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By Mail: 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 am an attorney who regularly represents claimants who have been denied ERISA welfare benefits; mostly disability benefits, but also life insurance, health insurance and other benefits. I am submitting the following comments on the proposed regulations amending the claims procedure regulations applicable to ERISA welfare benefits and disability benefit plans.

I am past-chair of the American Association for Justice (AAJ, formerly American Trial Lawyers Association) ERISA Healthcare and Disability Litigation Group, past-chair of the AAJ Social Security Disability Section, and past-chair of the Tennessee Bar Association Disability Law Section. I am currently president of the Tennessee Association for Justice (TAJ, formerly the Tennessee Trial Lawyers Association.) My firm has litigated hundreds of disability insurance or long term disability claims, mostly under ERISA, as well as other ERISA welfare benefits claims. I am also a regular speaker on many topics related to ERISA and ERISA benefits at national as well as local conferences.

Generally, I am writing in support of the Department of Labor's (DOL's) proposed regulations; however, I believe in most cases the proposed regulations do not go far enough to provide due process or substantive protections for employees who have ERISA welfare disability benefits claims. In other words, I support the proposed changes as better than no changes, but I believe these changes would still allow ERISA fiduciary decision-makers to deny valid claims without adequate protections for plan participants and beneficiaries.

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1. Comment on Notice for Applicable Statute of Limitations

Before commenting on the proposed changes to the regulations, I offer the following in response to the DOL's invitation for comments 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). I agree that this is a crucial area for regulation, and there remains significant confusion since *Heimeshoff*. Without further clarification from the DOL, there will continue to be extensive confusion and litigation.

While many states have a statute of limitations for contracts that is incorporated into ERISA, most states also allow insurance contracts to contain shorter periods of limitations, often referred to as "contractual periods of limitations." These contractual periods of limitations allowed under state law usually provide that a claimant must bring a law suit before a certain time (usually three years), but that time limitation begins to run from when a claim is first made or when benefits are first due. This has been interpreted under *Heimeshoff* and similar lower-court decisions to mean that the time for filing in court can run while a person is receiving benefits or while the mandatory administrative review is being conducted. Thus, for example, if a person is paid benefits for two years and then is denied ongoing benefits, and then it takes, say, nine months, to exhaust the required plan appeals, a person may only have three months to find an attorney, for the attorney to evaluate the claim, and then to file the lawsuit. Worse, if the person is paid for, say, four years, then under *Heimeshoff*, there is no clear rule determining how long the person has to file a lawsuit, just that the time from the final denial must be "reasonable."

I believe that the most clear rule the DOL should establish is that the time limit in a contractual period of limitation cannot run while a person is either on claim (i.e. while receiving the disability benefits) or while the person is exhausting his or her required appeals under the plan. Such a rule would provide the clearest and cleanest way for all involved to understand when a civil action could be brought. I also agree that requiring an ERISA administrator to state in a final adverse benefit determination when the case must be filed in court is a necessary rule that will provide clarity for all involved, as well as allowing unsophisticated plan participants and beneficiaries the information they need to know concerning how long they have to go to court.

Further, some ERISA plans do contain language that runs the time for filing in court from the date of the final denial of benefits, but provide for extremely short limitations, such as 90 days or less. Because of this, I submit that DOL should help define just what a "reasonable" time is, and define "reasonable" as something more than just 90 days. That short period of time is often not long enough for a claimant to find an attorney, for the attorney to order the relevant documents from the ERISA administrator, review the documents, prepare a complaint, and file the complaint. When such a short period applies, attorneys may be forced to file prematurely, resulting in even more unnecessary litigation.

I respectfully request that the DOL consider 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 a regulation should also make clear that no limitations period can run while a beneficiary is receiving benefits and while the beneficiary is exhausting the internal claim and appeals process. In order to provide a clear rule as to what is reasonable, I suggest a rule requiring at least a one-year period after the completion of the plan's appeals process in which a claimant can file suit. The justification for this rule is that it would cut down on litigation devoted to the issue of the running of the limitations period, and would provide clarity to beneficiaries and claimants as to just what the rules are.

I respectfully 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 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).

2. Comment on Timing of Right to Respond to New Evidence or Rationales

I commend the DOL for addressing the issue of ERISA fiduciaries ambushing claimants with new rationales and evidence during the review of an appeal. In my practice I have seen many cases in which we appeal our client's claim based on the reasons given in the first adverse benefits determination, and on appeal the ERISA fiduciary/decision-maker provides a new reason for denying the claim, or obtains new evidence to support the denial of benefits, but also states in the decision that this is a final decision and no further appeals will be considered. This "sandbagging" by ERISA fiduciaries and decision-makers is an ongoing problem.

One issue that the proposed regulations could be clearer about is that, if adopted, the regulations only give the claimant a "reasonable time" to address the new rationale or evidence. A chance to respond is better than no chance, and the proposed regulation is an improvement over the current regulations. However, for even greater clarity, rather than just saying "a reasonable time," perhaps the DOL should be more specific and provide a minimum time to allow the claimant to respond, such as 45 or 60 days.

3. § 2560.503-1(g)(1)(vii)(B) Improvements to Basic Disclosure Requirements.

Among several improvements in the current claims regulations (effective January 20, 2002) over prior regulations was to provide a claimant access to all of the documents that were "relevant" to the claim as defined in 29 C.F.R. § 2560.503-1(m)(8). The same regulations also required that similarly situated claimants be treated similarly. 29 C.F.R. § 2560.503-1 (b)(5).

One recurring problem is that many disability insurance companies that provide ERISA benefits have claims manuals that provide internal regulations, protocols, rules or standards that are used, or should be used when making claims decisions. However, when a claimant asks for these documents, either as part of the review process or later in court, many disability insurance companies claim that their internal regulations were not "relied upon" in a given particular case. This, of course, begs the question as to whether any particular decision was actually made in violation of their own internal rules, or at least,

whether they are treating similar claimants differently, by applying the internal rules in some cases and ignoring them in others.

The proposed language within the additional paragraph (g)(1)(vii)(B) uses the same “relied upon” language which has continued to be a problem from the pre-2001 regulations and in the current regulations.

I respectfully propose amending the proposed regulation by adding a section as follows and renumbering accordingly (added language is indicated by bolding and underlining):

Current:

(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.

Proposed:

(B) The “relevant” (as defined by ¶ (m)(8)(iii) and (iv) of this section) internal rules, guidelines, protocols, standards or other similar criteria of the plan, plan administrator, claims administrator or other entity making the adverse determination.

4. Effective Date of the Regulations

The current regulations at 29 C.F.R. § 2560.503-1(o) contained the following language that has proven problematic: “Applicability dates. This section shall apply to claims filed under a plan on or after January 1, 2002.” The big problem with this language is that in disability cases, a person becomes disabled and may be paid benefit for a period of years before being denied ongoing benefits. Over the last fourteen years we have had several clients who originally applied for disability benefits before January 1, 2002, but were not denied benefits until many years later. For those claimants, under the language in § 2560.503-1(o), their claims were and will always be controlled by the claims regulations in effect before January 1, 2002. Thus, rather than providing for consistent regulation for all claimants, older claims were treated differently, and continued to be treated differently.

To avoid the application of the previous regulations to disability claims that are currently being paid, but are denied in the future, or to claims that are currently pending, I respectfully suggest that the effective date for these regulations be stated as follows:

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

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Alternatively, if the decision is made to use language that the regulations will not apply to currently pending claims, but only to those that are denied in the future, I respectfully suggest the following language:

The regulations shall apply to all claims that are filed on or after the date that the regulations go into effect or any claim that receives an adverse benefit determination after that date.

In addition to these specific comments, I otherwise support the new proposed regulations. While there might be some other ways that the proposed regulations can be further improved, I commend the DOL for these proposed changes, and recommend that they be adopted.

Sincerely,

/s/ Eric L. Buchanan

Eric L. Buchanan