

December 30, 2015

By Email Only:

e-ORI@dol.gov

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

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:

I write to offer comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. I am interested in these regulations because I am an attorney whose practice is focused on the representation of claimants in ERISA-governed disability benefit disputes. ERISA claims currently make up about 70% of my practice. They include claims on accidental death and dismemberment insurance policies, health insurance policies, and disability insurance policies.

These comments are organized as follows. First, I address the most important substantive issues for the DOL to address as it finalizes the proposed regulations. These comments relate to where I think the DOL should make a substantive change in the proposed regulations. Second, I outline the most important technical issues in the proposed regulations. These are matters that do not change the substance of a proposed regulation but request language changes to clarify or conform with other regulations.

Comments on Substantive Matters in the Proposed Regulations

Notice for Applicable Statute of Limitations

The DOL has requested comment in 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). This is a crucial area for regulation, as the *Heimeshoff* decision has created confusion and much litigation. In a short amount of time, this has become the most researched issue in these cases with the least amount of guidance. The DOL can assist by creating standards for what is a reasonable plan-based limitations 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. Since *Heimeshoff* left open the possibility that an internal limitations period could run before the appeals process is complete (even where exhaustion is mandatory), the DOL is in a good position to clarify that such an approach 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 limitations period from the plan, as is already the case with other plan terms. As the DOL points out in the preamble to these proposed regulations, plan administrators are in a better position to know the date of the expiration of the limitations period. They should not hide the ball from claimants if the plan administrator is a true fiduciary.

One court has interpreted the existing regulations to require notice of the expiration of a limitations period. *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) (“[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)). This is a minority perspective ignored by many courts. Since ERISA is a national practice, there is a real disadvantage to having different standards across the country. The DOL should do more than interpret its own rules; it should re-write them to remove any ambiguity.

I recommend an amendment to the regulations governing the manner and content of notification of benefit determinations on review. 29 C.F.R. §2560.503-1(j) [proposed regulation]. The amended language should require the claims administrator to notify the claimant of the date of the expiration of any plan based limitations period and should include a definition of what is a reasonable limitations period. Such an alteration takes care of the different courts' views on when claims “accrue” in that 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 rule would cut down on litigation devoted to the threshold issue of the running of the limitations period. In addition, it may well lead to a standardization of internal limitations periods that would be salutary for both claimants and plan administrators.

Accordingly, I 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).

Timing of Right to Respond to New Evidence or Rationales

The DOL clearly wishes to improve things for claimants who are ambushed with new rationales or evidence during review on appeal. I commend this effort, since sandbagging has been a persistent problem in the ERISA appeals process and some courts have not fully understood how prejudicial this is to claimants. In fact, aside from the Fifth Circuit, many courts enact a strict requirement that documents provided after the close of all appeals do not need to be reviewed by the administrator.

Given that it is often very hard to supplement the record in litigation, 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.

There is a concern that while this extra opportunity to submit proof to the plan exists, claimants will extend their time without benefit payments. This is a problem that already exists and could be exacerbated. Plans have protested that giving the claimant the last word will make the internal appeals processes go on forever. This argument is out of touch with the reality of being an ERISA disability benefits claimant. These claimants, in my experience, would not continue the process *ad nauseum* while they are unable to pay their mortgages and feed their families. They just want a fair opportunity to respond to what is done in their claim.

The following suggestion places reasonable limits on both claimants and plan administrators and responds to the concern that claimants will have to wait too long for determinations on review. While claimants will want to make fast work of their responses because they are usually without income during this process, 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.”

Accordingly, I 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.

Independence and Impartiality - Avoiding Conflicts of Interest Alternative A

The proposed regulation regarding the impartiality of claims personnel is essential and I applaud the DOL's effort to minimize the effect that biased individuals have on the claims and appeals process. However, the proposed regulation needs clarification in three areas.

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. This clarification is necessary because, as a practical matter, plans frequently delegate the selection of experts to third-party vendors who, in turn, employ the experts. Cases are rife with the kind of financial incentives provided to these third-party vendors, which provides a practical incentive to deny that claimants are disabled. Finding too many claimants disabled tends to lead to the failure to renew contracts.

Second, clarification is needed concerning which individuals are "involved." Claims administrators often protest 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. Under this logic, plans may argue that consulting experts are not affected by the impartiality regulation.

Finally, the proposed regulation should make clear that not only claims adjudicators and consulting physicians must be impartial. Vocational experts and accountants are also frequently used in the claims process and should be included in the scope of the impartiality requirement.

In light of these concerns, I 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]

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 that the individual will support the denial of benefits.

Alternative B

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, I 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 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.

Opportunity to Supplement the Record

Although the EBSA has not chosen to regulate about this, it should do so. 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). Sometimes a claims administrator

may rush an appeal decision through simply to avoid the claimant being awarded SSDI and having that evidence in the claims file. 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. In light of this holding from *Vega*, I 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. As several cases in the Fifth Circuit have demonstrated, this is not an eternally open timeframe, but can be reasonably limited to allow the claimant to provide relevant information even after the administrator decides to close the claim.

The Denial and Its Relationship to SSDI or other Disability Awards - Alternative A

The regulation as presented, requiring a claims administrator to meaningfully distinguish the views of treating physicians or other entities that are paying benefits, will be helpful. Often, administrators ignore evidence that is favorable to the claimant. If the administrator pays any attention to contrary opinions, my clients receive pre-packaged or boilerplate paragraphs in the denial letters that have nothing to do with their claims. Because of this, they cannot mount a response. This stands in the way of full and fair review. Sometimes courts do not understand the difference between the type of explanation required by ERISA and these meaningless canned paragraphs. Assuming that this regulation is intended to change plans' reliance on this sort of explanation or a wholesale failure to address the contrary evidence, I am in favor of the regulation.

Alternative B

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.

Technical Matters in the Proposed Regulations

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, I 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.

Notice of Right to Request Relevant Documents

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] is an improvement since it was formerly missing from the regulation. However, it would be more helpful to claimants to 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 know what rights are given here.

Accordingly, I 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.

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. I 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**,

Deemed Exhaustion of Claims and Appeals Processes

It's great 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 has wisely separated the consequences into two categories, *i.e.* for serious violations and for minor violations. I 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]. I 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, I 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* on all factual and legal issues.**

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. I 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 confusion arising from how to interpret the phrase “reasonable time.” It would be better to specify a period of time. Ten (10) days should be sufficient.

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. I 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 on all factual and legal issues.**

Right to Claim File and Meaning of Testimony

There is confusion about what kind of “testimony” is contemplated by the new regulations.

In the preamble to the proposed regulations, the DOL has stated: “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 claims and appeals process.” Note the underscored language refers to “written testimony.” But the actual proposed regulation uses this phrasing: “[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.” 29 C.F.R. §2560.503-1(h)(4)(i)[proposed regulation]. Here the regulation refers to “testimony” without limiting the type of testimony to “written” testimony.

By comparison, 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].

Hence, there is an inconsistency between the preamble and the proposed regulation in that the preamble specifies “written testimony” whereas the proposed regulation just says “testimony.” This could lead to costly disagreements over whether the regulation contemplates actual live testimony, *i.e.* a hearing.

Furthermore, under the current regulation, sometimes claimants submit testimony in the form of an audio or video CD. This is particularly useful in cases where the claimant cannot read or write so that a written statement is impossible. It is also helpful in those cases where actually seeing the claimant might be important. As such, I am concerned that the reference to “written testimony” in the preamble might give plans the ammunition to disallow any audio or video submissions on the grounds that these forms of evidence do not represent “written evidence.” If this were the interpretation given to the language in the proposed regulation, it would put claimants in a worse position than they face at present.

Further, the proposed regulation’s verbiage, *i.e.* “evidence and testimony” could be interpreted to impose courtroom evidentiary standards for claimants submitting proof of their claim – something that is not normally applied in the ERISA context. Plans are in a position to observe rules of evidence as they have in-house counsel and other legal resources to rely upon to assure compliance with the rules of evidence. But claimants, who are often representing themselves, are not equipped to understand, much less apply, the usual evidentiary standards suggested by the phrase “evidence and testimony.” The agency needs to make clear that it is not curtailing or narrowing the types of information that claimants may submit to the administrator. Courtroom rules of evidence need not apply in this context.

Other Issues of Concern with the Regulations

Adverse Benefit Determination to Include Rescission - Alternative A

An addition to the regulation that an adverse benefit determination includes an adverse decision on coverage is necessary. However, I question whether the definition of “rescission” in 29 C.F.R. §2560.503-1(m)(4)(ii) [proposed regulation] is sufficient to 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. I suggest the following amendment (added language indicated by bolding and underlining):

29 C.F.R. §2560.503-1(m)(4)(ii) [proposed regulation]

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.

Alternative B

The proposed language regarding treating rescissions as adverse benefit determinations should be expanded to encompass any situation where a limitation is invoked so that the claimant can immediately appeal. For instance, a plan may approve benefits but may invoke a time limitation that exists in the plan, such as a mental illness limitation. Many insurers defer the right to appeal until the date that benefits end, which imposes significant economic hardship on claimants who may then be deprived of benefits for several months while appeals proceed. The claimant should have the option to immediately appeal that determination to avoid the economic hardship in the future.

Disclosure of Internal Rules

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 cannot learn of or discover in order to address them in the appeal. This will be even more true with the application of the revised Federal Rules of Procedure limiting discovery. 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. What good does it do for claimants to be judged on super secret rules that they cannot respond to? 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.”).

This common sense approach was recently adopted by a judge in the Southern District of Texas, who ordered that Humana produce the entire manual upon which it relies in deciding the medical necessity of mental health claims. *Ariana M. v. Humana Health Plan of Texas, Inc.*, Ca. No. H-14-3206 (hearing held on October 7, 2015).

Venue Selection Provisions Inconsistent with ERISA

There is a serious issue that is not addressed in the proposed regulations that should be considered. The regulations should make clear that ERISA’s broad venue provision cannot be thwarted by contrary plan or policy provisions. Some courts have permitted plans to draft around ERISA’s venue requirements. At a minimum, the present state of the law means that there will continue to be litigation on this question before the merits of a dispute can even be reached. Venue selection clauses are mostly used to disadvantage ERISA claimants in litigation or create barriers to their statutory right to sue. *McQuennie v. Carpenters Local Union* 429, No. 3:15-CV-00432, 2015 WL 6872444, at *5 (D. Conn. Nov. 9, 2015)(*pro se* litigant allowed to sue in home state of Connecticut because he could not afford to travel to California); *but see, Turner v. Sedgwick Claims Mgmt. Servs.*, No. 7:14-CV-1244-LSC, 2015 WL 225495 (N.D. Ala. Jan. 16, 2015).

In *Turner*, the court encouraged the agency to regulate in this area as opposed to filing amicus briefs in some cases and not others. *Id.* at 21(“[a]lso underwhelming is that the Secretary has expressed his view only rarely, through the ad hoc, highly informal means of amicus briefs in private litigation, rather than in a regulation, an enforcement setting, or even in a published statement of policy or guidance.”). There is a fear that other courts will take this same point of view, which would harm disability claimants.

Accordingly, I recommend that DOL propose a regulation requiring that in the final denial letter plans not only notify claimants of their right to sue and the date of the expiration of any internal limitations period, but also of the statutory ERISA venue provision.

Notice of Right to Retain Counsel for Appeal

Often ERISA claimants who have been wrongly denied disability benefits do not realize that they have the right to be represented in the administrative appeal process. Not knowing what evidence would have proven their claim to the plan administrator, and limited by the administrator or the court in submitting any new evidence in support of their claims in later litigation, they have often squandered their last, best opportunity to prove a meritorious claim. I 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.

Conclusion

I appreciate the amount of time and effort that has gone into the proposed revisions to the DOL regulations. With the suggested revisions, we can ensure that the odds against claimants in the ERISA context (no right to a jury, no extra contractual damages, etc) are improved. This is consistent with the original spirit of ERISA.

I thank you for your time in reviewing this comment. If you have any questions or concerns, do not hesitate to contact me.

Very truly yours,

PLUMMER | RAVAL

By: _____
Amar Raval