following amendments.

To begin, 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, proposed regulation 29 C.F.R. §2560.503-1(l)(2)(i) 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." 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 simply mean that the plan did not make a decision and another plan review (including remand) would be ordered rather than *de novo* judicial review. This would allow a perverse, unintended affect under the regulations, to allow plans violating the regulations to have another bite at the apple while claimants are left even longer without the ERISA benefits at issue (or at least final resolution of their benefits claim). To avoid a potential ambiguity on this point, we suggest the following amendment to proposed regulation 29 C.F.R. 2560.503-1(l)(2)(i) (added language is bolded/italicized):

> 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***.

Additionally, 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 the likely situation is that a claimant's 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. Likewise, given the ambiguous nature of the phrase "reasonable time," we believe it would be better to specify a certain period of time for action, e.g., ten (10) days. Similarly, we believe it would be beneficial to specify the standard of review as *de novo* when the court does not remand. As such, the following amendments to proposed regulation 29 C.F.R. 2560-503-1(l)(2)(ii) are suggested (added language is bolded/italicized; deleted language shown by strikethrough):

> 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***.

Simply put, a plan that has failed to follow the regulations in a serious way, and failed to exercise its discretion to render a decision in compliance with the regulations prior to a lawsuit being rightfully commenced, cannot fairly be entitled to the special deference required under arbitrary and capricious judicial review. A plan is not deserving of the deference required by a court reviewing its denial of benefits under the arbitrary and capricious standard of review under these circumstances. A different result undercuts the entire reason and meaning behind a plan's right to the very deferential arbitrary and capricious standard of judicial review under the appropriate circumstances.

I. Right to Claim File, Right to Review and Respond to New Information, and Meaning of Testimony – PR Preamble and PR 29 C.F.R. § 2560.503-1(b)(7)

In comparing the preamble to the proposed regulation to proposed regulation 29 C.F.R. § 2560.503-1(h)(4)(i), there is ambiguity as to what manner of "testimony" is contemplated by the new regulations. The preamble states "*the proposal would also grant the claimant a right to respond to the new information by explicitly providing claimants the right* ***to present evidence and written testimony*** *as part of the appeals process*." While the preamble refers to *written* testimony, the actual proposed regulation states "[*the processes for disability claims must] allow a claimant to review the claim file and* ***to present evidence and testimony*** *as part of the disability benefit claims and appeals process.*" The regulation verbiage does not limit testimony to written testimony. To note, the current regulation uses the following language: "*[the process must] provide claimants the opportunity to* ***submit written comments documents, records and other information*** *relating to the claim for benefits.*" 29 C.F.R. 2560.503-1(h)(ii)(2)[current regulation].

Based on experience, it is likely that the inconsistent language between the preamble, which specifies "written testimony", and the proposed regulation, which just states "testimony", will result in costly disagreements over the type of testimony can be submitted by a claimant. There are many cases in which audio or video testimony is most effective. Under the current regulation claimants are permitted to submit any type of testimony. We have had many denials overturned at the appeal stage or during mediation due to video testimony which most accurately conveyed our client's limitations and inability to work. Plans often utilized surveillance video to dispute a claimant's reported limitations and show they can function "normally". However and not surprisingly, surveillance video, often taken furtively from a distance does not capture the real story. The opportunity to provide the plan administrator with video proof of a claimant on a bad day or after performing even minimal activity, or audio evidence of their cognitive decline throughout the day is imperative to counter the plan's incorrect findings and present accurate proof of disability. Our concern is that the reference to written testimony in the preamble will give plans a basis to ignore or bar video or audio submissions which in certain cases is the most effective form of testimony for a claimant.

J. Adverse Benefit Determination to Specifically Include Rescission – PR 29 C.F.R. § 2560.503-1(m)(4)(ii)

The addition to 29 C.F.R. §2560.503-1(m)(4)(ii) [proposed regulation] that an adverse benefit determination includes an adverse decision on coverage is necessary. However, the proposed language does not sufficiently cover the situation where the plan asserts that coverage never existed in the first place. Coverage disputes regarding disability benefits should be appealable by the claimant as a matter of full and fair review. As such, adding additional language to the proposed amendment would remedy this situation. We suggest amending proposed regulation 29 C.F.R. § 2560.503-1(m)(4)(ii) as follows (added language indicated in bold/italics):

> In the case of a plan providing disability benefits, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage ***or any other repudiation of coverage*** that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

As noted, the proposed language to treat rescissions as adverse benefit determinations should be expanded to encompass any situation where a limitation is invoked so that the claimant can immediately appeal rather than wait for the rescission to take effect. For example, under many ERISA disability plans benefits payable for a disability due to a mental nervous condition are limited to twenty-four months. We have had many cases in which the plan administrator advised our client that benefits will terminate in a few months due to the plan's cap on benefits for mental/nervous disabilities while at the same time deferring the claimant's right to appeal until the date that benefits end. In these cases, the plan administrator incorrectly determined that our client, who suffers from an illness such as fibromyalgia, multiple sclerosis, lupus, or some other sickness which may include depression as a symptom or induce depression or anxiety because a cure is unlikely, was disabled for psychological reasons. Rather than provide the claimant with the opportunity to appeal that determination prior to the termination of benefits, plan administrators sometimes require that the claimant wait until benefits have been terminated before they will consider an appeal. By doing so plans impose significant economic hardship on claimants who are deprived of benefits during the appeals process. The claimant should have the option to immediately appeal that determination to avoid economic hardship in the future.

K. Disclosure of Internal Rules and Criteria Used to Make Decisions – PR 29 C.F.R. § 2560.503-1(g)(1)(vii)(B)

The 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. As is true in the healthcare context, plans sometimes argue that internal criteria are confidential or proprietary. But 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.").

L. <u>Notice of Right to Retain Counsel for Appeal</u>

Often ERISA claimants who have been wrongly denied disability benefits do not realize that they have the right to be represented by an attorney in the administrative appeal process; and they too often do not understand the importance of providing all possible proof of disability with the appeal. Not only is it important for the claimant to understand what evidence may have proven their claim to the plan administrator, but they should be fully advised of their limited ability to submit evidence after filing an appeal or in court. Most attorneys who handle ERISA disability claims have had to tell potential clients that they cannot accept their case, despite that person's apparent right to disability benefits under the plan, because there is not sufficient evidence in the claim file to show that the plan's decision was not only wrong, but arbitrary and capricious. Our firm has had to advise many individuals that because they did not understand the importance of the appeal process, their rights and limitations during and after the appeal, and were not aware that the appeal was their last opportunity to submit proof of their disability or counter the plan's erroneous determinations, that they missed their last, best opportunity to prove a meritorious claim.

As such, we 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. There is no reason to hide this right from claimants.

Thank you for your time, attention and diligent efforts. The importance of the proposed regulations to ERISA disability benefit claimants cannot be overstated, and we appreciate the opportunity to provide comments on behalf of ERISA claimants.

Should you have any questions or concerns as to the foregoing, or if we may assist in any way, please do not hesitate to contact any of us directly at (954) 989-9000.

Very truly yours,

s/ Alicia Paulino-Grisham
s/ Maggie M. Smith
s/ Mindy. L. Chmielarz

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