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By Mail: Office of Regulations and Interpretations,
Employee Benefits Security Administration
Room M-5655
U.S. Dept. of Labor
200 Constitution Avenue NW
Washington D.C. 20210

Re: Claims Procedure Regulations for Plans Providing Disability Benefits
RIN No.: 1210-AB39
Regulation: 29 C.F.R. §2560.503-1

Dear Assistant Secretary Borzi:

These comments are submitted on behalf of the New York City-Southern New York Chapter of the National Multiple Sclerosis Society. The Chapter serves the thousands of New Yorkers living with Multiple Sclerosis (“MS”) and their families by providing comprehensive support services and educational programs and by funding a national research initiative seeking the cause, treatments and cure for this chronic neurological disease. There are more than 12,000 people affected by MS in the area covered by the Chapter, which includes New York City and the Counties of Westchester, Rockland, Putnam, Orange and Sullivan. Many of these individuals are totally disabled and are completely dependent on ERISA disability benefits and Social Security disability for their livelihood. The importance of having a claims procedure that assures that they receive a full and fair review cannot be overstated.

Our organization strongly supports the proposed regulations which will significantly improve the processing of claims at insurance companies, and will make the process more fair and accountable.

We narrow our comments to the five areas that we believe will be most beneficial to the ERISA disability claims of individuals suffering from the disabling effects of MS. In summary, our comments address:

1. Adding a New Section Permitting Claimants the Opportunity to Reopen Claims Under Certain Circumstances
2. Clarifying the meaning of “persons involved” and “based upon the likelihood” in (b)(7)
3. Granting Deference to Social Security Disability Awards

4. Clarifying the Applicable Statute of Limitations
5. Lowering the Threshold for Culturally and Linguistically Appropriate Notices

1. Adding a New Section Permitting Claimants the Opportunity to Reopen Claims Under Certain Circumstances

The Department should add a new section to the proposed regulations that gives claimants the opportunity to reopen administrative remedies prior to a lawsuit being filed. We recommend a rule that permits a claimant to reopen administrative remedies using as a model based on Federal Rules 59(e) and/or 60(b)(2). The Department could put a time restriction on it, such that a claimant can reopen the appeal within 180 days of the close of administrative remedies as a matter of right, and then thereafter, could reopen administrative remedies if he or she has newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move to reopen administrative remedies within the initial 180-day period. The Department could make clear that reopening of administrative remedies pursuant to this right does not enlarge or otherwise stay the statute of limitations.

Such a right would alleviate the need for a lot of litigation, and would assure that insurance company determinations are more fair. Often relevant information is simply not available during the timeframes established by the current regulations. Moreover, the savings from avoiding needless litigation would more than offset any additional cost that insurers must bear in order to reopen administrative remedies.

Such a right would be consistent with 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.

Such a right would help many of individuals suffering from MS.

First, many individuals suffering from MS are in search of a proper diagnosis for a significant period of time. Many of the symptoms of MS also mimic other illnesses, making the initial diagnosis difficult. For many, administrative remedies are exhausted before a firm diagnosis of MS is even made.

Second, many individuals with MS also seek Social Security disability benefits. In the New York Metropolitan region, it could take over two years before SSDI benefits are finally awarded. At that point, administrative remedies have already been exhausted.

Third, many individuals with MS in our geographical region are non-English speakers or are otherwise unsophisticated. Before ever consulting with a lawyer, they often do their own appeal, sending in a short letter to the insurer asserting that the insurer was incorrect. The insurer then denies the appeal and closes the record. Because these individuals did not create an adequate administrative record, their claim has very little chance of success in court. This result is extremely unfair, particularly when there is no requirement that the insurer even warn the claimant that he/she has the right to obtain an attorney and/or that if information is not sent to the insurer during the appeal, a court will not consider it later.

Having a procedure to reopen a claim would help these claimants get a full review. While it is important that claims be considered expeditiously and in a cost-effective manner, having a procedure to reopen claims under certain circumstances is worth the added delay and/or cost. Without it, many claimants with meritorious claims are being denied a full review and then a meaningful day in court.

2. Clarifying the meaning of “persons involved” and “based upon the likelihood” in (b)(7)

We propose the following changes to subsection (b)(7)(added language is bolded and underlined) in order to clarify which persons are “involved” with the decision and to clarify what is meant by “based upon the likelihood”:

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, in **whole or in part,** that the individual will support the denial of benefits.

First, the proposed regulation should make clear that impartiality is ensured, even where the plan, itself, is not directly responsible for hiring or compensating the individuals involved in deciding a claim. This clarification is necessary because, as a practical matter, plans almost always delegate the selection of experts to third-party vendors who, in turn, employ reviewing doctors and other experts.

Second, the regulation should make clear that if the conflict plays any part in the decision to retain, hire, or compensate the claims handler or other expert, the decision would violate the regulations. As currently drafted, the regulation could lead to added litigation over whether instances of “mixed-motive” are prohibited.

3. Granting Deference to Social Security Disability Awards

The proposed regulation as written would be helpful but we believe that a deferential review requirement would be more helpful to individuals suffering from MS, many of whom are also awarded SSDI benefits, under stricter standards than those in their ERISA policies. We recommend

that the Department use the same language as the regulatory settlement agreements that have been used by many state insurance commissioners in response to concerns about disability claims processes used by 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 be helpful to assure that plans give the appropriate weight to an award made by the SSA.

4. Comment on Notice for Applicable Statute of Limitations

The DOL has invited comments on the statute of limitations issues that have developed since the Supreme Court's decision in *Heimeshoff v. Hartford Life & Accid. Ins Co.*, 134 U.S. 604 (2013). We agree that this is a crucial area for regulation as the *Heimeshoff* decision has created confusion and much litigation. The DOL can assist by creating standards for what is a reasonable plan-based limitations provision in the same way that the DOL used its regulatory power to create timing deadlines for the claims process in prior versions of the regulations. Since *Heimeshoff* left open the possibility that an internal limitations period could run before the appeals process is complete (even where exhaustion is mandatory), the DOL is in a good position to clarify that such an approach would deny a claimant a full and fair review as required by 29 U.S.C. §1133. Additionally, because contractual limitations periods are plan terms, the claimant should receive notice about the limitations period from the plan just as is the case 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 the limitations period and should not be hiding the ball from claimants.

We recommend an amendment to the regulations adding a new (j)(7) and making the existing (j)(7) in the proposed regulations, into (j)(8):

(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. the administrator provides notice to the claimant of the date that the contractual limitations period will run; and

d. the contractual limitations period will not abridge any existing state limitations period that provides for a period longer than one year.

(8) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (p) of this section).

This amendment will give needed clarity to both the claimant and the insurer. It also will assure that a claimant has sufficient time to file a lawsuit by mandating that the limit be at least a year. A minimum period is needed for individuals with MS because many of them are dependent on caregivers for not only their medical care, but also for managing their financial affairs. Caregivers often are preoccupied with day to day care needs and medical crises, and need sufficient time to focus on legal issues.

5. Lowering the Threshold for Culturally and Linguistically Appropriate Notice

As the proposed regulations are presently drafted, the requirements of section (p) are triggered when the percentage of a county's population in a specific non-English language is 10% percent or more. This provision is unhelpful to many if not most of the non-English language populations in NYC, which consists of 5 distinct counties, New York County (Manhattan), Kings County (Brooklyn), Bronx County, Queens County and Richmond County (Staten Island). According to Wikipedia, approximately 800 languages are spoken in New York City, and 36% of the City's population is foreign born. Because the population is so large and the diversity of the population is so high, any given non-English language group is unlikely to satisfy the 10% threshold. Therefore, an unintended and regrettable consequence of the proposed regulation as written would be to leave uncovered the vast majority of non-English language claimants in NYC even though NYC is the situs of a significant percentage of all non-English individuals in the United States.

We believe that the requirements of (p) should be triggered by a 5% County threshold, instead of a 10% County threshold. This will put the regulations on par with the requirements of Medicare and Medicaid. In addition, we urge the Department to add an alternative threshold requirement that will help cover non-English language groups in NYC--The threshold of Section (p) should alternatively be satisfied if 5% of the plan's participants are from the same non-English language group.

CONCLUSION

As an organization, we applaud the Department's efforts in drafting the proposed regulations. We strongly support them, and believe that they will make the claims and appeals process more full and fair. We believe that individuals suffering from MS will benefit even more with the five important changes outlined above.

Sincerely yours,

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cc. Anne Davis, Esq.
Director, Legal Programs & Services