

One Federal Street  
Boston, MA 02110

**T** 617-338-5241  
888-211-6168 (toll free)  
**F** 617-338-5242  
**W** www.healthlawadvocates.org

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January 16, 2016

**By Electronic 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:

Thank you for the opportunity to submit comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. Our organization is a public interest law firm, whose mission is to provide pro bono legal representation to low-income residents of Massachusetts. Our clients, who are chronically ill and disabled, are directly impacted by the limitations imposed by ERISA on their ability to access health and disability benefits. Our comments are informed by our considerable experience representing claimants in ERISA-governed benefit disputes and advocating for fair claims decision-making processes for some of our nation's most vulnerable consumers. The proposed regulations represent another step forward in promoting the requirements of ERISA for a "full and fair review" of claims, by strengthening vital consumer protections related to notice and ensuring "meaningful dialogue." *See 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" between the insurer and claimant.

We have organized our comments as follows. First, we address the most important substantive issues for the DOL to consider as it finalizes the proposed regulations. These comments relate to where we believe the DOL should make a substantive change in the proposed regulations. Second, we have set out what we see as 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 for purposes of greater clarity or conformity with other regulations.

## **I. Comments on Substantive Matters in the Proposed Regulations**

### **Comment on Notice for Applicable Statute of Limitations**

The DOL has invited 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). We agree that this is a crucial area for regulation as the *Heimeshoff* decision has created confusion for consumers and spurred significant litigation under health and disability plans. We urge the DOL to create 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 preclude a "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. We support the DOL's preamble to these proposed regulations as to the remarks that plan administrators are in a better position to know the expiration date of the limitations period and should not be hiding the ball from claimants if the plan administrator is functioning as 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. To adequately protect consumers, the DOL should go beyond interpreting its own rules; it should re-write them to remove any ambiguity.

We 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 exact date of the expiration of any plan-based limitations period and should include a definition of a "reasonable limitations period". This amendment would settle the different courts' views on when claims "accrue" by clarifying that no limitations period can start before the internal claim and appeals process is complete. Specifically, we recommend the provision of no less than 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 limitations period. In addition, the rule may promote a standardization of internal limitations periods, thereby

bringing consistency to the issue that would benefit claimants and plan administrators alike.

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

29 C.F.R. 2560.503-1 (j)(6) [proposed regulation]

In the case of an adverse benefit decision with respect to disability benefits— (i) A discussion of the decision, including, to the extent that the plan did not follow or agree with the views presented by the claimant to the plan of health care professionals treating a claimant or the decisions presented by the claimant to the plan of other payers of benefits who granted a claimant’s similar claims (including disability benefit determinations by the Social Security Administration), the basis for disagreeing with their views or decisions; and (ii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

**(7) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, a statement of the date by which a claimant must bring suit under 502(a) of the Act. However, where the plan includes its own contractual limitations period, the contractual limitations period will not be reasonable unless:**

**a. it begins to run no earlier than the date of the claimant’s receipt of the final benefit determination on review including any voluntary appeals that are taken;**

**b. it expires 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).

**Comment on Timing of Right to Respond to New Evidence or Rationales**

It is evident the DOL aspires to improve the claims review process for claimants who are ambushed with new rationales or evidence during review on appeal. We commend this effort, since sandbagging has been a persistent problem in the ERISA appeals process and some courts have failed to appreciate how prejudicial this is to claimants. In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), the court articulated the problem as follows:

[w]ithout knowing what “inconsistencies” the Plan was attempting to resolve or having access to the report the Plan relied on, Abram could not meaningfully participate in the appeals process. . . This type of “gamesmanship” is inconsistent with full and fair review.

*Id.*

We have heard from consumers and fellow advocates that it is very difficult to supplement the record in litigation. The proposed change offers some assurance that a claimant may be allowed to contribute his or her relevant evidence to the record for the court’s review. There is, however, a countervailing concern that while this extra opportunity to submit proof to the plan exists, claimants will be extending their time without benefit payments. Plans have protested that giving the claimant the last word will make the internal appeals process continue forever. This argument is out of touch with the reality of being an ERISA benefits claimant. These claimants, in our experience, would not continue the process *ad nauseum* while they are unable to pay their mortgages and feed their families or, in the case of individuals seeking health insurance benefits, waiting for what is often life-saving treatment.

We suggest an amendment to the proposed regulation that places reasonable limits on both claimants and plan administrators, easing 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. Our suggested amendment below recognizes that these professionals are not always readily available for quick turn-arounds and may need weeks to evaluate the new information. For this reason, we suggest providing claimants at least 60 days to respond to new evidence or rationales provided by the plan on appeal. In addition, the period for the decision on review to be completed should be tolled during this 60-day period. Following the claimant’s response, 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 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**

The proposed regulation regarding the impartiality of claims personnel is essential. We applaud the DOL's effort to minimize the effect that biased individuals have on the claims and appeals process. However, we urge the DOL to provide 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.

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, we suggest that the proposed regulation language be amended as follows (added language is bolded and underlined):

29 C.F.R. §2560.503-1(b)(7) [proposed regulation]

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.

### **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, many claimants' conditions are progressive or defined by developing or changing diagnoses. In these cases, updated medical information is often crucial to proving disability claims. However, a diagnostic workup may take up to several years to complete, especially for claimants without continuous affordable health insurance coverage. For claims based on conditions without a definitive diagnosis, testing often emerges long after the disability claim is filed that sheds light on the nature of the claimant's illness back to the onset of disability. 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. 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*, 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.

## II. Comments on Technical Matters in 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 often not represented, may not understand what rights are given here.

Accordingly, we suggest the following amendment to the proposed regulation (added language is underlined and bolded):

29 C.F.R. §2560.503-1(g)(1)(vii)(C)[proposed regulation]

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to **the claimant’s claim file, including** copies of all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

### Right to Claim File and Meaning of Testimony

We find the proposed regulations’ contemplation of the manner of “testimony” lacks clarity.

In the preamble to the proposed regulations, the DOL 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. However, 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].

In comparison, 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.” We anticipate this leading to costly disagreements over whether the regulation contemplates actual live testimony, *i.e.* a hearing. 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, due to their disabling condition, cannot read or write. It is also helpful in those cases where actually seeing the claimant might be relevant to the disability determination. As such, we are 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.

Further, we worry 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 unrepresented, are not equipped to understand, much less apply, the usual evidentiary standards suggested by the phrase “evidence and testimony.” We urge the agency to clarify that it is not curtailing or narrowing the types of information that claimants may submit to the administrator.

### **III. Other Issues of Concern with the Regulations**

#### **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 essential because internal rules, guidelines, protocols, standards, claims manuals, and similar materials often create hidden plan terms that the claimant is unable to address 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.

#### **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. We have

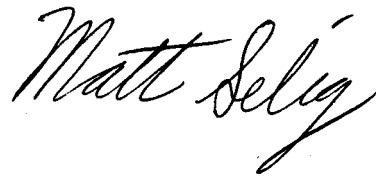


heard from many claimants who were told by either their employer or plan administrator that they do not need representation. Not only are claimants laypeople faced with navigating the complex world of ERISA, but they are also facing a medical crisis, often suddenly and for the first time in their lives. Though their financial security is at stake, claimants are either cognitively, physically, or psychologically impaired in their ability to understand the denial rationale and develop an adequate response. We strongly urge the DOL to 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.

#### **IV. Conclusion**

Health Law Advocates appreciates this opportunity to provide its comments on the proposed rule. If you find additional information from our organization may be helpful, please contact Executive Director Matt Selig at (617) 275-2986, or President of the Board of Directors Mala M. Rafik at (617) 723-7470.

Sincerely.

A handwritten signature in black ink that reads "Matt Selig". The signature is written in a cursive, flowing style.

Matthew Selig  
Executive Director