

Comments on regulations 29 C.F.R. §2560.503-1

By Email only: e-ORI@dol.gov
 Phyllis C. Borzi, Assistant Secretary of Labor
 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 Secretary Borzi:

I am the ERISA chair of the Massachusetts Employment Lawyers Association (MELA). MELA is a not-for-profit organization comprised of attorneys who devote a majority of their practice to representing employees, rather than employers. We have approximately 175 members. Our mission is to enforce and to advance employee rights. We do this by working to increase awareness, improve advocacy, monitor legislation and support members in their practices.

I am able to offer these comments on behalf of MELA as I focus my practice in representing individuals in ERISA matters. I have been a lawyer for about 30-years. I began concentrating in ERISA in the early 1990s and since that time have devoted more and more of my time exclusively to ERISA work. At this time, in excess of 80% of my time is spent on ERISA matters. Of that time, the vast majority relates to long-term-disability claims. This focus is consistent with the litigation statistics noted by the Secretary and the Federal Judicial Center. Therefore, my comments are tuned to this area.

In addition to my volunteer work at MELA, I have served in other bar capacities focusing on ERISA, or ERISA related areas of the law. I have served as Chair of the Health and Disability Committee under the Torts Trial and Insurance Practices section of the American Bar Association; Chair of the Insurance Section with the American Association for Justice; Chair of the ERISA litigation group with the American Association for Justice; and I am a contributing editor to *Employee Benefits Law*, Bloomberg/BNA, which is the leading treatise on employee benefits.

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MELA applauds the Secretary of Labor (DOL) for the department's efforts to bring the current claims regulations up to date. As ERISA affects in excess of 150 million Americans, the current regulations do need amendments and updating.

ERISA is a very challenging area of law. For a law that was enacted to protect the rights of individuals, the law has developed through the Courts in the opposite manner. This is evident by the lack of attorneys that practice in this area representing individuals.

When Congress enacted ERISA, Congress created a strict fiduciary standard for those individuals and entities involved in the administration or management of employee benefit plans or their assets, a standard that requires those persons or entities to make decisions solely in the interests of the plan's participants and their beneficiaries. Over time this has not panned out. ERISA is a shield for those actors insulating them from unfair conduct, and a sword at the same time.

Given the importance of pre-suit exhaustion under ERISA, the Secretary's claim regulations are essential for providing clarity to both employees and plans. Also, considering that Congress did not impose parallel substantive standards on health care plan, long-term-disability plans or other welfare benefit plans as it did for the pension side of ERISA, claims regulations fill an important void left by Congress.

What follows are comments addressing two areas: (1) substantive matters addressed by the regulations; and (2) suggest technical corrections.

I. COMMENTS ON SUBSTANTIVE MATTERS IN THE PROPOSED REGULATIONS

A. DOL Must Require Adverse-Benefit-Decision Notices To Set-Forth The Last Date Permissible to File Suit.

DOL can eradicate confusion caused by *Heimeshoff v. Hartford Life & Accid. Ins Co.*, 134 U.S. 604 (2013). The Supreme Court did not provide a satisfactory answer identifying limitations periods. Merely telling plans and individuals that plans may set contractual limitations has resulted in an increase litigation rather than a reduction on the issue of limitations.

As Full and Fair review is an ERISA statutory requirement, amending the proposed regulation will serve that purpose. 29 U.S.C. §1133. On the welfare-side of ERISA, the ERISA statute requires little more than describing the benefit offered. Given that ERISA is mostly about notice and procedure, advising a plan beneficiary of the last date to appeal a claim, and last date

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to file suit is reasonable. The typical plan language, which often tracks state insurance laws is confusing. Running a contractual limitations period from when “proof of loss is due” is hard to decipher and has resulted in needless litigation.

Considering that contractual limitations periods are plan terms, the plan fiduciary should be tasked with advising the plan beneficiary regarding the last permissible date to file suit. As the DOL states in the preamble to these proposed regulations, plan fiduciaries are in a better position to know the date of the expiration of the limitations period and should not leave the guess-work to plan beneficiaries. I use the term plan fiduciaries as the terms Administrator, Plan Administrator and Claims Administrator are tossed-about loosely, often so a party involved in ERISA plan governance can avoid duties or escape liability for its errors or omissions for some activities, but reap the benefits of deferential review afforded to a trustee for others.

ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4) states, “The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.” However, too many courts have substituted the terms “plan administrator” for “administrator.” See *Tetreault v. Reliance Standard Life Ins. Co.*, 769 F.3d 49 (1st Cir. 2014) (only plan administrators can be held liable for statutory penalties under 29 U.S.C. § 1132(c)); accord *Lee v. Burkhardt*, 991 F.2d 1004, 1010 (2d Cir. 1993); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 62 (4th Cir. 1992); *Benham v. Disability Portion of Life & Disability Plan*, 6 Fed. App’x 280 (6th Cir. 2001); *Klosterman v. W. Gen. Mgmt., Inc.*, 32 F.3d 1119, 1122 (7th Cir. 1994); *Brown v. J.B. Hunt Trans. Serv.*, 586 F.3d 1079 (8th Cir. 2009); *Moran v. Aetna Life Ins. Co.*, 872 F.2d 296 (9th Cir. 1989); *Thorpe v. Retirement Plan of the Pillsbury Co.*, 80 F.3d 439, 444 (10th Cir. 1996); *Davis v. Liberty Mutual Insurance Co.*, 871 F.2d 1134, 1139 n. 5 (D.C. Cir.1989).

My point is that any “administrator” should be charged with identifying the contractual limitations date. An insurer should not duck this task by claiming that it is only a “Claims Administrator.” Too often the Plan Administrator does not understand its duties as it believes that the insurance company will address matters, including production of SPDs and Plan Instruments. Requiring “an administrator,” which tracks the statute, shall provide the date for determining the final limitations date.

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 purpose of the suggested amendment is to create certainty. This benefits both plans and plan beneficiaries and the judiciary. Clarity leads to predictable results. This saves judicial resources too.

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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. an 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).

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B. DOL Must Codify *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005).

“Sandbagging” plan beneficiaries is a persistent problem perpetrated by fiduciaries during the pre-suit appeals process. Relying on newly developed substantive evidence during the pre-suit appeal is a common fiduciary abuse that undermines “Full and Fair” review. 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.

Given that in some jurisdictions it is virtually impossible to supplement the record in litigation, the proposed change offers some assurance that the pre-suit appeal process is not rigged against the plan beneficiary. Fiduciaries should not be permitted to use new substantive evidence to avoid paying a claim without permitting the plan beneficiary to respond to the evidence. Again, ERISA is about notice and procedure. A fair process is undermined if the fiduciary can withhold evidence to the last minute knowing that the plan beneficiary cannot respond. “We have invoked our equitable and common law powers to prevent a plan from taking actions, even in good faith, which have the effect of ‘sandbagging’ claimants *Bard v. Boston Shipping Ass’n*, 471 F.3d 229, 244 (1st Cir. 2006). The guess-work of weighing the equities and creating certainty may be achieved by codifying *Abram* by regulation. Courts will not need to wrestle with whether the later developed evidence by the plan was substantive, known in advance, reasonably known in advance, otherwise undermined Full and Fair Review.

Considering that judicial review addresses the final ERISA administrative decision, the method of reaching the final decision must be fair. The Courts’ fixation with pre-suit finality speaks for the need to codify *Abram*. “It would offend interests in finality and exhaustion of administrative procedures required by ERISA to shift the focus from that decision to a moving target by presenting extra-administrative record evidence going to the substance of the decision.” *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 519 (1st Cir. 2005).

I suggest a reasonable time limit applying to both plan beneficiaries and plan fiduciaries.

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Plan beneficiaries 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 plan beneficiary responds, the plan fiduciary 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.” Making the regulation apply to both will again provide a level of clarity for both the fiduciary and beneficiary. Failing to cover both topics will likely lead to more litigation, not less, as the plan will claim the evidence is not new, but

The disparity reflects the reality that individuals need time to make appointments with physicians. Plans seem to have easy access to physicians, either in-house or through their vendors. In addition, individuals have incentives to more the appeal along as an individual out of work due to injury or sickness still has bills to pay even though s/he is no longer working.

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.**

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C. DOL Must Prevent Plans and Vendors From Retaining Biased Professionals By Disclosing Financial Interests.

The proposed regulation should make clear that not only claims adjudicators and consulting physicians must be impartial but so must all experts retained by the plans. This includes vendors retained by plans. The burden to ensure impartiality must extend to the vendors so plan fiduciaries may not create the appearance of impartiality by suggesting that the vendor, rather than the fiduciary alone, selected the professional.

Plans and insurers regularly argue in Court that the plan did not select Dr. X, the vendor did. As explained below, the vendor industry has undergone significant consolidation. Insurance companies are repeat customers for the vendor industry, not individuals. Doctors know that who pays them.

In response, Aetna provided Maiden’s file to two “independent” consultants. (See DE 27-3 at 87–92, 95–99.) I put quotations marks around the word “independent” because one might reasonably wonder just how independent the reviewers— Dr. Malcolm McPhee and Dr. Leonard Schnur—really are. Their bread has been buttered by Aetna before; each of them has been hired by Aetna multiple times to conduct these kinds of disability reviews. *See, e.g., Pearson-Rhoads v. Aetna Life Ins. Co.*, 2011 WL 5116633, at *9 (E.D. Penn. Oct. 28, 2011); *Flatt v. Aetna Life Ins. Co.*, 2015 WL 5944365, at *10–11 (W.D. Tenn. Oct. 13, 2015); *see also Aschermann v. Aetna Life Ins. Co.*, 2011 WL 6888840, at *10 (S.D. Ind. Dec. 30, 2011); *Barrett v. Aetna Life Ins. Co.*, 2012 WL 2577505, at *3 (W.D. Ky. July 3, 2012); *Wiggin v. Aetna Life Ins. Co.*, 2013 WL 6198181, at *6 (D. Maine Nov. 27, 2013); *Hulst v. Aetna Life Ins. Co.*, 2014 WL 4594528, at *7 n. 4 (E.D. Ky. Sept. 15, 2014); *Rall v. Aetna Life Ins. Co.*, 565 Fed. App’x 753, 756 (10th Cir. 2014); *Hammonds v. Aetna Life Ins. Co.*, 2015 WL 1299515, at *8 (S.D. Ohio Mar. 23, 2015); *Carrier v. Aetna Life Ins. Co.*, 2015 WL 4511620, at * 7 (C.D. Cal. July 24, 2015); *Jalowiec v. Aetna Life Ins. Co.*, 2015 WL 9294269, at *10 (D. Minn. Dec. 21, 2015).

Maiden v. Aetna Life Ins. Co., 2016 WL 81489, at *2 (N.D. Ind. Jan. 6, 2016)

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The regulation needs greater teeth. Merely requiring professionals to make statements that the professional is not biased is not enough.

The ability of a plan beneficiary to unmask the bias is difficult given that discovery is limited. Moreover, “Full and Fair” review means hiring professionals who provide an objective opinion not a foregone conclusion. In those rarer instances when discovery is permitted, the plan beneficiary learns that some insurance carriers hire the same doctor in excess of 1000 times in a single year. That physician becomes or is beholden to the plan or insurance company. Below is a portion of a deposition transcript from *Kinser v. Plans Admin. Comm. of Citigroup, Inc.*, 488 F. Supp. 2d 1369, 1370 (M.D. Ga. 2007). There the Court held for the participant. When deposed, the plan’s consultant [REDACTED] a psychiatrist, admitted that in 2005, he conducted approximately 1800 file a years for a combination of MetLife and AETNA.

15 Q So we have 100,000 dollars from MetLife,
16 approximately 60,000 -- I'm not talking exact numbers,
17 we're just talking specifics. 100,000 MetLife for
18 2005, 60,000 from Aetna, 11,000 for Medicare, 10,000
19 from the Social Security Administration, and 7,000
20 from a couple nursing homes.

21 A Yes.

22 Q Any other income for your professional
23 services other than what we've just discussed?

24 A For what period of time?

25 Q 2005.

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1 A Yes.

2 Q What else?

3 A I had done similar consulting work for an
4 insurance company called Liberty Mutual from 5/04 to
5/10/05

23 Q And what was your approximate 1099 income from
24 Liberty Mutual in 2005?

25 A Perhaps 100,000 dollars. Again, an estimate.

1 Q And you were doing the same type of work at

2 Liberty Mutual that you were doing at MetLife and

3 Aetna?

4 A Yes.

5 Q File reviews?

6 A Yes.

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4 Q So on an annual basis at least beginning 2005
5 because of the increased workload at MetLife you're
6 doing approximately 100 a month at MetLife and
7 approximately 50 a month at Aetna?
8 A Let me just do a quick calculation there.
9 In that ballpark, but very approximate.

The doctors who do this work regularly understand what the plan or insurance company wants. Given that doctors who do this work routinely assert there is no physician-patient relationship, and the doctor knows that s/he may hide with impunity under the ERISA shield, the opportunity for abuse abounds.

As another example, I have been involved in a case that started in 2003 and still has not been resolved. My client, Susan Mead (she gave me permission to write about her case) applied for long-term-disability benefits in 2003. In late Fall 2015, she turned 65. She has yet to be paid a penny by the long-term-disability insurance carrier. She filed suit on December 29, 2005. *Mead v. Reliastar Life Ins. Co.*, No. 2:05-CV-332, 2015 WL 4203956, at *3 (D. Vt. July 10, 2015).

The litigation is on-going. Recently, the insurance company sent Ms. Mead for a third IME. The first two found her disabled. ERISA insulates the insurer from its improper conduct.

In this case however the appeal committee gave obviously false or misleading reasons to discredit the record review of its neurologist [File reviewing and IME neurologist Kevin Sheth, MD who is Associate Professor of Neurology and of Neurosurgery at Yale Medical School] and to justify its reliance on its nonexamining file reviewers. This is a paradigm of arbitrary and capricious decisionmaking.

Mead v. ReliaStar Life Ins. Co., 755 F. Supp. 2d 515, 537 (D. Vt. 2010).

Despite this finding, the District Court remanded the case to the fiduciary again. The insurer appealed to the Second Circuit, and lost but managed to avoid paying benefits for another 3-years. *Mead v. Reliastar Life Ins. Co.*, 768 F.3d 102 (2d Cir. 2014). To date, this straightforward case has generated 4 District Court opinions and one Second Circuit opinion.

How could this happen? Despite the determination of every treating physician, and 3 examining IME physicians concluding that Ms. Mead is disabled, the insurance company has secured opinions from no less than 8 file reviewing physicians who all claim she can either work

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in her prior occupation as an insurance executive, or in an undefined sedentary occupation. One of those physicians is the same as identified in the *Maiden* case referenced above. These physicians surely understand that they will never testify in Court. They understand the insulation that ERISA provides. They understand what the insurance company wants.

When discovery is permitted, the financial bias becomes more evident. For example, In *Boles v. Unum Life Insurance Company of America*, Case No. 11-CV-03031-RGKCRZ, United States District Court for the District of Nebraska on January 22, 2013 wrote a memorandum compelling discovery

Dr. Bress reviewed an average of 250 UNUM claims per year, and of that, approximately 11 claims per year requested recovery of disability benefits arising from alleged “myalgia and myositis, unspecified” or “chronic fatigue syndrome;” (Filing No. 50-3, at CM/ECF p. 1-3, interrogatory responses 2 & 3; Filing No. 50-4, at CM/ECF pp. 1-2, interrogatory response 3). For the years 2008 and 2009, Dr. Bress received an average of \$237,500 per year for his work on UNUM files. (Filing No. 50-7, pp. 1-3).

Even a small sample may be telling

The parties, as might be expected, disagree over the interpretation of the discovery that was produced. Harvard claims that there is no demonstrable pattern to the conclusions reached by its examiners in the prior IMEs. The court disagrees. McGahey points out that Dr. McManama recommended denial of every long-term disability claim in the twenty-two cases that he reviewed for Harvard during the specified time period. Dr. Clayman recommended denial in 80 percent of the cases he reviewed (twenty-five of thirty-one).

McGahey v. Harvard Univ. Flexible Benefits Plan, 685 F. Supp. 2d 168, 180 (D. Mass. 2009)

In finding for the plan beneficiary, the Court continued

Fourteen medical professionals treated McGahey or were consulted in her case. Of the fourteen, only the three doctors employed by Harvard concluded that she was malingering. There is nothing necessarily sinister afoot. It may simply be that the examiners chosen by Harvard have a skeptical view of patient complaints (many doctors do), or from personal experience may have acquired a jaundiced view of disability claimants. But when their opinions are factored into the refusal of the BAC to consider the SSDI and workers' compensation awards, and its seeming indifference to the opinions of McGahey's treating physicians, the court

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is of the view that the BAC's decision was arbitrary and capricious. It is true that the arbitrary and capricious standard is highly—one might even say reverentially—deferential to plan administrators. **It is also true that plaintiffs seldom if ever prevail when the standard is applied.** But seldom if ever cannot mean never at all, or the promise made to claimants that federal courts will review their benefits decisions for abuses of discretion would be a cruel and illusory exercise. (emphasis added)

Id at 180 (D. Mass. 2009)

But when Courts refuse to allow discovery, unmasking the relationship between the insurance company, the physician and vendor is not possible. “Tracia has not pointed to anything in the record which makes even a threshold showing that Liberty's decision was based on bias.” *Tracia v. Liberty Life Assur. Co. of Boston*, 2014 WL 6485873, at *4 (D. Mass. Nov. 19, 2014). The District Court’s tend to place a burden that is impossible to overcome even when the participant points-out that the physician reviewer is a regular reviewer for insurance companies. “Tracia also cites to the fact that Dr. Brenman's opinions have been rejected in several cases.” *Id.* at *4. For these reasons, DOL must take an active role in assuring that the claims process affords unbiased reviews.

The sourcing of physician reviewers has undergone a private equity roll-up and consolidation in the public markets. One publicly traded company Examworks Group, Inc. (NASDAQ symbol EXAM) has acquired a substantial number of the so-called independent medical (IME) review companies. In its year ending 2011, 10-K, Examworks states

We operate in highly fragmented industry and have completed numerous acquisitions key component of our business strategy is growth through acquisitions that expand our geographic coverage provide new or complementary lines of business expand our portfolio of services and increase our market share **Another central feature of our business strategy is to grow our business organically by selling additional services to existing clients cross-selling into additional insurance lines of business and expanding our geographic footprint with existing clients** (emphasis added)

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Comments on regulations 29 C.F.R. §2560.503-1

The February 20, 2015 Annual Report for Examworks discloses that it has acquired the following “Independent Medical Exam” companies: ReliableRS; Expert Medical Opinions; Ability Services Network and MedAllocators; Solomon Associates; Assess Medical; Gould & Lamb; Newton Medical Group; Cheselden; Evaluation Resource Group; AGS Risk Limited; PMG; MedHealth; Makos; Bronshvag; Matrix Health Management; Capital Vocational Specialists; North York Rehabilitation Centre; MLS Group of Companies; Medicolegal Services; Premex Group; MES Group; National IME Centres; Royal Medical Consultants; BMEGateway; UK Independent Medical Services; Health Cost Management; Verity Medical; SOMA Medical Assessments; Direct IME; Network Medical Review; Independent Medical Services; 401 Diagnostics; Metro Medical Services; American Medical Bill Review; Medical Assurance Group; MedNet I.M.S.; QualmedIME Operations of Physicians' Practice; The Evaluation Group; Benchmark Medical Consultants; IME Software Solutions; Florida Medical Specialists; Marquis Medical Administrators; Ricwel; CFO Medical Services; Crossland Medical Review Services Southwest Medical.

How much did Examworks pay to acquire some of these companies? For example, Examworks reports that, “on February 28, 2011 the Company completed the acquisition of 100% of the outstanding stock of MES Group Inc MES for aggregate consideration of \$215.0 million...” For Premex Group, “the Company...[paid] aggregate consideration of \$108.4 million...” The number of companies acquired in the last 4 years is significant.

When a management level employee at a well-known IME provider was deposed on December 2, 2014 in, *Lagana v. Paulyette Evans and Meemic Insurance Company*, Case No. 13-4532-NI, Circuit Court for the County of Macomb, State of Michigan, the deponent disclosed

3 Q. Did [REDACTED insurance company] from what I gather from that last answer,
4[REDACTED insurance company] didn't have any protocols set in place other
5 than to request a certain IME from you guys?

6 A. Yes.

7 Q. From [REDACTED Medical Review Company]?

8. A. Correct.

9. And so by that I mean -- by that I mean, if [REDACTED insurance company]

10 wanted to they could say I specifically want Doctor

11 [REDACTED] or I specifically want Doctor REDACTED?

12 A. Yes.

A. Yes. With [REDACTED insurance company] there were certain doctors

2 that was on a list like do not use doctors because

3 they were looking for certain things. They were

4 looking for doctors to generate reports according to

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Comments on regulations 29 C.F.R. §2560.503-1

5 what they were looking for. **So we would call those**

6 cutoff doctors. (emphasis added)

7 **Q.** That do not use list that you just talked about

8 there, is that do not use list is that on the OMS

9 system?

10 **A.** No.

11. Is it posted in anyplace in [Redacted medical review company]?

12 **A.** It's posted in the scheduling at each schedulers'

13 desk. It's not an internal thing in OMS [the software system].

14 **Q.** So the do not use list, there is a do not use list

15 for certain carriers?

16 **A.** Yes.

Deponent continues and identifies a number of major insurance carriers.

2 And then when you say the insurance carriers were

3 looking for specific doctors you called them cutoff

4 doctors?

5 **A.** Yes.

6 **Q.** What do you mean by that?

7 **A.** **They're the doctors that are going to give you the**

8 report that you're looking for saying they can

9 return back to work or, you know, that they're fine. (emphasis added)

To partially remedy this problem, I suggest that when a fiduciary relies on a physician or psychologist or other professional such as a vocational specialist, the person must be licensed in the same jurisdiction where the plan beneficiary resides. This assures, for example, that the reviewing doctors is governed under the same standard of care as the treating physician who provides cares for the plan participant. This recognizes: (1) there this no national standard of care in the practice of medicine; (2) the physician rendering an opinion is subject to discipline if that physician issues an indefensible or false opinion regarding a plan beneficiary; and (3) the physician must have the same level of credentialing as the treating physician.

For example, to protect residents of Massachusetts, and states having similar laws, the retained physician must practice at the same level of competence as the treating healthcare provider. Given that the reviewing physician tries to avoid a relationship with the plan participant that is physician-patient, the reviewer avoids duties arising under the Hippocratic Oath, or other common law or statutory duties, requiring licensing in the same jurisdiction may keep the physician honest.

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In 2015, to protect residents of this Commonwealth, Massachusetts amended its regulation as to conduct that constitutes practicing medicine

(b) The Practice of Medicine includes the following:

1. Telemedicine, as defined in 243 CMR 2.01: Telemedicine; and
2. **Providing an independent medical examination or a disability evaluation.**

243 CMR 2.01

In light of these concerns, I suggest the proposed regulation language (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. **The total compensation paid during a rolling 12-month look-back period paid to the vendor, and the individual service provider, must be disclosed to the plan beneficiary and made part of the ERISA record. The total number of claims reviewed during a rolling 12-month look-back period paid to the vendor, and the individual service provider, must be disclosed to the plan beneficiary and made part of the ERISA record. All medical consultants, medical evaluators or persons serving similar duties that offer an opinion on the participant's physical or psychological condition, shall be licensed to practice medicine or psychology in the state where the participant resides.**

D. DOL Must Require Deference to the Social Security Administration Decision.

The regulation requiring a discussion about the difference between the plan's decision and awards made by the Social Security Administration (SSA), should follow a deferential standard, requiring a detailed and meaningful explanation if the decision conflicts with SSA.

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Equity dictates this result, because ERISA Plans almost universally require plan participants to seek governmental benefits. Requiring the plan beneficiary to represent to the government that s/he is totally disabled, yet for ERISA plan come to the opposite conclusion, is demonstrates an abuse of discretion. Saddling the tax payer with the burden of paying benefits but allowing the plan to shirk its financial obligation undermines notions of financial responsibility. As the First Circuit remarked,

After the expiration of the “own occupation” period under the policy (typically two years), a claimant needed to show that he was incapable of performing “any occupation” in order to continue to receive benefits. To assess whether a claimant was disabled under its “any occupation” standard, Unum would ask whether, based on the claimant's training, education, and experience, and given his restrictions and limitations, the claimant was capable of working in an occupation that could pay him sixty percent or more of his predisability earnings. SSA's evaluation of whether an applicant is capable of performing “substantial gainful activity” is *304 similar, and, in fact, was referred to as “the Social Security Administration's ‘any occupation’ eligibility requirement” at trial; however, Unum's “any occupation” analysis is less rigorous than the SSA's “any occupation” analysis. When the SSA evaluates whether an applicant is capable of performing “substantial gainful activity,” it does not limit the sphere of jobs which the applicant is capable of doing based on the applicant's predisability earnings

U.S. ex rel. Loughren v. Unum Grp., 613 F.3d 300, 303-04 (1st Cir. 2010)

The regulation should adopt same language that Unum Group agreed to in the Regulatory Settlement Agreement in 2004. After all, Unum Group is the world’s largest disability insurance carrier. Unum Group made this agreement in the 2004 Regulatory Settlement Agreement along with the California Settlement Agreement in 2005 which together covered all 50-states. By imposing this regulation on all insured plans, and self-funded plans, Unum Group will not be singled out for a unique standard. This will bring a level of fairness to plans and insurance companies that requires them to offer the same standards imposed on the Unum Group. Below is the language from the Unum Group Regulatory Settlement Agreement that DOL should include in the regulations.

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The Companies [UNUM] 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.

II. COMMENTS ON TECHNICAL MATTERS IN THE PROPOSED REGULATIONS

A. The Effective Date of The Regulation Must Apply To All Outstanding Claims.

To avoid the application of the previous regulations to disability claims that are already in process before the effective date, I suggest the following:

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

The Eight Circuit which authored *Abram v. Cargill*, 395 F.3d 882 (8th Cir. 2005), undermined its decision, without specifically over-ruling it *en banc* when the it later concluded that *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 needless litigation, and unfair result, the claims regulations as amended must apply to all outstanding claims.

B. Relevant Documents Must Include All Documents Comprising the Claim Record.

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,” or “claim record” 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 don't. “Claim record” or “Claim file” are terms that non-lawyers grasp.

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

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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 or claim record, 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.

If DOL needs additional information, then kindly contact the undersigned at jonathan@erisaattorneys.com or 617-357-9700.

Thank you.

Sincerely,

/s/Jonathan M. Feigenbaum
Chair – MELA ERISA Committee

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