



January 19, 2016

Submitted via: e-ORI@dol.gov

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Re: Claims Procedure Regulation Amendment
for Plans Providing Disability Benefits [RIN 1210-AB39]

Ladies and Gentlemen:

AARP appreciates the opportunity to comment on the Department of Labor's (the Department) proposed regulation amending the claims procedure for plans providing disability benefits. On behalf of our millions of members, we have a strong interest in ensuring that participants and beneficiaries receive the benefits to which they are entitled. In order to do so, participants must be able to successfully access and resolve benefits disputes through ERISA's claims procedures. Without meaningful access, participants cannot adequately protect their claims to benefits, which may spell the difference between independence and impoverishment in their old age.¹

It has been over fifteen years since the claims procedure was updated. Significantly, there have been meaningful changes in jurisprudence affecting the claims process; courts now permit plans to abolish participant protections with the stroke of a pen. *E.g.*, *Davidson v. Wal-Mart Associates Health and Welfare Plan*, 305 F. Supp. 2d

¹ We know that, as workers age, disability rates increase. *Persons With A Disability: Labor Force Characteristics – 2014*,² (June 16, 2015), <http://www.bls.gov/news.release/pdf/disabl.pdf>. For example, with \$791 as the median weekly earning of a fulltime worker, see *U. S. Dep't of Labor, Labor Force Statistics from the Current Population Survey: Table 37*, Bureau of Labor Statistics (last modified Feb. 12, 2015), <http://www.bls.gov/cps/cpsaat37.htm>, and a replacement percentage of sixty percent, see *America's Health Ins. Plans (AHIP), An Employer's Guide to Disability Income Insurance* 9 (2007), www.ahip.org/EmployersGuidetoDisabilityIncome, a disability claimant would receive the modest amount of approximately \$475 per week.

1059 (S.D. Iowa 2004) (upholding plan provision shortening limitation period to sue for benefit claims denial). Although AARP believes that the proposed amendments to the current disability claim regulations are good first steps towards providing more transparency and accountability to claimants concerning their benefits,² there are additional steps that can be taken to strengthen, improve, and update the current rules governing the internal claims and appeal process and court review for disability benefit plans governed by ERISA.

AARP believes that the integrity of the administration of employee benefits plans, in general, and of disability benefit plans in particular, would be markedly improved by strengthening notice and disclosure protections, prescribing more exacting standards of conduct on review of claims denied initially, and ensuring that claimants' access to the claims process itself and court review is not circumscribed. AARP makes the following suggestions aimed at strengthening the rules applicable to the internal claims and appeal process for ERISA disability plans.

I. The Purpose of Full and Fair Review of Benefit Claims Denials

Congress enacted ERISA to protect participants' and beneficiaries' interests in employee benefit plans by setting out substantive regulatory requirements, including standards of conduct, responsibility, and obligation for fiduciaries, and by providing for appropriate remedies, sanctions, and ready access to the courts. ERISA § 2(b), 29 U.S.C. § 1001(b); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). Among the safeguards that Congress enacted was a claims procedure intended to resolve disputes over benefit claims prior to litigation by affording participants "a reasonable opportunity . . . for a full and fair review" of a denied claim. ERISA § 503(2), 29 U.S.C. § 1133(2) (2012). Congress also recognized that, despite the pre-litigation plan review procedures of § 503, plans might still deny participants the benefits to which they were entitled under ERISA. To address such situations, Congress enacted § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B) (2012), which provides that participants or beneficiaries may bring a "civil action . . . to recover benefits due to him under the terms of his plan [or] to enforce his rights under the terms of the plan. . . ." See generally *Salovaara v. Eckert*, 222 F.3d 19, 28 (2d Cir. 2000) ("[P]rivate actions by beneficiaries seeking in good faith to secure their rights under employee benefits plans are important mechanisms for furthering ERISA's remedial purpose.").

² AARP notes that at least one major law firm has commented that many disability plans are already in compliance with several of the proposed amendments. One could conclude that the burden on plans to come into compliance will not be substantial. Neil Shah, *DOL Proposes to Bring ERISA Disability Denials in Line with the Affordable Care Act*, Proskauer's ERISA Practice Center Blog (Dec. 2, 2015), <http://www.proskauer.com/blogs/erisa-practice-center-blog/dol-proposes-to-bring-erisa-disability-denials-in-line-with-the-affordable-care-act-12-02-2015/>.

The claims procedure regulation furthers Congress' intent by establishing requirements that a plan's internal claims process must meet. 29 C.F.R. § 2560.503-1 (2000); Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70,246 (Nov. 21, 2000). The purpose of these regulations is to provide participants with the information needed for a meaningful review of their denial of benefits so that they can address the determinative issues. See *Grossmuller v. Int'l Union, UAW, Local 813*, 715 F.2d 853, 857-59 (3d Cir. 1983). This information must include an adequate explanation of the denial of benefits and a record of what evidence the plan relied upon in denying the benefit. The process must provide the participants with an opportunity to address the accuracy and reliability of that evidence and to have the plan consider the participants' arguments prior to reaching its decision. See *id.*; *Richardson v. Cent. States, Se. & Sw. Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981); *accord Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388, 393-95 (5th Cir. 1998); *Booton v. Lockheed Med. Benefit 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."); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 689 (7th Cir. 1992).

The typical administrative process pits an unsophisticated claimant, unfamiliar with the finer details of the plan, unaware of the necessity of critical thinking, and unsure of just how important the process is against a plan administrator who handles such claims every day, all day, and knows the rules backwards and forwards. Complete disclosure and transparency are necessary for the unsophisticated claimant to even have a chance of playing on the field.

Recently, plans have attempted not only to write ERISA protections out of the plan, but also to discourage claimants from even filing suit. The plans accomplish these goals through plan provisions ranging from shortened statute of limitations, e.g., *Davidson v. Wal-Mart Associates Health and Welfare Plan*, 305 F. Supp. 2d 1059 (S.D. Iowa 2004) (upholding 45-day limitation period to sue for benefit claims denial as reasonable), forum and/or venue selection requirements for filing suit, e.g., *Smith v. AEGON Cos. Pension Plan*, 769 F.3d 922 (6th Cir. 2014), shifting of evidentiary burdens, and requiring payment of attorneys' fees and expenses, if the claimant loses.³ Although any one of these provisions alone may be discouraging, many plans use more than one of these types of provisions. The rationale for these provisions can only lead to one conclusion – these provisions are designed to discourage claimants from filing suit to obtain their benefits, regardless of the merit of the claim. AARP submits that these types of provisions – especially taken collectively -- prevent claimants from receiving a full and fair review in violation of Section 503 of ERISA, 29 U.S.C. § 1133.

³ The Department should reiterate that except in the collective bargaining context, mandatory arbitration is prohibited under the internal claims procedure.

II. Reduction of Conflicts of Interest to Ensure Independence and Impartiality

AARP applauds the Department's attempt to resolve issues surrounding conflicts of interest and to ensure independence and impartiality. The examples provided are telling. Prohibiting the use of compensation and related employment matters to encourage the denial of benefit claims, even if the plan is not directly responsible for these employment decisions, is important. However, the second example is even more common. For decades, claimants have confronted the same problems with insurers and their handling of claims. More often than not, a medical reviewer who too often rules in favor of the claimant will not have that job for long. And there is no doubt that the insurers make sure that these reviewers know it. Indeed, medical experts frequently are selected because of their reputation for outcomes in contested cases. We think the Department's regulation can go even further to ensure impartiality and independence.

The only way a reviewer can be truly "independent" is to be subject to review and termination by both sides. If the reviewers know that only the insurance companies pay them, there exists an inherent bias to side with them – more often than not. Only if there is effective review of their decisions, and consequences for poor ones, will there be true independence. A court decision has suggested that even if a reviewer found 99 percent of the claimants who s/he reviewed not to be disabled the judge would not find that the reviewer was biased. See Section VIII., D., *infra*. The regulation should confirm that claimants are entitled to review disability claims that are similar to their claim to ensure that they are handled similarly.

One suggestion to improve the independence of reviewers is random audits of independent reviewers. A panel of physicians or other appropriate providers could perform random sampling of the determinations of the reviewer. If a significant disagreement between the panel and the review is revealed, one of two remedies could be imposed: 1) suspend that reviewer, or 2) put the reviewer on "probation" for two years during which time the reviewer must employ an independent panel to perform random audits of his or her medical reviews.

Finally, the regulation should clarify that any type of reviewer (e.g., claims adjudicators, medical reviewers, accountants, vocational experts) is included within its purview.

III. Improvements to Disclosure Requirements

AARP commends the Department's improvements to basic disclosure requirements that will assist claimants to better determine whether they should appeal their claims denial.

It is imperative for a plan to fully articulate the reasons and differences between the plan's decision and findings in contrast to those of other payers of benefits (such as the Social Security Administration). AARP suggests that the regulation emphasize that the plan cannot "draft" around this requirement, that is, a plan could not have a provision stating it has no duty to consider these other decisions.

AARP supports the requirement that the adverse benefit determination must contain the internal rules, guidelines, etc. that the plan used to deny the claim or a statement that such rules and guidelines do not exist. The regulations should emphasize that if the plan relies on an internal rule, the plan cannot maintain it is confidential and not disclose it. Moreover, the regulation should require that the plan provide a copy of the rule or guideline upon which the plan relied at the time the adverse benefit determination is issued. This requirement will short circuit the inevitable request for these documents and will facilitate a more expeditious and efficient claims process.

For the same reasons, AARP supports the requirement of including a statement that at the claims stage participants may request and receive documents that are relevant to their appeal. Relevance should be defined as every document in the claims file, whether or not the plan or insurer relied on, or even looked at, the document. The claimant should be assured that the information provided to the insurer or plan is in the claims file. In addition, the regulation should require the plan to specify which information the plan considered, relied on or generated. Finally, the regulation should specifically state that the Secretary rejects courts' interpretation requiring claimants to prove prejudice or detrimental reliance to obtain their claims file. *See, e.g., DiGregorio v. Hartford Comprehensive Emp. Benefit Serv. Co.*, 423 F.3d 6 (1st Cir. 2005) (holding participant had no right to her claims file unless she was able to show that the failure to receive it was prejudicial).

Finally, the Department should ensure that plan participants are aware of the exhaustion requirement by requiring that the requirement be included in the plan document and the Summary Plan Description. In addition, the notice of adverse benefit determination should state explicitly that all plan administrative remedies must be exhausted before a lawsuit can be filed, and that a suit filed in advance of exhaustion is likely to be dismissed. Such a requirement would further the expeditious and efficient resolution of claims.

IV. Deemed Exhaustion of Claims and Appeal Process

AARP appreciates the Department's attempt to provide claimants protection where the plan has not adhered to the requirements of Section 503 and we endorse the deemed exhaustion concept so that claimants may seek immediate court action. However, the regulation must explain what "minor errors" are. For example, a denial letter that does not provide an explanation of the information needed to appeal the benefit denial should not be considered a minor error. In addition, the regulation should explain the impact of collective "minor errors." Without such detail, claimants will be subject to another litigation issue. We also support the regulation's provision that permits refiling of the claim so that the claim would not be foreclosed by going to court too soon. This is especially important given the short internal statute of limitations that many plans have adopted.

We believe that the Department's position concerning the lack of deference to a plan's decision in this scenario makes sense because if a plan exercises discretion in violation of the law, a court has no appropriate exercise of discretion to which it can defer. *Cf. Mansker v. TMG Life Ins. Co.*, 54 F.3d 1322, 1328 (8th Cir. 1995); *Gritzer v. CBS, Inc.* 275 F.3d 291, 295 (3d Cir. 2002) (if plan does not exercise discretion, court will not defer to decision to deny benefits).

V. Adverse Benefit Determination

AARP is pleased that an adverse benefit determination now includes rescission of coverage. Loss of insurance coverage or benefits clearly adversely affects claimants potentially leaving them without coverage when they need it most. AARP submits that coverage should continue pending the outcome of an internal appeal. We note that rescission frequently occurs when an employer switches insurers or providers.

VI. Culturally And Linguistically Appropriate Notices

Many individuals are not proficient in English. AARP has always believed that individuals should receive all necessary information so that they can make informed choices about their benefits. AARP backs the requirement that plans must provide notices to claimants in a "culturally and linguistically appropriate manner." This requirement acknowledges the growing diversity of claimants of all ages and will help ensure that they can understand and exercise their rights.

Since 1977, the Department's regulation, 29 CFR § 2520.102-2(c), has required plans to provide those participants who are not proficient in English with access to language services. The threshold for these services depends on the size of the plan as well as the number and percentage of persons who are proficient in the same non-English language.

The proposed amendment would require a notice about language services only if a claimant's address is in a county where 10 percent or more of the population residing in that county, as determined by American Community Survey (ACS) data published by the United States Census Bureau, are literate only in the same non-English language. Prop. Reg. § 2560.503-1(p)(2).

AARP believes that the Department may have unintentionally reduced protections for non-English speaking participants. Although a particular county may not meet the current threshold requiring language services under the proposed rule, particular workforces may meet the Department's thresholds under § 2520.102-2(c). The final rule should clarify that non-English speaking participants could be eligible for language services under either the proposed rule or § 2520.102-2(c).

AARP also suggests that the Department amend its Model Statement of ERISA Rights for disability plans in order to include notification of eligibility for language services.

VII. The Department's Regulations Should Require Explicit Disclosure of Conditions that Limit Claimants' Rights to Pursue Benefit Claims.

Since the implementation of the Department's 2000 revisions to the ERISA claims regulations, it has become apparent that further measures are needed to clarify for claimants what is required of them and what they may expect in connection with the benefit claims process. If claimants do not take certain actions in presenting a claim in the first instance, it irreparably may prejudice the outcome of the process.⁴

- A. The Department should prohibit plan statute of limitations that are shorter than the general state statute of limitations.

The Department should prevent plan administrators from sidestepping statutes of limitations by providing in-plan contractual limitations that are shorter than the applicable state limitations that generally are between one to three years. Courts have held that a time limitation in ERISA plans as short as 45-days was a "reasonable" time limitation and thus was enforceable. See *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013); *Davidson v. Wal-Mart Associates Health and Welfare Plan*, 305 F. Supp. 2d 1059 (S.D. Iowa 2004) (upholding a plan-imposed 45 day claims-filing limitation); *Doe v. Blue Cross & Blue Shield of Wisconsin*, 112 F.3d 869, 875 (7th Cir.

⁴ For example, during the internal claims process, if claimants are late with responses, most courts have held that claimants have waived their rights. In contrast, if a plan is late with responses, claimants must show prejudice. There is no reason for this difference – both parties should be required to show prejudice.

1997) (suggesting a 30 days claims filing limitation is reasonable). Permitting a contractual statute of limitations undercuts the purpose of even having a statute of limitations. The Department should explicitly prohibit the modification of the state statute of limitations through the use of plan language.

If the Department will not prohibit such short statute of limitations, then when claimants receive an adverse benefit determination, they need to know the exact date upon which the plan believes that the statute of limitations runs, noting any tolling that would apply and under what circumstances. This may avoid confusion on the part of claimants as to their rights and any applicable limitations. This is especially relevant when the plan's contractual limitations period is shorter than the state statute of limitations and when the contractual accrual date for any claim differs from the accrual date under the law. The average participant simply cannot be expected to understand these concepts. Because participants must be told of their right to file a lawsuit, it makes sense to also require the plan to state the date by which it must be filed.⁵ If the Department finds any such rule to be onerous, it can be limited to situations where the plan has a contractual limitations period or when the plan has its own accrual rules.

Finally, the Department should declare that all applicable statutes of limitations and contractual limitations periods are tolled during the pre-suit administrative appeal process, including during any voluntary administrative appeal process or voluntary arbitration. Claimants are required to exhaust the administrative process before bringing suit to challenge a denial of benefits. The contractual statute of limitations may run when the claimant is unable to bring suit due to the requirement to wait for the resolution of the matter by the plan administrator. Currently, the circuit courts are divided on whether the statute of limitations on claims should be tolled during the administrative appeal process. Compare *White v. Sun Life Assur. Co. of Canada*, 488 F.3d 240, 252 (4th Cir. 2007) (statute of limitations tolled during the appeal process), with *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008) (statute of limitation accrues while appeal is pending), and *Abdel v. U.S. Bancorp.*, 457 F.3d 877 (8th Cir. 2006) (statute of limitations not tolled).

- B. In order for claimants to receive full and fair review of their benefit claims denial, the Department should prohibit the use of forum and venue selection clauses that are less favorable than the statutory provision.

Another provision being added by plans to discourage appeals of claims denials is forum and/or venue selection requirements. See *Smith v. AEGON Cos. Pension Plan*, 769 F.3d 922 (6th Cir. 2014) (requiring all lawsuits be filed in Cedar Rapids, Iowa). These provisions frequently are added to plans when mergers of companies or offices

⁵ We also suggest that the denial letter include a statement that the claimant has the right to retain an attorney to assist with the appeal, similar to Social Security denial letters.

occur. These provisions require claimants to litigate in a forum nowhere near their place of residence. *Carnival Cruise Lines, Inc. v. Shute*, 499 U.S. 585, 595 (1991) (forum selection and venue clauses place an immediate and excessive burden on claimants “forced to litigate in distant forums”). These clauses frequently conflict with ERISA’s venue selection provision:

Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

29 U.S.C. § 1132(e)(2).

When plans narrow the venue options where participants can bring claims, plans are removing rights explicitly afforded to individuals in ERISA’s venue provision. Indeed, forum selection and venue clauses directly conflict with the main remedial goal of ERISA - - to protect the rights of participants and beneficiaries by providing “ready access to Federal courts,” ERISA § 2(b), 29 U.S.C. §1001(b), as well as contravene ERISA’s requirement to provide claimants a full and fair review of benefit claims denials. The *Smith* case is illustrative. There, a Louisville, Kentucky resident was required to sue to challenge a benefits claim denial in Cedar Rapids, Iowa, a distance of 504 miles and 7 hours, 30 minutes of driving time (without traffic). *Smith v. AEGON Cos. Pension Plan*, 769 F.3d 922.

In order to ensure that claimants obtain full and fair review of their benefit claims denials, the Department should prohibit venue and forum selection provisions that are contrary to 29 U.S.C. § 1132(e)(2).

- C. In order for claimants to receive full and fair review of their benefit claims denial, the Department should prohibit plan provisions requiring claimants to pay the plan’s attorneys’ fees if they lose.

Under ERISA, attorneys’ fees may be granted by a judge’s discretion. 29 U.S.C. § 1132(g)(1). The Department should prohibit contrary provisions because they undercut Congress’ desire to ensure that claimants have ready access to courts to protect their benefits.

VIII. Because Claimants Bear The Burden Of Proof, The Rules For Producing Evidence Should Skew In Favor Of The Claimant.

- A. Claimants should have the opportunity to rebut any additional evidence offered by the plan.

Several circuits have prohibited claimants from rebutting evidence put forth by the plan and relied upon to deny benefits. *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161 (10th Cir. 2007) (plan was not required to make available for review and rebuttal medical reports it relied on), *accord Rizzi v. Hartford Life & Accident Ins. Co.*, 383 F. App'x 738 (10th Cir. 2010) ; *Ballmer v. Reliance Standard Life Ins. Co.*, 601 F.3d 497, 502-03 (6th Cir. 2010); *Midget v. Washington Group Int'l Long Term Disability Plan*, 561 F.3d 887, 896 (8th Cir. 2009) (full and fair review does not include reviewing and rebutting prior to determination on appeal); *Glazer v. Reliance Standard Life Ins. Co.*, 524 F.3d 1241 (11th Cir. 2008). This is particularly troubling because the burden is upon the claimant to establish his or her right to plan benefits. *See Ruttenberg v. United States Life Ins. Co.*, 413 F.3d 652, 663 (7th Cir. 2005). Prohibiting the claimant from responding to the plan's evidence not only denies the claimant an opportunity to fully plead his or her case at the administrative appeal level, but significantly impedes the claimant's prospects upon filing a lawsuit. Moreover, this rule permits the plan to decide whether the evidence the claimant wishes to proffer is "new" or "different" evidence. Finally, it permits the plan to "sandbag" the claimant by holding the reasons for the denial until a time when the claimant cannot respond. Because the administrative record is closed upon receipt of the final claims denial letter, the district court will end up relying only on unrebutted evidence put forth by the defendants. Such an outcome clearly contradicts the full and fair review requirements of ERISA.

We applaud the Department's decision to amend the regulations to conform to the health plan internal claims process requirements so that claimants have the opportunity to review and respond to any new or additional evidence put forth by the defendant. The claimant, not the plan, should get the last word in adding evidence to the claims file. This is consistent with civil court practice and is consistent with attempting to level the playing field between the expert plan and the unsophisticated claimant. The courts have expressed concern that if the claimant is allowed to address the plan's medical evidence, and the plan is then allowed to address the claimant's new evidence, it will result in an endless cycle of back-and-forth submissions *See, e.g., Metzger*, 476 F.3d at 1166. However, other courts have stated that they know from trial experience that this is never the case. Granting due process to both parties to address the other side's evidence has not resulted in an endless loop of submissions, and there is no reason to believe that such would occur if due process were allowed into the claims administrative process. Finally, we are unaware of any problems in the health plan context after the Department changed its regulation.

Regarding timing, we suggest that the regulation establish a maximum time of 75 days (*compare* with 29 C.F.R. § 2560.503-1(f)(3)) for the claimant to respond to the plan's provision of new or additional information. Although some may believe that 75 days is too lengthy, the reality is that the claimant is motivated to appeal in a lesser time, in order to obtain benefits, and the plan is not harmed since it is extremely rare that one claim can affect their financial or fiduciary concerns. We note that there may be times where 75 days may be too short a time to respond. For example, it will take a relatively short period of time for a claimant to respond to one report of a health care professional. However, it is a different process where, on appeal, the plan or insurer provides multiple reports (such as a neuropsychiatrist, an orthopedist, a functional capacity evaluation and a vocational report) to which the claimant must respond. In those cases, a longer response time may be needed. The Department should indicate that a plan's failure to grant a requested extension of time for a claimant to respond is arbitrary and capricious review.

Similarly, if the plan receives any additional materials relevant to the claim not previously provided to the claimant (such as materials provided by a health care professional), it must immediately provide those to the claimant and give the claimant the proposed 75 days to address them and submit additional evidence. In addition, the regulation should permit requests for extensions of time. Likewise, we endorse the tolling rule to encourage a complete dialogue between the parties. *E.g.*, *Booton v. Lockheed Med. Benefit 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.").

- B. In order for claimants to receive full and fair review of their benefit claims denial, they must be notified that they will generally be unable to introduce evidence after the final claims denial.

AARP suggests that the claims process would be greatly improved for claimants if the regulations were to include a required statement that in most scenarios the claims record closes when the claimant receives the final claims denial; that if the claimant chooses to file a lawsuit, the court will not consider any further evidence; and that it is essential that any evidence the claimant has to submit be submitted during the appeal process. Because most courts have concluded that no evidence may be presented after the closing of the record, *see, e.g.*, *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 616 (6th Cir. 1998), this information is essential to the participant. Claimants are typically unaware that upon the denial of the appeal they will be foreclosed from presenting any new evidence. In our experience, most claimants believe that ERISA benefit claims are no different from other legal claims – that court review will be de novo and that they will be entitled to present "all" their evidence to the judge. Because this is not so, and because the rules with respect to ERISA benefit claims are inconsistent with the reasonable expectations of even sophisticated laypersons, this information should be provided in the claims denial letter.

- C. The Department should promulgate a rule addressing the circumstances that justify the admission of claim evidence after the close of the administrative record.

ERISA cases are typically determined based upon the administrative record as it stood at the time of the final appeal. The courts have, however, occasionally granted that there are circumstances in which additional evidence may be permitted for consideration on appeal to the district courts. See, e.g., *Quesinberry v. Life Ins. Co. of North Am.*, 987 F.2d 1017, 1027 (4th Cir. 1993) (allowing additional evidence for “claims that require consideration of complex medical questions or issues regarding the credibility of medical experts” and “evidence regarding interpretation of terms of the plan”); *Locher v. Unum Life Ins. Co. of Am.*, 389 F.3d 288 (2d Cir. 2004) (uncertain review process justified additional evidence). In other cases, the courts have been reluctant to admit new evidence. See, e.g., *Opeta v. Northwest Airlines Pension Plan for Contract Employees*, 484 F.3d 1211 (9th Cir. 2007) (finding that the district court erred in admitting evidence outside of the claims record).

The Department should promulgate a regulation inserting an appropriate measure of flexibility in the standards governing the admission of evidence outside of the claims record. For example, an appropriate standard would permit the introduction of additional evidence to correct inaccuracies within the record, clarify language or other evidence that would have materially impacted the claims denial had the claimant discovered it during the administrative proceedings, etc. This type of regulation would ensure that the claims proceedings are conducted fairly and that the claimant is adequately protected.

- D. The Department should adopt a treating physician rule in order to ensure the most accurate claims processing record possible.

In *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), the Supreme Court held that a treating physician rule did not apply to ERISA plans because the Department had chosen not to adopt such a rule when the Department had issued its revised claims regulation in 2000. *Id.* at 831-833. The Court made it clear that had the Department properly adopted such a rule it would be entitled to deference. *Id.* at 831. AARP believes that the time has come for the Department to adopt a treating physician rule for disability and other claims similar to that adopted by the Social Security Administration.

Many court decisions indicate that the reviewing physicians hired by insurers may be conflicted, biased and/or otherwise unsatisfactory. See, e.g., *Solomon v. MetLife*, 628 F. Supp. 2d 519 (S.D.N.Y. 2009) (reviewer derived 99 percent of income from paper medical reviews for third parties, with well more than 55 percent of that income from Met Life); *Caplan v. CNA Financial Corp.*, 544 F. Supp. 2d 984 (N.D. Cal. 2008) (reviewer found no disability in 193 out of 202 cases); *Bernardo v. Am. Airlines*,

Inc., 297 Fed. Appx. 342 (5th Cir. Oct. 22, 2008) (finding an “unexplained gap” between the reviewing and treating physicians conclusions and finding that the reviewing physician’s “conclusions do not reflect a rational connection between the known facts and the decision to deny benefits”); *Denmark v. Liberty Life Assur. Co.*, 2005 U.S. Dist. LEXIS 27180 (D. Mass. Nov. 10, 2005) (insurer contracted with a medical reviewer that could not point to one instance where it had ever recommended payment of a claim); *Gunn v. Reliance Std. Life Ins. Co.*, 399 F. Supp. 2d 1095, 1105 (C.D. Cal. 2005) (characterizing physician-reviewer as a “man with a mission – to deny claims,” given the frequency insurer used the physician-reviewer). Many insurers hire the same physician-reviewers time and again. The consequences of a biased reviewing physician are compounded in situations in which the court applies a deferential standard of review. With the record closed, and with the only likely evidence being that chosen by the defendant, the claimant is unlikely to prevail.

Giving appropriate weight to the physician who has treated and examined the plan participant will help to ensure that the claims process is producing more accurate claims decisions, see *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), so that the court has the most complete and accurate record available for its review and the integrity of the process is maintained. It will also put an end to the battle of numbers where the insurer utilized a number of reviewers to counteract the treating physicians. See, e.g., *Thomas v. Liberty Life Assurance Co.*, 226 F. Supp. 2d 735 (D. Md. 2002) (insurer used four physician-reviewers to contradict the treating physician’s opinion).

At a minimum, the regulation should state that it is not reasonable, and therefore is arbitrary and capricious, for an insurer merely to state in its benefit denial that the reviewing physicians disagree with the treating physician(s). Rather, an insurer may reject a treating physician’s opinion only if there is a good reason, that is, a reason that goes to the adequacy or basis of the treating doctor’s opinion. Alternatively, the Department could adopt many of the same considerations as are stated in the Social Security regulations -- the amount of deference depends on the duration of the treatment relationship and frequency of evaluations, specialization of the treating physician, nature and extent of clinical examinations and corroborative medical testing, supportability, and consistency with the record as a whole. See Section II, *supra*.

IX. The Department Should Include Guidance Concerning Recoupment Of Overpayments.

- A. The amount of offset from any one benefit payment should be limited in order to minimize hardship to claimants.

Similar to recoupment for overpayments of pension payments by the PBGC, 29 CFR § 4022.82(a)(2), or offset of payments under the suspension of benefits regulation, 29 CFR § 2530.203-3(b)(3), the benefit claims regulations should specify procedures that a disability plan should use when recouping payments for any reason (e.g.,

subrogation, overpayments) from a participant. Although courts have upheld plan language that allowed employers to withhold the total amount of a benefit payment for unspecified lengths of time in order to recoup overpayments, *see, e.g., Northcutt v. Gen. Motors Hourly-Rate Emps. Pension Plan*, 467 F.3d 1031 (7th Cir. 2006), such an outcome contradicts the purposes of ERISA and instead adversely impacts a party that did not commit any wrongdoing. In order to prevent unnecessary hardship and to encourage plan administrators to make accurate payments, the Department should permit the plan to recoup or offset a maximum of 10 percent of the total amount of overpayment from any one benefit payment where the reason for the overpayment is not primarily the fault of the participant. The Department should also entirely prohibit recoupment or offset in cases where so doing would cause extreme hardship.

- B. Because recoupment of an overpayment concerns a participant's benefits, the benefit claims process applies.

When participants are informed that they have received an overpayment of their benefits, the letter does not inform them that they may challenge this determination through the plan's internal benefits claims process. AARP submits that this is a violation of ERISA's requirement for a full and fair review of benefits determination. Section 503 of ERISA, 29 U.S.C. § 1133. When participants receive these notifications of overpayment they typically do not receive a "Statement of ERISA Rights" describing the plan's review procedures and their right to sue in court. 29 C.F.R. § 2560.503-1(g).

Furthermore, these letters ordinarily do not notify the participants of the reason(s) or cause(s) for the overpayment. A plan should be required to provide both an explanation as well as a work sheet showing the new calculation as compared to the original calculation. Not surprisingly, most participants are suspicious of the accuracy of the new calculation.

In any event, the proposed amendments should clarify that recoupments of disability benefit payments are subject to the internal benefits claims process.

X. The Department Should Clarify The Meaning Of "One Honest Mistake."

The Department should issue guidance on the meaning of "one honest mistake" in light of *Conkright v. Frommert*, 559 U.S. 506, 513 (2010). For example, the Department could state that it believes that the burden of proving "one honest mistake" is on the plan or insurer. The Department could also state that any pattern or practice of bad faith claims handling (such as the well-documented issues involving UNUM Life Ins. and CIGNA) or a finding from a state insurance department of incorrect or poor claims handling nullifies a claim of a single honest mistake. In addition, the Department could state that the handling of a particular claim where the plan has consistently ignored evidence would not be "one honest mistake."

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AARP appreciates this opportunity to provide its additional views on the proposed rule updating the claims benefit process. If you have any questions, please feel free to contact me or Michele Varnhagen of our Government Affairs office at 202-434-3829.

Sincerely,

A handwritten signature in cursive script, appearing to read "David Certner".

David Certner
Legislative Counsel and
Legislative Policy Director
Government Affairs