

JOHNSTON LAW OFFICE
131-A Stony Circle, Suite 500
Santa Rosa, California 95401
(707) 939-5299
Fax (707) 837-9532
e-mail: RichardJohnstonEsq@gmail.com

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Via electronic mail transmission to e-ORI@dol.gov

The Honorable Phyllis C. Borzi
Assistant Secretary for Employee Benefits Security
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 CFR § 2560.503-1

Dear Ms. Borzi:

I write to comment on proposed amendments to claims-procedure regulations for ERISA-governed disability benefit plans. These regulations interest me greatly because, in my law practice, I focus on representing claimants in disputes respecting these sorts of claims. I have considerable experience in how these regulations impact claimants and the claims process, as I have represented both claimants and institutional defendants in ERISA disability disputes over my 29-year legal career.

I have organized my comments as follows. First, I discuss areas where DOL should make a substantive change in the proposed regulations. Second, I discuss the most important technical issues; these comments will not address the substance of a proposed regulation, but will offer suggestions for greater clarity or conformity with other regulations.

I. Comments on Substantive Matters in the Proposed Regulations

A. Comment on Notice of Applicable Statute of Limitations

DOL has invited comment on statute-of-limitation issues in the wake of the Supreme Court's decision in *Heimeshoff v. Hartford Life & Accid. Ins. Co.*, 134 U.S. 604 (2013). This is a crucial area for regulation; *Heimeshoff* has generated significant confusion and protracted litigation. The regulations should impose standards for reasonable plan-based limitations provisions in the same way they already impose deadlines in other respects. Since *Heimeshoff* left open the possibility that a plan-based limitations period could run even before the internal-appeal process is complete (and even where exhaustion is

mandatory), the regulations should clarify that this approach fails to provide the full and fair review required by 29 USC § 1133. Already I have had claimants approach my office with likely-meritorious claims that were potentially foreclosed by the application, under *Heimeshoff*, of a respective plan-based deadline. Additionally, because contractual limitations periods are plan terms, the claimant should receive—from the plan—clear and timely notice about the limitations period as required in connection with other plan terms. As the DOL aptly points out in the preamble to these proposed regulations, plan administrators are in a better position to know the date of the expiration of a limitations period, and should not be hiding the ball from their claimants if they are to fulfill their fiduciary obligations.

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*, 2014 WL 562557, *4 (E.D. Mo.), *aff'd sub nom. Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 790 F.3d 799 (8th Cir. 2015). This, however, is a minority perspective. Here, DOL should do more than interpret its own rules; it should re-write them to ensure claimants are made aware of any plan-based deadline to initiate litigation and to avoid ambiguity.

I recommend an amendment to the regulations governing the manner and content of notification of benefit determinations on review. See 29 CFR § 2560.503-1(j) [proposed regulation]. The amended regulation should require the claims administrator to notify the claimant of a date certain for the expiration of any plan-based limitations period; the regulations should also define just what a reasonable limitations period is. This would resolve different courts' views on when claims “accrue” and make clear that no limitations period can start before the internal claim and appeals process is complete. It should also provide that there must be at least a one-year period after the completion of the plan's appeals process in which a claimant may file suit. This would cut down on litigation over the threshold issue of the impact of a plan-based limitations period, and may well lead to a salutary standardization of plan-based limitations periods.

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

29 CFR § 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. 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 one 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-law 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).

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

DOL clearly wishes to improve things for claimants who are ambushed with new rationales or evidence during internal appeal. Indeed sandbagging has been a persistent problem in the ERISA appeals process, and some courts have recognized the prejudice to claimants. In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), for example, the court observed:

[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.

Given that it is often very hard to supplement the record in litigation, the proposed change offers some assurance that a claimant can contribute his or her relevant evidence to the

record that the court will review. Once in court, the claimant, as plaintiff, has the burden of proof on most issues, so this only makes sense—in most litigation contexts, the party with the burden of proof is given the last word. Here, giving the last word to the claimant during the claims appeal process is, in effect, giving claimant an appropriate right of rebuttal in litigation.

There is, however, a countervailing concern. First, this extra opportunity to submit proof to the plan will frequently mean that claimants must extend the time during which they must subsist without benefit payments. Plans, for their part, have protested with notable hyperbole that giving the claimant the last word will make the internal appeals processes go on “forever.” This is out of touch with the reality of being an ERISA disability benefits claimant. These claimants, in my experience, would not—and could not—continue the process *ad nauseum* while they are unable to pay their mortgages and feed their families.

The following suggestion places reasonable limits on both claimants and plan administrators and responds to the concern that claimants and plans 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 proffered by the plan may require hiring an expert such as another physician, psychologist, or vocational consultant. These professionals are not always readily available for quick turn-arounds and, depending on the new information they are responding to, they may need weeks to evaluate the new information. For this reason, claimants should have at least 60 days to respond to new evidence or rationales provided by the plan on appeal. And the period for the decision on review to be completed should be tolled during this 60-day period. When the claimant has responded, the plan administrator should be allowed whatever time was left under the existing regulations or 30 days, whichever is longer, to issue its determination on review. This rule should apply whether the new information is a new “rationale” or new “evidence.”

Accordingly, I suggest the following amendment to the proposed regulation (new language indicated by bolding and underlining):

29 CFR § 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 the claimant before the decision on appeal is issued and the claimant must be afforded at least 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 then 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.

C. Independence and Impartiality - Avoiding Conflicts of Interest

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

First, the proposed regulation should make clear that impartiality must be ensured, even where the plan is not itself 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.

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 in turn by a claims adjudicator. Under this logic, plans may argue that consulting experts are not affected by the impartiality regulation.

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

In light of these concerns, I suggest that the proposed regulation language be amended as follows (added language is bolded and underlined):

29 CFR § 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.

Alternatively, or additionally, the regulation should provide that if a conflict plays any part in the decision to retain, hire, or compensate a claims handler or other expert, the decision would violate the regulations. In light of these concerns, I suggest that the proposed regulation language be amended as follows (added language is bolded and underlined):

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

Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made, **in whole or in part**, based upon the likelihood that the individual will support the denial of benefits.

D. Opportunity to Supplement the Record

The EBSA has not issued any regulations on this topic; it should. Many meritorious disability claims are denied—and courts affirm these denials—because of issues regarding the scope of the record on review in the court. For instance, Social Security Disability Insurance decisions, which are the focus of some of the proposed rules, are often crucial to proving disability claims. However, the Social Security Administration (SSA) takes considerable time in issuing its decisions, and SSA's ruling often comes well after the final denial on appeal of a disability plan. This is true as well for other kinds of evidence. Even where it would be easy to do so, plan administrators often refuse to consider this type of evidence, choosing instead to shut the door on a meritorious claim. And plans often counterclaim against claimants to recover contractual offsets based on an SSA benefit. *See, e.g., Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). Indeed in my experience it is not at all unusual for a claims administrator to expedite an appeal decision precisely to avoid having evidence of a pending SSDI decision make it into the claim file.

There is a clear solution to this that would track the Fifth Circuit's *en banc* holding in *Vega v. National Life Ins. Serv., Inc.*, 188 F.3d 287, 300 (5th Cir. 1999), where the court wrote:

We hold today that the administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it. Thus, if the information in the doctors' affidavits had been presented to National Life before filing this lawsuit in time for their fair consideration, they could be treated as part of the record. Furthermore, in restricting the district court's review to evidence in the record, we are merely encouraging attorneys for claimants to make a good faith effort to resolve the claim with the administrator before filing suit in district court; we are not establishing a rule that will adversely affect the rights of claimants.

In light of *Vega's* holding, I recommend a rule that would require the plan administrator to accept and review evidence and treat it as part of the record, so long as it is sent in time for the administrator to consider the evidence before litigation is commenced.

The regulation as presented, requiring a claims administrator to meaningfully distinguish the views of treating physicians or other entities that are paying benefits, will be helpful. Administrators often ignore evidence that is favorable to the claimant. In my experience, if the administrator pays any attention at all to contrary opinions, that is addressed with boilerplate denial-letter verbiage having nothing to do with the respective claim. Because of this claimants cannot mount a much of a response. This is the antithesis of full and fair review. Sometimes courts don't understand the difference between the type of explanation required by ERISA and this empty, meaningless boilerplate. Assuming that this regulation is intended to change plans' reliance on this sort of explanation, or on wholesale failure to address contrary evidence, I am in favor of the regulation.

Moreover the regulation requiring a discussion about the difference between the plan's decision and awards made by other systems, such as Social Security, should provide for deference to these other (and almost always more impartial) decision-makers. The regulation could use the same language as regulatory settlement agreements between various state insurance commissioners and insurers such as UNUM. For example, in the regulatory settlement agreement UNUM was required to follow, this language was used:

The Companies must give significant weight to evidence of an award of Social Security disability benefits as supporting a finding of disability, unless the Companies have compelling evidence that the decision of the Social Security Administration was (i) founded on an error of law or an abuse of discretion, (ii) inconsistent with the applicable medical evidence, or (iii) inconsistent with the definition of disability contained in the applicable insurance policy.

Including similar language in the proposed regulation would help assure that plans give the appropriate weight to an award made by another entity.

II. Comments on Technical Matters in the Proposed Regulations

A. Effective Date of Proposed Regulation

The beneficial holding in *Abram v. Cargill*, 395 F.3d 882 (8th Cir. 2005), was seriously undermined when the Eighth Circuit later concluded that *Abram* was grounded in the pre-2000 version of the claims regulations, and would not apply to cases decided under post-2000 regulations. See *Midgett Washington Group Int'l LTD Plan*, 561 F.3d 887, 894-96 (8th Cir. 2009). To avoid this sort of problem occurring again, the following suggested

language should be added to the proposed regulations:

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

B. Notice of Right to Request Relevant Documents

The regulation concerning notice of the right to request relevant documents contained in 29 CFR § 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 CFR § 2560.503-1(h)(4)(i) [proposed regulation]. Attorneys understand the language of (g)(1)(vii)(C), but lay persons, who are the actual participants and often not represented, may not realize what rights are given here.

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

29 CFR § 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.

C. Deemed Exhaustion Drafting Issue

This regulation should be edited to clarify that the deemed exhausted provision applies to both claims and appeals, not just “claims.” Certainly, if there is a violation of the regulations, the claimant should be able to invoke judicial remedies regardless of whether the violation occurs in the “claim” or the “appeal” stage. I suggest the following clarifying language (added language is bolded and underlined):

29 CFR § 2560.503-1(l)(2)(i) [proposed regulation]

In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim **or appeal**,

D. Deemed Exhaustion of Claims and Appeals Processes

I am pleased that DOL has undertaken to clarify the consequences that will result when the plan does not comply with the regulations’ procedural requirements. DOL has

wisely separated the consequences into two categories, i.e. for serious violations and for minor violations. I see four areas that could be improved in the proposal.

First: the applicable standard of judicial review requires clarification because of a potential conflict between language in the preamble and the proposed regulation. The preamble says: “in those situations when the minor errors exception does not apply, the proposal clarifies that the reviewing tribunal *should not give special deference to the plan's decision, but rather should review the dispute de novo.*” The emphasized language clearly contemplates that a court should exercise de novo review. However, the regulation itself says: “if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review *without the exercise of discretion by an appropriate fiduciary.*” 29 CFR § 2560.503-1(l)(2)(i) [proposed regulation]. I anticipate that plans will argue that this emphasized language does not go so far as to require a court to exercise de novo review. For example, this language could mean simply that the plan did not make a decision and another plan review would be ordered, rather than de novo judicial review. To avoid a potential ambiguity on this point, I suggest the following amendment to the proposed regulation (added language is bolded and underlined):

29 CFR § 2560.503-1(l)(2)(i) [proposed regulation]

if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary, **and the reviewing tribunal should not give special deference to the plan's decision, but rather shall review the dispute de novo.**

Second: the portion of the proposed regulation concerning refiled appeals requires clarification. The claimant whose appeal is refiled may need to supplement the record for the refiled appeal, since it is likely that his attempt to communicate with the plan was compromised. I suggest amending the regulation to require the plan to give the claimant notice of his or her right to supplement the appeal.

Third: the phrase “reasonable time” could cause confusion. Ten days seems reasonable.

Fourth: for the same reasons described above with regard to the appropriate standard of judicial review, it would be beneficial to specify the standard of judicial review is de novo when the court does not remand. I suggest the following amendment (added language is bolded and underlined, deleted language shown by strikeout):

29 CFR § 2560-503-1(l)(2)(ii) [proposed regulation]

If a court rejects the claimant's request for immediate review under paragraph (l)(2)(i) of this section on the basis that the plan met the standards for the

exception under this paragraph (l)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within a reasonable time **ten days** after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission **and notify the claimant of the right to supplement the appeal if she chooses. If the court accepts the claimant's request for immediate review, the court will retain jurisdiction and decide the case applying de novo review.**

E. Right to Claim File and Meaning of "Testimony"

The new regulations' references to "testimony" are unclear.

In the preamble, DOL has stated: "the proposal would also grant the claimant a right to respond to the new information by explicitly providing claimants the right *to present evidence and written testimony* as part of the claims and appeals process." Note the emphasized 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 CFR § 2560.503-1(h)(4)(i) [proposed regulation]. Here the regulation imposes no limitation to "written" testimony.

By comparison, the current regulation uses the following language: "[the process must] provide claimants the opportunity *to submit written comments, documents, records, and other information* relating to the claim for benefits." 29 CFR § 2560.503-1(h)(ii)(2)[current regulation].

Thus, the preamble and the proposed regulation are inconsistent; the preamble specifies "written testimony" and the proposed regulation just says "testimony." This could lead to costly disagreements over whether the regulation contemplates actual live testimony, i.e. a hearing. Under the current regulation, claimants sometime submit testimony in the form of an audio or video CD. This is particularly useful in cases where the claimant cannot read or write so that a written statement is impossible. It is also helpful in those cases where actually seeing the claimant might be important. I am concerned that the reference to "written testimony" in the preamble might give plans ammunition to unduly disallow any audio or video submissions. If this were the interpretation given to the language in the proposed regulation, it would actually make things worse for claimants than they are now.

Further, the proposed regulation's verbiage, i.e. "evidence and testimony" might 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 at the ready. But claimants, who often represent themselves, are not equipped to understand, much less apply, the standards potentially suggested by the phrase "evidence and testimony." The agency should make clear 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

A. Adverse Benefit Determination to Include Rescission

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

B. Disclosure of Internal Rules etc.

DOL's proposed regulation regarding disclosure of internal rules or criteria used to make a disability benefit decision, 29 CFR § 2560.503-1(g)(1)(vii)(B) [proposed regulation], is helpful because internal rules, guidelines, protocols, standards, claims manuals, and similar materials often create hidden plan terms that the claimant is unable to learn of or discover in order to address them in the appeal. I am currently litigating a case where a third-party claims administrator applied internal criteria to my client's claim that were materially different (and more onerous) than the criteria imposed by the plan itself; this ought not to occur at all, much less be an issue requiring judicial scrutiny. Moreover, 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 contravenes a most basic premise of ERISA: benefits must be administered "in accordance with the documents and instruments governing the plan." 29 USC § 1104. In addition, much litigation would be avoided if the claimant could know what criteria he needed to meet in an appeal. See, e.g., *Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111, *10 (S.D.N.Y.); *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 (D.Ariz. 2007). Given that the regulations require adverse benefit determinations to include the reasons for the denial and the applicable plan terms, this additional requirement should not be onerous and would promote the dialogue between claimant and plan that ERISA contemplates. *Booten v. Lockheed Med. Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) ("in simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries.").

C. Venue Selection Provisions Inconsistent with ERISA

There is a serious issue that is not addressed in the proposed regulations that should be considered. The regulations should provide that ERISA's broad venue provision cannot be thwarted by contrary plan or policy provisions. Some courts have permitted plans to draft around ERISA's venue requirements. At a minimum, the present state of the law means that there will continue to be litigation on this question before the merits of a dispute can even be reached. Venue selection clauses are mostly used to disadvantage ERISA claimants in litigation or create barriers to their statutory right to sue. *McQuennie v. Carpenters Local Union 429*, 2015 WL 6872444, *5 (D. Conn.) (pro se litigant allowed to sue in home state of Connecticut because he could not afford to travel to California); *but see Turner v. Sedgwick Claims Mgmt. Servs.*, 2015 WL 225495 (N.D. Ala.). In *Turner* the court encouraged the agency to regulate in this area as opposed to filing amicus briefs in some cases and not others. *Id.* at 21 (“[a]lso underwhelming is that the Secretary has expressed his view only rarely, through the ad hoc, highly informal means of amicus briefs in private litigation, rather than in a regulation, an enforcement setting, or even in a published statement of policy or guidance.”). I am concerned that other courts will take this same point of view, which would harm disability claimants.

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

D. Notice of Right to Retain Counsel for Appeal

Often ERISA claimants who have been wrongly denied disability benefits don't realize that they have the right to be represented in the administrative appeal process. Not knowing what evidence would have proven their claim to the plan administrator, and limited by the administrator or the court in submitting any new evidence in support of their claims in later litigation, they have often squandered their last, best opportunity to prove a meritorious claim. I propose that the DOL adopt a regulation that benefit denials must advise claimants of their right to hire an attorney to represent them in the appeal phase. The Social Security Administration does this; there is no reason to hide this right from ERISA claimants.

Thank you for the opportunity to comment on these very important regulations.

Very truly yours,


Richard Johnston