



January 19, 2016

**By Electronic 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:

I write on behalf of the National Alliance on Mental Illness of Massachusetts (NAMI Massachusetts). I offer comments on behalf of this constituency on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. I am interested in the content of these regulations because NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services and treatment, and is steadfast in its commitment to raising awareness for all of those in need. Since our inception in 1979, NAMI has been dedicated to improving the quality of life of individuals and families affected by mental illness.

Many people who go on disability insurance can, with treatment and time, return to work and again be productive members of society. However, safeguards must be in place to ensure that the disability insurance coverage they have to cover some of the costs associated with their recovery from mental illness are fairly and effectively administered.

I would like to offer my comments on just a few of the proposed regulations that I view as most pertinent to people with mental illness that we serve at NAMI Mass.

**1. Adequate Notice for Applicable Statute of Limitations**

The DOL has invited comment 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). I 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 violate full and fair review required by 29 U.S.C. §1133. Additionally, for claimants, it is imperative that they receive notice regarding any contractual limitations periods that may be within the terms of the plan. Such notice should be given regarding these limitations, in the same way notice is given to claimants regarding 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 if the plan administrator is functioning as a true fiduciary. While this is an accurate statement as applied to all claimants, it is particularly critical when dealing with claimants with mental illness. Making sure insureds are notified in plain language about their rights under their disability plans is crucial. Rewriting the regulations to remove any ambiguity is imperative. These policies are meant to protect individuals during perhaps the most vulnerable time in their life. Clear language should be used informing them of their rights.

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 defines 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. This timeframe is necessary, particularly when a claimant suffers from mental illness as they may need assistance in not only understanding their rights, but also in finding appropriate advocacy for their claim.

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; and**

**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; and**

**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).

## **2. Opportunity to Supplement the Record**

Although the EBSA has not chosen to regulate about this issue, it should do so. Many meritorious disability claims are denied and the courts affirm these determinations because of issues regarding the scope of the record on review. 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 time in issuing its decisions and the SSA's ruling often occurs after the final denial on appeal of the disability plan. This is true as well for other kinds of evidence. Even where it would not be a problem to do so, plan administrators often refuse to consider this type of evidence, choosing instead to shut the door on a meritorious claim. For many people with mental illness, it may take some time to get proper treatment. Rushing them to prove their limitations is simply not justified.

Meanwhile, plans will often counterclaim to recover the offset that is provided by the SSA benefit. See *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). Sometimes a claims administrator may rush an appeal decision through simply to avoid the claimant being awarded SSDI benefits and being forced to deal with such evidence in the claims 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.

*Id.*

In light of this holding from *Vega*, 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.

### **3. Discussion of the Decision and Its Relationship to SSDI or other Disability Awards**

The regulation requiring a discussion about the difference between the plan's decision and awards made by other systems, such as Social Security, should be expanded to set forth a deferential review requirement. The regulation could utilize 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 Group. For example, in the regulatory settlement agreement Unum was required to follow, the following 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 ensure that plans give the appropriate weight to an award made by another entity. For claimants suffering from mental illness, this is critical as they are often awarded Social Security disability benefits and without any explanation whatsoever, an insurance company will simultaneously deny their claim for disability benefits. This is highly confusing to any claimant as they have just been told by a federal agency that their medical records support a finding that they are not able to work in any occupation. A claimant in this situation deserves to understand why the very same medical records can be reviewed by an impartial agency and the opposite conclusion reached by a self-interested insurance company. Someone with mental illness may or may not have insight into

their illness and how it affects their ability to function. Many families face great strife in their attempts to help their loved ones, obtain appropriate treatment and ensure financial stability. Faced with these diametrically opposed opinions from the Social Security Administration and an insurer charged with the same evaluation only adds to their level of confusion and chaos.

#### **4. Notice of Right to Retain Counsel for Appeal**

Claimants with mental illness and their families are often in need of advocates to assist them in navigating the confusing waters of health care and disability benefits. More often than not, 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 should be submitted to prove their claim to the plan administrator, and limited by the administrator or by a reviewing court in submitting any new evidence in support of their claims in later litigation, ERISA claimants often squander 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. This type of notice is not uncommon. The Social Security Administration does so. There is no reason to hide this right from ERISA claimants.

Thank you for your time and consideration in reviewing my comments. Please do not hesitate to contact me with any questions or concerns.

Sincerely,



Laurie Martinelli, JD, MPH  
Executive Director