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Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW, Room N-5666
Washington, DC 20210

Attention: Claims Procedure Regulation Amendment for Plans Providing Disability Benefits

Submitted Electronically to e-ORI@dol.gov and via the Federal eRulemaking Portal at *http://www.regulations.gov*.

Subject: Claims Procedure for Plans Providing Disability Benefits (RIN 1210-AB39)

To Whom It May Concern:

On behalf of Sun Life Financial, we offer these comments with respect to the amendments to the claims procedures for disability income insurance proposed by the Department of Labor ("DOL" or "Department"). Sun Life Financial entities offer group disability policies to approximately 18,400 employers nationwide.

We appreciate the opportunity to provide the Department with our comments, as the amended regulations will have a significant and lasting impact not only upon the administration of ERISA-governed disability claims, but also upon the very existence and nature of the employee welfare benefit plans under which such disability coverage is offered.

With respect to each of the amended regulations at issue, we have endeavored to (1) comment upon the proposed amendment; (2) provide an alternative proposal that we believe will better accomplish the intended purpose of the amendment, while also avoiding the unintended and detrimental consequences of the proposed amendment; and (3) revise the language of the amended regulation at issue to comport with our suggested alternative proposal.

I. RIGHT TO REVIEW AND RESPOND TO NEW INFORMATION (Section (h)(4)(i),(ii) and (iii))

These proposals require a plan to provide the claim file to the claimant during the claim review process and to allow the claimant to provide "testimony" and "evidence" as part of the review process. (See (4)(i)). These proposals also require that, before an appeal determination can be issued, the plan provide to the claimant as soon as possible and sufficiently in advance of the date upon which the determination is due, the following documents or information so that the claimant has an opportunity to respond in advance of the determination deadline:

- any "new or additional evidence" considered or generated by or at the direction of the plan, so that the claimant has an opportunity to provide a response on such evidence; and
- any "new or additional rationale" on which the appeal benefit determination will be based. (See (4)(i) and (ii).)

A. Comments and Alternative Proposals

1. Section (4)(i): These proposed amendments are placed under Section (h), "Appeal of adverse benefit determinations," so it appears that these amendments are intended to apply only to the appeal process. Therefore, we ask that the Department clarify Section (4)(i) by deleting the reference to "claims [process]" such that (4)(i) will apply only to the "disability benefit appeals process," which clarification appears to comport with the Department's intent. In the event the Department intended to apply these changes to the initial benefit determination process, then we suggest that the Department reconsider its position, as such amendments are not necessary for the following reasons: Following receipt of an initial adverse benefit determination, the claimant has a right, free of charge, to a copy of the claim file and group policy, along with any other relevant documents as defined by the current regulations. This would include any independent medical evaluation ("IME") reports or other medical reviews. If a claimant chooses to appeal, then the claimant has 180 days to review the relevant documents, including the claim file, and prepare his appeal. As part of the appeal, the

claimant may submit his response to any medical information, including any IME reports or other medical reviews. These responses are considered by the plan administrator as part of the appeal review.

We also ask the Department to delete the reference to "testimony" in Section 4(i), as information during the appeal process is submitted by documentary evidence, and therefore the reference to "evidence" accounts for any written statement the claimant may wish to submit. We also note that the Department's preamble to the proposed regulations uses the phrase "*written* testimony," which appears to confirm the Department's intent to limit evidence to written submissions. If the Department has some other meaning in mind with respect to "testimony," we ask that this term be further defined.

We address the Department's proposal that the claimant be allowed "to review the claim file" as part of the "claims and appeals process" in connection with Sections (h)(4)(ii) and (h)(4)(iii), below.

Because the claimant has the ability under the current regulations to present evidence as part of the claims process and the appeal process, which ability will be retained and expanded in some form under the amendments, we believe there is no need for Section 4(i), and ask that it be deleted. However, if the Department deems it necessary to maintain Section 4(i), then we ask that the Department consider adopting our suggested revisions as set forth above, and our alternative proposals and suggested revisions of the language applicable to Sections (4)(ii) and (4)(iii) as set forth below.

2. <u>Section (h)(4)(ii)</u>: With respect to the appeal process, it does not serve any useful purpose to allow the claimant to review the entire claim file during the pendency of the appeal while the appeal remains a work in progress. It appears that the Department's primary concern is that there be ongoing communication between the plan and the claimant. Our concern is not with the goal, but with the logistics of achieving that goal. The vast majority of disability claims determinations hinge on the medical evidence. We believe our comments, below, which set forth an alternative proposal, fully address the Department's goal by allowing the claimant an opportunity to review and comment upon any medical report, including any IME report, obtained or generated by the plan during the appeal. Our proposal also resolves concerns about delays to the timing of the appeal process that would necessarily result from the claimant's review of the claim file, when and how such reviews should take place, and the costs of such reviews. These concerns must be weighed against the merit, if any, of allowing unfettered access to the claim file before it is complete and before any appeal decision has been made.

Although the Department's stated goal is to coordinate claim procedures for disability claims with procedures for medical claims, there is a vast difference between these two types of claims. Most medical claim determinations are automated; most disability claims are not. By their nature, disability claim decisions require manual and thoughtful processing. Claims personnel routinely consult with doctors and other specialists. This is good for claimants and is required by the regulations. However, having more people involved in the claim evaluation process takes time. If claimants are given time to comment upon and respond to new evidence and new rationales, then plans must be given adequate opportunity to review these comments and responses and to have trained specialists provide advice regarding these comments and responses so that plans can render accurate decisions.

We suggest that the Department clarify this section by revising "new and additional information" to "new medical reports or reviews, including any Independent Medical Evaluation ("IME") reports, that discuss new evidence or render new opinions."

The plan would consider the claimant's response to the medical review(s) as part of the appeal process. This would likely require that the claimant's or claimant's doctor's response be read by the plan's medical reviewer(s) and commented upon. Whether and how the claimant's response affects the disability determination would then be addressed in the determination letter. It does not appear that the Department contemplated, by way of the proposed amendments, that the claimant and plan should engage in an endless back and forth of reviewing and replying to the other's review and comments, as this would not serve the interests of either party, and would unnecessarily prolong the appeal process and the decision. Therefore, under our proposal a claimant would be permitted access to a new medical report generated by the plan as part of the appeal process so that the claimant may submit his response or comments on that new medical report, which the plan will then consider as part of its appeal evaluation and before it renders a determination on review. This accomplishes the Department's goal of giving the claimant a chance to weigh in on the medical evidence before a determination is made. Obviously, the plan will always have, and must necessarily have, the last word because it is the plan that must make the benefit determination.

Further, to keep the appeal on track and ensure that it is not unduly delayed while exchanging this medical information with the claimant and allowing the claimant time to respond, we suggest that the claimant be given 21 days from the date the plan sends the new evidence to the claimant to provide his responses to the plan, that the 45-day decision period be tolled during this 21-day period (or less, if the claimant provides the plan with his response in less than 21 days), and that the plan be given the greater of

14 days or the remainder of the 45-day decision period to issue a decision upon receipt of a claimant's response. We believe this provides the claimant a reasonable time to provide his response, while also keeping the appeal process moving forward such that a decision can be timely rendered.

Suggested Revision to the Proposed Language of Section (h)(4)(ii): "Provide that, before the plan can issue an adverse benefit determination on review of a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any medical report, including any independent medical evaluation ("IME") report that includes new evidence, that was considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; the claimant shall have up to 21 days from the date the plan sends such medical report(s) to the claimant to provide the plan with a response on the medical report(s). The time for an appeal determination shall be tolled from the date the plan sends the medical report(s) to the claimant until the date the plan receives the claimant's response(s) to the medical report or expiration of the 21-day response period, whichever occurs first. The plan shall render its decision as soon as practicable but in no event shall the plan have less than 14 days after the date it receives the claimant's response or expiration of the claimant's 21-day response period, whichever occurs first, to render its determination on review."

3. Section (h)(4)(iii): In the event that a new reason is relied upon by the plan for an adverse determination on review that was not relied upon as part of the initial claim decision, the practice of the industry, in accord with well-developed case law, is to provide the claimant with the right to appeal the new basis for the determination. This type of situation occurs infrequently, and we see no reason to amend the regulations to alter the current requirements. Therefore, we ask that Section (4)(iii) be deleted.

If the Department deems it necessary to proceed with this proposed amendment, then we ask that "new or additional rationale" be revised to "any new reason" to clarify this reference consistent with the well-developed case law. "Any new reason" includes those situations on appeal in which the plan finds that there is an entirely new basis or grounds to support an adverse benefit determination that was not relied upon as part of the initial claim decision. For example, if the initial decision is that the claimant is not disabled, and then on appeal the plan either upholds or overturns the initial decision, but also determines that the claimant is not eligible for disability coverage or that a plan provision applies to exclude coverage for the claimant's disability claim, this is a new reason for the appeal determination on review.

Suggested Revision to the Language of Section (h)(4)(iii): We ask that

the language of Section (h)4(iii) be revised consistent with our proposal, above, and with the time and tolling requirements of our suggested revision of Section (h)(4)(ii), as follows: "Provide that, before the plan can issue an adverse benefit determination on review of a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new reason the plan contends supports an adverse benefit determination; the claimant shall have up to 21 days to provide a response to the new reason to the plan. The 21-day response time shall run from the date the plan sends the new reason the plan contends supports an adverse benefit determination to the claimant. The time for an appeal determination shall be tolled from the date the plan sends the new reason for the adverse benefit determination to the claimant until the date the plan receives the claimant's response to the new reason or the 21-day response period expires, whichever occurs first. The plan shall render its decision as soon as practicable, but in no event shall the plan have less than 14 days after the date the plan receives the claimant's response or expiration of the claimant's 21-day response period, whichever occurs first, to render its determination on review."

II. IMPROVEMENTS TO BASIC DISCLOSURE REQUIREMENTS

In Section (g)(1)(vii)(A)("Manner and content of notification of benefit determination") and Section (j)(6)(i)("Manner and content of benefit determination on review"), the proposed amendment requires, in the event the plan did not follow or agree with the views of the claimant's treating physicians, or the decisions of other payers of benefits who granted the claimant's similar benefits, a discussion of the basis for the plan's disagreement with their views and/or decisions. The proposed amendment states: "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;"

A. Comments and Alternative Proposal

Whether a claimant is entitled to disability benefits is a determination that must rest upon the terms of the plan, including but not limited to the plan's definition of "disability." The burden is on the claimant to prove he is "disabled" as defined by the plan. This proposed amendment upends one of the founding principles of ERISA, which is, the claim administrator is not to look beyond the terms of the plan to determine whether the claimant meets the terms of the plan. Further, the Supreme Court has held that ERISA plans are not required to defer to and accept the opinion of the treating

physician. *The Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003).

The reference to "the views" of treating healthcare professionals is very broad, and it is not clear what is intended by this reference. "Views" is not synonymous with a healthcare professional's opinion or conclusion about whether a claimant is disabled. In fact, many healthcare professionals do not provide an opinion on the claimant's disability at all, and if they do, they are not providing an opinion of disability as defined by the plan. Further, a typical claim file may contain hundreds, if not thousands, of pages of medical records from various doctors, nurses, and physical therapists. To require a plan to discuss why it did not agree with the "views" expressed by a myriad of healthcare professionals does nothing to help explain why a claim administrator found that the claimant was not disabled under the terms of the plan.

The references to "other payers of benefits" and "similar claims" are similarly broad, and it is not clear what these references are intended to encompass. To the extent these references encompass other disability insurers, we have concerns about such a requirement, as the terms of some other plan or policy are completely irrelevant, and the judgment and discretion used by another claim examiner should have no bearing on the plan's decision. Another plan or policy will have its own eligibility requirements, terms, conditions, exclusions, etc., all of which will differ, and none of which are relevant to, the plan under which the decision must be made. A claim administrator should not be required to review another insurer's claim file and policy or plan, and then be forced to distinguish the other insurer's decision from the determination it made under the plan. In fact, a claimant would likely complain – and rightly so – if a claim administrator relied upon another disability insurer's denial to support a determination that the claimant is not disabled under the plan.

Further, the time and labor involved in obtaining and reviewing another claim file -- which could run hundreds to thousands of pages -- imposes an undue burden upon the claim process and would surely result in delayed claims handling, and would add no merit to the claim decision. Significantly, the decisions of other disability insurers would have to be monitored and tracked constantly, as the claimant's right to disability benefits depends in general upon the claimant's proof of his continuing disability each month; therefore, another disability insurer's decision that a claimant is disabled under the terms of that insurer's policy is not static and permanent, but rather, is subject to change and the other insurer may issue a new claim determination as the claim progresses. This proposed amendment would require plans to regularly obtain and review the on-going claim files and decisions of other insurers, and continuously determine whether their decisions are the same as, or differ from, other insurers' most recent decisions, and then issue a written explanation to the claimant to explain the

difference, if any.

To the extent that "other payers of benefits" of 'similar claims" is also intended to include payers of worker's compensation benefits, mandatory short-term benefits, state disability benefits, medical or health benefits, and the like, we object for the same reasons as set forth immediately above. We also have concern with the notion that these claims are "similar" to ERISA disability claim benefits. The standards applicable under these other programs for determining "disability" vary considerably and would have no relevance to disability determinations under a plan, and often involve plans or policies with completely different terms and standards for entitlement to disability benefits.

This proposed amendment, by using the language "presented by the claimant" with respect to each category of information – the views of healthcare professionals and the decisions of other payers of benefits -- also leaves the choice entirely up to the claimant as to what the claimant submits or does not submit to the plan for comment. If another disability insurer denied his benefits claim, then the claimant need not submit this decision to the plan, or may elect not to submit certain medical records that may not favor disability. If adopted as currently worded, this proposed amendment therefore gives the claimant the right to choose only that information that may support his disability, with no requirement that he submit ALL such information, whether it may weigh in favor of disability or not.

It is the general practice of the industry to review Social Security files and determinations submitted by a claimant, and explain why the plan came to a different conclusion. Social Security files tend to be small files, with an award letter that is short and succinct, and therefore do not require the same investment of time and labor that other disability files would generally entail. Once the Social Security Administration renders a decision, disability files tend to be static, unlike disability files of private plans which change constantly as they are updated. The primary problem here is that obtaining the Social Security file can take many weeks or months and much of the time a plan needs that file in order to determine the basis for a Social Security decision and the evidence that supports such a decision. This too causes delays in the disability claim process.

We agree that Social Security determinations should be addressed by the plan, and therefore, propose the following suggested revision to these two Sections:

Suggested Revision to the Language of Section (g)(1)(vii)(A) and Section (j)(6)(i): "A discussion of the decision, including, to the extent that the plan did not follow or agree with a disability benefit determination by the Social Security Administration, the basis for disagreeing with the decision by the Social Security Administration;"

III. EXHAUSTION OF ADMINISTRATIVE REMEDIES

A. Comments and Alternative Proposal:

We have significant concerns about the proposed amendments regarding the exhaustion of remedies. As the goal of the Department is to reduce ERISA disability benefit litigation, these amendments, as presently drafted, will undoubtedly have the opposite effect by allowing claimants to file suit over any perceived claim procedure violation, thereby truncating the claim review process and leading inevitably to lengthy litigation over whether the violation was minor and non-prejudicial. This will lead to premature litigation, countless remands of the claim by the courts to the plan, and unnecessary and lengthy delays of the claim determination. Moreover, by permitting such suits without advance notice to the plan except in the claimant's discretion, claimants will miss opportunities for the plan to clarify misunderstandings, and provide explanations for or correct minor violations before the parties incur substantial litigation costs. The Department may suggest that claimants are not anxious to file suit and are not likely to do so unless the claim process is fatally flawed. However, this misses the potential gamesmanship that can occur where a lawsuit is filed with the hope that the plan will find settlement less costly than litigation costs or where an unscrupulous plaintiff's attorney anticipates a fee award if he can achieve a remand for further review, even without achieving a monetary award for the claimant.

1. Section (l)(2)(i): By way of example, these proposed amendments will spawn litigation where the dispute will be whether the plan "strictly adhere[d]" to "all" requirements of this section (referring to the language in the first sentence of Section (l)(2)(i)); further, this section states that once the exhaustion is deemed denied, ". . . the claimant is free to pursue any 502(a) remedies on the basis that "**the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.**" (emphasis added)(referring to the language in the second sentence of Section (l)(2)(ii)). Therefore, it appears that the Department intended that the lack of strict adherence to any or all requirements of this section would result in a

failure to provide a claims procedure that would yield a decision on the merits of the claim, yet it is without dispute that not all violations would lead to such a result. Therefore, there is a significant disconnect between the first and second sentences of (l)(2)(i). This disconnect is not "repaired" by (l)(2)(ii), but rather, (ii) only further confuses the issue in that it appears to provide certain exceptions to the "deemed exhausted" remedy, but those exceptions do not appear to have anything to do with whether a plan failed "to provide a claims procedure that would yield a decision on the merits of the claim," which is the standard set forth in (i). With respect to the last sentence of Section (l)(2)(i), we have doubts about the Department's authority to dictate judicial review standards, especially when this amendment appears to contradict binding United States Supreme Court authority. This sentence appears to allow a claimant to take away a plan's discretion simply by filing a Complaint with a court alleging that the plan has not adhered to all requirements of this section, with no requirement that the claimant actually prevail in court on the merits of those allegations. In other words, the Department is proposing that discretion is taken away merely on the basis of unproven allegations. This is grossly unfair, and there is simply no reason for such a harsh result with no requirement of an actual violation of this section, or that the violation caused the claim process to be futile or otherwise meaningless for the claimant.

2. <u>Section (l)(2)(ii)</u>: This Section raises a host of issues ripe for disputes between claimants and plans that will give rise to a volume of litigation not previously seen in the ERISA disability benefits realm. For example, disputes will arise whether a violation is "*de minimis,"* and even if such violation is shown to be *de minimis*, this proposed amendment will require the parties to dispute whether that *de mimimis* violation nevertheless has already caused or could cause in the future ("likely to cause") "prejudice or harm" to the claimant. First, to the extent that this amendment allows for a "likely to cause" scenario, then it essentially asks the parties to speculate on what may occur in the future, and thereby invites premature disputes and eventually, premature litigation. Next, there is no test or standard set forth for what constitutes "prejudice" or "harm" or what degree is required to satisfy this section; further, this prejudice or harm must be "to the claimant," which does not in any way speak to prejudice or harm to the claim process or the claim determination. Even if it is shown that the violation did not cause and is not likely to cause prejudice or harm to the claimant, the plan must still prove that the violation was for "good cause" or "due to matters beyond the control of the plan" AND that the violation occurred "during an ongoing, good faith exchange of information between the plan and the claimant." This raises questions concerning what constitutes "good cause" or what may be "beyond the [plan's] control," and whether the exchange of information was "ongoing" or in "good faith" or even whether an "exchange" of information was taking place. By way of example on the "exchange" of information, if

the plan asks for certain information from the claimant, and the claimant does not send the information to the plan or refuses to do so, do these circumstances constitute an "exchange"? One could certainly see arguments falling on both sides of that question.

In the end, one has to ask, if no harm flows from a violation why does any of this matter? If there is no harm to the claim process it should not matter whether the violation was *de minimis* or not, or whether there was "good cause," or whether it was part of a good faith exchange. Harm or prejudice to the claim process ought to be the sole criterion.

But even after all that, the potential disputes continue based upon the proposed amendments to Section (l)(2)(ii): Even if the plan proves a *de minimis* violation did not and is not likely to prejudice or harm the claimant, AND that such violation was for good cause or due to matters beyond the plan's control AND that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant, the dispute is not over: Next, the parties will have to resolve whether "the violation is part of a pattern or practice of violations by the plan."

Before addressing the language here, a preliminary question is this: Why does a "pattern and practice" of *de minimis* violations that have not and will not cause harm or prejudice to the claimant, and which were for good cause or beyond the plan's control and which occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant, *actually give rise to an exception from the exception?* In other words, the likelihood is that violations that are *de minimis* and that cause no harm to the claimant or to the claim process will not be part of a pattern or practice but will instead be the result of human beings unintentionally making human mistakes.

Alternatively, if the Department did not intend that so-called "pattern and practice" violations be *de minimis* violations that cause no harm, then it raises the question, "What type or nature of violation must the claimant be subjected to, that is also be part of a pattern and practice of such violations?" Based upon the current draft of the proposed amendment, the violation at issue would necessarily have to be any time that the plan did not "strictly adhere" to "all requirements of this section [(l)(2)(i)]."

But, under (i), a claimant merely has to allege – not prove – a violation; he would then apparently be entitled to "pattern and practice" discovery WITHOUT any showing that the violation at issue caused any harm. This cannot be what the Department intended. And it makes no sense in light of section (ii), which recognizes that not all violations involving less than strict adherence to the requirements result in harm. Yet

(ii) arguably does not allow the parties to first address – or to *ever* address in certain situations -- whether the alleged violation at issue caused harm or did not cause harm before immediately jumping to "pattern and practice" violations ("This exception is not available if the violation is part of a pattern or practice of violations by the plan.") If the claimant's complained-of violation did not cause harm, then it does not serve anyone's interest to jump to "pattern and practice" violations. And for the sake of argument, even assuming a pattern and practice of violations that harmed other insureds, it does not mean that the violation in dispute harmed this particular claimant.

The "pattern and practice" language of Section (l)(2)(ii) raises many concerns. What constitutes a "pattern and practice" of violations? If a violation occurs, it arises within the particular facts and circumstances of a specific claim. What gave rise to a violation in one matter may differ entirely from what gave rise to a violation in another matter. What may be a *de minimis* violation that caused no harm in one claim may have caused harm had it occurred in the context of another claim, as each claim is different. Therefore, it is wrong to characterize these two violations, with different consequences, as a "pattern and practice." Moreover, the "pattern and practice" language would require the parties, and the courts, to hold mini-trials on other violations occurring in other claim files with other claimants who have nothing to do with the particular claim at issue or, for that matter, the alleged violation in dispute in the particular claim at issue.

Another issue is at what point may a claimant seek evidence from the plan of a "pattern and practice"? There is no requirement here that, before a claimant is allowed to request "pattern and practice" information, the claimant must first establish that a violation has occurred in his claim process that in some way prejudices or harms him (or whatever the test may be. As pointed out above, it is not clear what the resulting harm from the violation must be to obtain the "deemed exhausted" remedy.) Yet, if a claimant has not shown a violation has occurred on his claim that has caused the requisite (as yet undefined) harm, then there is no reason a claimant should be able to obtain any information about alleged violations from the plan involving other third-party claim files.

Again, one must ask – why this concern over violations if there is no harm or prejudice to the claims process or the ability to obtain a claim determination on the merits? If there is no harm or prejudice to the claimant, then pattern and practice does not matter.

Next, Section (l)(2)(ii) allows the claimant to request a written explanation of the violation from the plan, and the plan must explain why the violation should not cause

the "deemed exhausted" remedy. As a preliminary matter, this amendment assumes that a violation has occurred. It is unclear when the claimant is allowed to request such information – is it only in the context of an alleged *de minimis* violation (as this right appears in the section on *de minimis* violations); further, there is no time limit within which the claimant is required to request such information. For any meaningful dialogue to take place, there should be a requirement that the claimant must make such a request, and that such request must be made within a reasonable time after the alleged violation has occurred but in no event later than a certain number of days, such as 10 or 15 days.

Next, Section (l)(2)(ii) states that if a court rejects the claimant's request for an 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, the claim shall be considered as re-filed. This does not take into account the unavoidable delay that will arise while the case works its way through the litigation process. As part of any federal litigation process, the parties will have to engage in a number of court appearances and make mandatory filings with the court, all long before the claimant is able to file its motion with the court on the exhaustion issue. For example, this litigation process, per the Rules of Civil Procedure, requires the parties to meet and confer to file the Joint Scheduling Order, engage in Automatic Disclosures, attend the mandatory Rule 26(f) Conference with the Court, engage in whatever discovery may be allowed once the court has considered and ruled upon the parties' respective discovery motions, and then, ultimately, the parties will be allowed to file their respective briefs and opposition and reply briefs on the exhaustion issue. It is typical that the filing of such briefs would not take place for 8 to 12 months after the claimant files suit. And given the heavy docket of the courts, it is not unusual to wait months and often longer, for the court's ruling. Therefore, the claimant and plan would often be waiting, at a minimum, 8 to 12 months for the court to rule on the exhaustion issue.

If the court rules against the claimant, then the claim is remanded to the plan (as the proposed amendment recognizes). The delay that would necessarily be caused while the case was in court would detrimentally affect the claim process. With the passage of so much time, the information in the claim file would grow stale. The plan would have to re-review the file to determine where the claim process stopped and what the next steps should be to get the claim back on track to a decision.

The proposed amendments could also negatively impact the claimant in those instances when the plan decides the claim in the claimant's favor. A sizeable gap of time would always result while the litigation process occurs and the claim process is "on hold", during which time the plan would have had no information of the claimant's

condition and alleged continuing disability. Therefore, even if the plan determines the claimant is disabled, the plan could only pay benefits up to the most recent date for which information is available in the claim file. The claimant would then be in the unfortunate position of having to play "catch up," and submit the required information for the "gap" of time during which the claim process was on hold due to the litigation, in order to demonstrate that his disability continued after the date to which benefits had been paid.

In sum, the proposed amendments would create disputes that may otherwise not exist or have no effect on the claim process, and lead to a tsunami of interlocutory litigation that no one wants.

We advocate maintaining the current text of (l) that is in effect today, and adding language to it to codify in these amendments the current case law developed by the courts that have determined when a claimant may pursue 502(a) remedies without exhausting the administrative remedies or, stated another way, where the administrative remedies have been deemed exhausted. We believe that this will effectuate the purpose of the proposed amendments to ensure that a claimant is provided a full and fair review of the claim by the plan, while also avoiding the unwanted consequences of premature and increased litigation that will develop over whether a violation has occurred, etc.

Proposed Revision to the Language of Section (l): "(l) Failure to establish and follow reasonable claims procedures. (1) In general. Except as provided in paragraph (l)(2) of this section, in the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(2) In the case of a claim for disability benefits, a claimant is deemed to have exhausted the administrative remedies available under the plan when (i) the claimant has not been provided with meaningful access to review procedures or (ii) where further review would be futile."

IV. CULTURALLY AND LINGUISTICALLY APPROPRIATE NOTICES

A. Comments and Alternative Proposal:

We seek clarification on what constitutes "notices" as this term is used in Sections

(p) and (p)(1)(iii) and "notice" as this term is used in Section (p)(1)(ii).

If the references to "notices" in Section (p) and Section (p)(1)(iii) and to "notice" in Section (p)(1)(ii) mean the determination letter (either the initial determination letter or the appeal determination letter, or both), then this should be clarified in these Sections. If "notices" or "notice" means something other than, or in addition to, the initial determination letter or the appeal determination letter, then this phrase should be explicitly defined; otherwise, plans will be left with no direction as to what is intended by this Section and we have serious concerns about this requirement. It would be a burden, in terms of cost and effort, to include such a statement in all claims-related documents. Further, we ask that the Department be mindful that certain forms, if revised, may have to be filed with state insurance departments for approval before those forms can be used with policyholders and/or plan participants.

The potential issues identified above could be avoided. We suggest the Department consider whether the requirement to include such a statement in all notices is unnecessary in light of the requirement in Section (p)(1)(i) to provide the oral language services in the applicable non-English language. If the claimant has any questions or requires assistance with respect to any aspect of the claim process, the claimant will have the assistance of the language service. If, however, the Department deems it necessary to include a statement indicating how to access the language services provided by the plan, then we suggest the Department's goal can best be achieved by requiring such a statement in the "acknowledgment of claim" letter, which the claimant would receive at the outset of the claim process. The claimant would be notified at the beginning of the claim process of the availability of the language service and how to access it, and would have the benefit of this service throughout the claim process.

V. RESCISSIONS

We believe these proposed amendments are consistent with current industry practice, and have no comments with respect to them.

VI. INDEPENDENCE AND IMPARTIALITY

A. Comments and Alternative Proposal:

Section (b)(7) requires that the plan ensure that all claims and appeals are adjudicated in a manner that ensures independence and impartiality, including that decisions regarding hiring, firing, compensation, promotion, etc. "must not be made based upon the likelihood that the individual will support the denial of benefits." We believe that these proposed amendments reflect current industry practice. However, we also believe that the proposed wording is ambiguous, and will likely give rise to disputes between the plan and the claimant. The Department's concern regarding the independence and impartiality of the appeal process is already the very subject of the well-developed body of case law on conflict of interest; in light of this, and to avoid the disputes that are sure to arise around the meaning of the current draft, we do not believe that this new proposed regulation is necessary.

VII. SUIT LIMITATIONS PROVISION AND SUIT DATE

A. Comments and Alternative Proposal:

The Department has asked for comments whether on whether the appeal determination letters should be required to notify the claimant of the date by which suit must be filed. We urge the Department not to adopt this proposal, but we offer an alternative proposal that we believe will address the Department's concern.

We ask that the Department not adopt this proposal since the date by which suit must be filed may be subject to dispute. This date is dependent upon one's interpretation of the policy's contractual suit limitations provision, and the application of the particular facts of a claim to the contractual limitations provision. In some circumstances, reasonable minds might differ as to when the limitations period begins to accrue, which is central to determining when the contractual limitation period expires. In fact, this is often a question that is the subject of litigation. Therefore, if a claimant or their attorney disagrees with the date that the plan provided as the last date for filing suit, then this could be the subject of a dispute between the claimant and the plan, further prolonging the claim process.

We suggest that rather than requiring the plan to provide a specific suit expiration date, that the Department instead require plans to include the plan's contractual limitations provision in full in the final appeal decision letter. Such contractual provisions are mandated by the state departments of insurance. This serves

to put the claimant on notice of the time for filing suit under the plan, while avoiding the potential for dispute should the claimant disagree with the plan's specific suit expiration date.

VIII. IMPLEMENTATION AND EFFECTIVE DATES OF THE NEW REGULATIONS

Any amendments of the disability claim regulations are currently set to take effect 60 days after publication of the final rules. To ensure that the Department's new regulations are implemented and executed in a seamless manner, plans will need sufficient time to review and digest the new regulations, develop processes, revise or create forms, and hire, train and staff departments as may be required by the new regulations, including the non-English oral language services and related written translation requirements. Given the time and investment of resources that will likely need to be dedicated to execute the plan's full compliance with the new regulations, we propose that the Department make the new regulations prospective in nature, such that the new regulations would apply to claims filed on or after (1) January 1, 2019, or (2) 24 months after the final publication date of the new regulations, whichever deadline occurs last. We also ask that the Department stagger the implementation dates of the new regulations. Alternatively, if the Department is not inclined to adopt our proposal, then we ask that the Department apply the foregoing deadlines to the three regulations that will impose the greatest burden upon plans in order to comply with those amended regulations: The right to review and respond to new information, improvements to basic disclosure requirements and the exhaustion of remedies. The purpose of the new regulations will not be served if plans are not given sufficient lead time to hire, train and staff their departments, and obtain those resources necessary to become fully compliant with all the new requirements imposed by the new regulations. Sufficient lead time will help to ensure that the regulations are implemented and carried out as contemplated by the Department.

Conclusion

We thank the Department in advance for its careful consideration of our comments and suggested alternative proposals to the amendments of the disability claim regulations.

Sincerely,

Debra A. Conner
Assistant Vice President
Life, Disability, Absence Management & Voluntary Benefits