

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:

I write to offer comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans.

As an attorney who works in a law firm where one of the primary area of practice is representing individuals in ERISA-governed disability benefit disputes, 29 C.F.R. §2560.503-1 impacts both me and my clients. I currently practice with an attorney who has practiced in this area for nearly 25 years, and is familiar with the impact of the changes made to the claim regulation in 2000. He has personally represented well over 3500 individuals in ERISA claims and litigation since he accepted his first ERISA case in 1991. He has lectured and written on the topic of ERISA claims and litigation numerous times, including CLE conferences sponsored by the American Bar Association and The Florida Bar. He has also chaired an ERISA Litigation Group for the American Association for Justice. I offer the following comments:

Context:

The vast majority of disability plan administrators (or at least claim decision-makers) are insurance companies. In *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2350 (2008), the Supreme Court clearly stated that ERISA imposes,

higher than marketplace quality standards on insurers ... [a] special standard of care ..., namely, that the administrator “discharge [its] duties” in respect to discretionary claims processing “solely in the interests of the participants and beneficiaries” of the plan, [under ERISA, 29 U.S.C.] §1104(a)(1)...

Id. This emphatic statement regarding the standard to which the Court holds these administrators must be reflected in the claim regulations.

Comment on Requiring Administrator to Explain Why It Rejected Treating Medical Professional Opinions and SSD Decision and Proposed Additional Language:

I applaud the DOL for suggesting the addition of the language articulated in proposed regulation §2560.503-1 (g)(vii)(A) and (j)(6)(i) requiring an explanation for why treating physician or agency decisions were rejected. However, the addition should extend to vocational rehabilitation opinions that are often used in disability claims, as well as a requirement that administrators actually explain how they weighed the evidence in the claim. This should include not only why a professional’s opinion was rejected, but also why another professional’s opinion was relied upon.

Disability plan administrators will commonly accept one medical or vocational source’s opinion over another. However, unlike other fact finders such as the federal district courts or Administrative Law Judges in Social Security Disability claims, ERISA disability plan administrators do not have to explain the reasons why weight was provided to one provider over another. This hampers federal court review, because administrators are free to accept one provider over another without explaining why the selected provider was better qualified or position to offer an opinion, or why that provider’s rationale was more reliable than another’s.

To remedy this problem, I propose the addition of the following bold/underlined language to the language proposed for addition to §2560.503-1 (vii)(A):

(A) 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 **or vocational rehabilitation** professionals 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 the disagreeing with their views or decisions **and an explanation of every reason why a particular professional's view was selected over another.**

Limited the administrator's requirement to why it rejected a particular professional's view requires the administrator to provide only half of the story. By mandating that administrators explain why other professional's views were relied upon, reviewing courts will have insight into whether a principled decision was made. A reviewing court will also have clear facts upon which it can determine if the administrator made a correct or reasonable decision under the applicable standard of review.

Comment on the "Minor Errors" Provisions of Proposed Rule §2560.503-1(l)(2)(ii):

As articulated in the proposed rule and preamble, deemed exhaustion will not be available in the case of "minor errors." This proposed rule presents significant hurdles in light of common insurance administrator practices that include serial requests for additional information. Many carriers will wait until a large portion of the time to decide the claim passes, and then send out 2, 3, or even several request for information over the course of a few weeks. These requests often create an environment where insurers repeatedly claim that any deadlines are tolled while responses to various requests are outstanding, without stating when the tolling expires or what the "new" decision deadline is. When one also considers that a claimant is not afforded any type of extension to his or her appeal period, the "minor errors" provisions off the proposed rule are inequitable, because they create an environment where the administrator has greater rights than the claimant. The proposed rule also creates uncertainty, because one cannot know the actual decision deadline in play.

The proposed rule does not appear to change the administrator's deadline (i.e. the number of days). However, it easily will create a quagmire in which many claims will descend. Administrators are encouraged to fail to make a decision within the maximum 90 day period, yet claim that one of the various minor errors applies to the claim.

I acknowledge that a "pattern or practice" exception is included in the proposed regulation, but proof of such a pattern or practice will be difficult and primarily anecdotal. Further, a claimant will have to be fortunate enough to hire experienced plaintiff ERISA counsel to tap into their knowledge base of past claims. Because the plaintiff's bar is quite limited in ERISA cases, this may prove to be very difficult. Worse, proving the pattern or practice will prove to be very costly for both sides in ERISA litigation, as there are no standards for demonstrating the level of proof required when arguing that such a pattern or practice existed. If this proposed rule is kept, continuing to place the burden of proof on plan administrators to rely upon this exception is crucial.

Comment Related to 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." Presumably, if there is a violation of the regulations, the claimant can seek review regardless of whether the claim is in the "claim" or the "appeal" stage. I suggest the following clarifying language (added language is bolded and underlined):

29 C.F.R. §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**,

Comment on Notice for Applicable Statute of Limitations:

The DOL has invited comment related to 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). I agree that this is a

crucial area for regulation as the *Heimeshoff* decision has created confusion and 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 violate full and fair review required by 29 U.S.C. §1133. Additionally, because contractual limitations periods are plan terms, the claimant should receive notice about the limitations period from the plan just as is the case with other plan terms. As the DOL aptly points out in the preamble to its 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 if the plan administrator is functioning as a true fiduciary.

One court has interpreted the existing regulations to require notice of the expiration of a limitations period. *Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, No. 4:12CV53 HEA, 2014 WL 562557, at *4 (E.D. Mo. Feb. 13, 2014), *aff'd sub nom. Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 790 F.3d 799 (8th Cir. 2015) (“[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of [ERISA] following an adverse benefit determination on review.” 29 C.F.R. § 2560.503–1(g)(iv)). This is a minority perspective. Here, the DOL should do more than interpret its own rules; it should re-write them to remove any ambiguity.

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 amended language should require the claims administrator to notify the claimant of the date of the expiration of any plan based limitations period and should include a definition of what is a reasonable limitations period. Such an alteration takes care of the different courts' views on when claims “accrue” in that it makes clear that no limitations period can start before the internal claim and appeals process is complete. It also makes clear that there will be at

least a one-year period after the completion of the plan's appeals process in which a claimant can file suit. The justification for this rule is that it would cut down on litigation devoted to the threshold issue of the running of the limitations period. In addition, it may well lead to a standardization of internal limitations periods that would be salutary for both claimants and plan administrators.

Accordingly, 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 no earlier than 1 year after the date of the claimant's receipt of the final benefit determination on review including any voluntary appeals that are taken;

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

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

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

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

The DOL clearly wishes to improve things for claimants who are ambushed with new rationales or evidence during review on appeal. I commend this effort, since sandbagging has been a persistent problem in the ERISA appeals process and some courts have not appreciated how prejudicial this is to claimants. In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), the court articulated the problem as follows:

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

Id. 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. Where the claimant, as plaintiff, has the burden of proof on most issues, 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 the right of rebuttal in litigation.

There is, however, a countervailing concern that while this extra opportunity to submit proof to the plan exists, claimants will be extending their time without benefit payments. This is a problem that already exists and could be exacerbated. Plans have protested that giving the claimant the last word will make the internal appeals processes go on forever. This argument is out of touch with the reality of being an ERISA disability benefits claimant. These claimants, in my experience, would 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 will have to wait too long for determinations on review. While claimants will want to make fast work of their responses because they are usually without income during this process, the type of evidence they often need to respond to new evidence or rationales by the plan may require hiring an expert such as another physician, psychologist, or vocational consultant. These professionals are not always readily available for quick turn-arounds and, depending on the new information such experts 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. Moreover, 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):

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.**

Comment and Suggest Language Related to Notice of Right to Request Relevant Documents:

The regulation concerning notice of the right to request relevant documents contained in 29 C.F.R. §2560.503-1(g)(1)(vii)(C) [proposed regulation] is an improvement since it was formerly missing from the regulation. However, it would be more helpful to claimants to use the words "claim file," which is plain language and is consistent with the amendment at 29 C.F.R. §2560.503-1(h)(4)(i) [proposed regulation]. Attorneys understand the language of (g)(1)(vii)(C), but lay persons, who are the actual participants and often not represented, may

not realize what rights are given here. It also would be more helpful to specify that the claim file includes documents contained in the administrator's computer system, not just paper copies or selected records.

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

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

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to **the claimant's claim file, including** copies of all documents, records, and other information relevant to the claimant's claim for benefits, **to include any information kept in digital or electronic format.** 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.

Comment Related to Disclosure of Internal Rules etc.:

The DOL's proposed regulation regarding disclosure of the internal rules or criteria used to make a disability benefit decision, 29 C.F.R. §2560.503-1(g)(1)(vii)(B)[proposed regulation], is 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. As is true in the healthcare context, plans sometimes argue that internal criteria are confidential or proprietary. But keeping the rules that are used to administer a plan a secret is inconsistent with the most basic premise of ERISA. Benefits must be administered "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104. In addition, much litigation would be avoided if the claimant could know what criteria he or she needed to meet in an appeal *See e.g. Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111, at *10 (S.D.N.Y. Jan. 30, 2004); *Craig v. Pillsbury*, 458 F.3d 748, 754 (8th Cir. 2006)(decrying the use of "double-secret" plan terms);

Samples v. First Health Group Corp., 631 F. Supp. 2d 1174, 1183 (9th Cir. 2007). Given that the regulations require adverse benefit determinations to include the reasons for the denial and the applicable plan terms, this additional requirement should not be onerous 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.”).

Proposal to Adopt Language Requiring Notice of Right to Retain Counsel for Appeal:

Often ERISA claimants who have been wrongly denied disability benefits do not realize that they have the right to be represented in the administrative appeal process. Not knowing what evidence would have proven their claim to the plan administrator, and limited by the administrator or the court in submitting any new evidence in support of their claims in later litigation, they have often squandered their last, best opportunity to prove a meritorious claim. More individuals than I can count have called me over the years and expresses surprise at the way the record is closed once the final appeal decision is issued in ERISA cases. Not only claimants, but many attorneys fail to not understand the standards of review or the significance of submitting all substantive evidence before the final decision is made by the administrator. 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, and that they will not have the opportunity to submit additional evidence once the final decision is made, including during a lawsuit.

Respectfully submitted,

/s/ Lauren M. Pulido

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