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January 11, 2016

Phyllis C. Borzi
Assistant Secretary of Labor
Employee Benefits Security Administration
U.S. Dept. of Labor
200 Constitution Avenue NW, Suite S-2524
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 Ms. Borzi:

It has come to my attention that the Department of Labor (D.O.L.) is considering amendments to the existing regulations regarding the Employee Retirement Income Security Act (ERISA).

My name is Barry Kirschner and I practice law in Tucson, Arizona. The emphasis for my practice of 35 years has been representing insurance claimants with an ever increasing portion of my clients who have been denied disability benefits with terms of the benefit governed by the Plan (Insurance policy) and ERISA. There are many things detrimental about ERISA's scope and application to what used to be state governed contracts. From a systemic view, there is little if any disincentive for improper denials and termination of benefits. The number of qualified beneficiaries who drop out by not pursuing administrative appeals or litigation far surpass the number of beneficiaries who have the emotional and financial ability to retain counsel and fight for a remedy after being improperly denied or terminated. That remedy is never better than what the claimant was entitled to get if the claim had been properly handled in the first instance, minus attorneys' fees and costs.

Some of the changes needed to improve justice for claimants as would be consistent with the express statutory purpose lies in judicial or congressional action. This letter addresses several issues which could and should be within the scope of what could end should be done by the D.O.L.

Forum Selection Clauses Certain employers have burdened beneficiaries with provisions that the only place that an employee may file suit to enforce Plan benefits is in a specific location, for instance the District Court which sits in St. Louis, Missouri. The Forum Selection Clauses (FSC) is an unjust burden on claimants and a high barrier to allowing a just result. In the ERISA system of decision making, there is no true neutral evaluating a claim for benefits or the decisions on that claim until it reaches the judicial level. The idea that the insurance company guarding its own funds is neutral is unrealistic. The persons in the appeals division of those same companies go to the same company picnics of decision makers whose work products they review. They come from a common pool of local employees and frequently share in the benefits of the same profit sharing or bonus funds. These are not true neutrals. The judicial language describing this as a "structural" conflict of interest is correct, but very deferential in tolerating unfair, even cruel outcomes. The issue of some of the medical reviewing agencies is another example of bias in the system. The recruitment of persons to override treating physicians without meeting the claimant is being abused.

The FSCs multiply the problems of ERISA and seeking to accomplish the express purpose of the law. A claimant who lives in Arizona will not seek out a lawyer in Missouri to assist during the administrative appeal or original application phase. A lawyer will rarely agree to practice before an out-of-state court where the remedies are typically modest and may bleed out as $1-2,000 monthly if the company agrees to continue payments (without interruption) after a claimant prevails. The location of an FSC chosen by the insurer or Plan can, and is indeed likely, to be the product of a judicial bench in that district which may be particularly sympathetic to favorable ERISA defense outcomes. The Department should take a position prohibiting FSCs in Plan documents.

Statute of Limitations There is needless confusion over statutes of limitations, all acting to the detriment of those who are supposed to be protected in ERISA. This topic is a potential trap for claimants, almost none of whom understand how to calculate a statute of limitations. The idea that the statute runs from the time of alleged disability instead of from the time of denial of the claim is also contrary to the civil law in many states. Many lawyers in my state are unaware that calculations of limitations may be governed without regard to the dates of denial or denial of an appeal. Claimants suffer and injustice occurs.

Attached is the letter of a colleague Patrick Mause, who takes the time to address specific corrective action. I endorse his proposals as helpful in attempting to mitigate injustice which is now occurring with regards to FSCs, statutes of limitations, and notices to claimants. I agree with all of the well thought out proposals with specific language from Mr. Mause.

Thank you for considering these comments.

WATERFALL, ECONOMIDIS, CALDWELL,
HANSHAW & VILLAMANA, P.C.

/s/ Barry Kirschner

BK/jj

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January 11, 2016

Via Electronic Mail
(e-ORI@dol.gov**)**

Employee Benefits Security Administration
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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:

For the past ten and a half years, I have been handling ERISA short- and long-term disability claims; initially as a defense lawyer and for the past four and a half years representing claimants. Because my practice is almost exclusively in the area of ERISA-governed STD and LTD claims, I wish to comment on the proposed amendments to the regulations governing STD and LTD claims procedures.

1. Notice Regarding Applicable Statute of Limitations.

Since *Heimeshoff v. Hartford Life & Accid. Ins Co*., 134 U.S. 604 (2013), there has been much confusion regarding when an applicable statute of limitations may run. Certainly, most STD or LTD claimants — who are not working, not receiving income (because their claims were denied), are likely suffering severe medical or psychological conditions, and are facing the potential of financial ruin — are not aware of *Heimeshoff* and the issues it raises. When I meet with potential clients, they typically are not aware of the applicable plan statutes of limitations and likely either do not have, or have not read, the benefit plan. In some cases, the claimants' deadlines can be repressively short; sometimes only a few months.

ERISA claim administrators do not hesitate to cite or quote plan terms favorable to them when denying a claim. There is no burden to them to likewise notify claimants of additional information that would have an adverse effect on their claim, such as when any applicable deadlines or statutes of limitations would run. Moreover, notifying claimants of such deadlines is consistent with the administrators' fiduciary obligations to act in the claimants' interests. This is especially true since *Heimeshoff* leaves open the possibility that a statute of limitation could

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run even before the claimant has exhausted his or her administrative remedies, or shortly thereafter.
For example, some plans mandate that claimants go through a second level appeal. They might also have a short statute of limitations for filing claims; say one or two years. Thus, if the administrator and claimant take the maximum time period for submitting information and deciding a claim, the statute of limitations could run *before* the claimant could exhaust his or her administrative, or could run within days or weeks of a final decision. Failing to apprise the claimant of his or her rights and the applicable deadlines can lead to legally harsh and personally devastating consequences. A claimant who lost her home shouldn't be barred from exercising her ERISA rights simply because the fiduciary administering her claim set short deadlines and failed to apprise her of that information. As the DOL itself discusses in the proposed regulations' preamble, plan fiduciaries know the date any applicable statutes of limitation would expire. As fiduciaries under ERISA, they should not be allowed to keep that information from sick, potentially destitute claimants and then spring it on them later.

The amended language to 29 C.F.R. §2560.503-1(j) should require the claims administrator to advise the claimant of the date any deadlines or statutes of limitations would expire. This would resolve the difficulties of determining when a claim accrues and address the likelihood that unsophisticated, disabled claimants would not be aware of limitations buried in plan documents they may never have seen. The proposed regulation also makes clear that claimants will have at least one year after the completion of the plan's appeals process to file suit. It is fundamentally unfair to bar a claimant's "ready access to the federal courts," 29 U.S.C. § 1001(b), where the plan limitation expires before or shortly after the administrative appeal process is exhausted. The alternative, of course, would be clogging the courts with potentially moot *protect-the-statute-of-limitations* lawsuits filed before the administrator makes a final decision.

Thus, I propose amending the proposed regulation by adding the language indicated in bold and underlined:

> 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).

2. Notice of Right to Request "Claim File".

The regulation regarding a claimant's right to request relevant documents, 29 C.F.R. §2560.503-1(g)(1)(vii)(C) [proposed regulation], would more clearly advise claimants of their rights by using the words "claim file" rather than more technical terms a lay person is not likely to understand. Adding "claim file" is also consistent with the amendment to 29 C.F.R. §2560.503-1(h)(4)(i) [proposed regulation]. Thus, I suggest modifying the proposed regulation as follows, with the added language in bold and underlined:

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. 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.

3. The Regulations Should Provide That Claims That Are Deemed Exhausted Should Be Reviewed *De Novo*.

When a claimant does not comply with his or her ERISA deadlines, such as filing suit after an applicable plan statute of limitations has passed, the claim is barred and the claimant is likely out of luck. On the other hand, when claim administrators do not comply with their deadlines — such as their deadlines to make a decision on an appealed claim — they at most risk a "deemed exhausted" lawsuit subject to the same plan terms including, in many cases, discretionary review. This is fundamentally unfair. ERISA administrators should not be permitted to use deadlines as both a shield and a sword.

Thus, I recommend amending the regulations to provide that "deemed exhausted" claims are to be reviewed *de novo*. In the absence of such a regulation, and given that noncompliant administrators then quibble about whether the violation was *de minimis* or significant, there is no clarity. If claimants do not meet their ERISA-imposed deadlines, there is a bright-line rule: No claim for you. There should likewise be a bright-line rule for administrators: If the administrator does not comply with its ERISA-imposed deadlines, it may not benefit from discretionary review. Thus, I propose amending the regulations as follows:

> 29 C.F.R. 2560.503-1(l)(2)(i) [proposed regulation]
>
> if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary, **and the reviewing tribunal should not give deference to the plan's decision but shall review the dispute *de novo*.**

4. Forum Selection Clauses Should Be Deemed Inconsistent With ERISA And Therefore Unenforceable.

Congress' purpose in enacting ERISA was to protect "the well-being and security of millions of employees." 29 U.S.C. § 1001(a). Congress therefore provided that "it is desirable in the interests of employees and their beneficiaries" that "safeguards be provided with respect to the

establishment, operation, and administration of such plans." *Id*. To ratify its intent and reflect the public policy embodied in the statute, Congress then included multiple *employee*-protective elements in the statute; including setting standards of conduct for fiduciaries and by providing employees with "ready access to the Federal courts." 29 U.S.C. §1001(b).

To further protect employees, Congress permitted plan beneficiaries to bring suit "to recover benefits due to him under the terms of his plan" or "to enforce his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Then, to facilitate this employee-protective term, Congress authorized claimants to bring suit "where the plan is administered, *where the breach took place*, or where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2) (emphasis added).

Congress also required each fiduciary to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" and "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter." 29 U.S.C. § 1104(a)(1)(D). Under ERISA, therefore, plan terms that interfere with claimants' "ready access to the Federal courts" or that violate the fiduciaries' obligations to act in beneficiaries' interests are unenforceable.

Some disability plans include forum- or venue-selection clauses, specifying that a claimant — regardless of where he or she may live and regardless of his or her circumstances — may only file suit in a specific district court. This unfairly impedes claimants' "ready access to the Federal courts" and interferes with the claimant's right to exercise her Congressionally-granted right to bring suit "…where the breach took place…" Because forum- or venue-selection clauses interfere with claimants' rights, the EBSA should invalidate them.

First, disability plans' ability to enforce forum-selection clauses results not from any intent of Congress, but from the statute's inartful drafting. If we reword 29 U.S.C. § 1132(e)(2)'s venue provision to omit Congress' passive voice, it would read: "*A beneficiary may bring suit* under this subchapter in the district where the plan is administered, *where the breach took place*, or where defendant resides or may be found." (emphasis added). Congress' intent should be clear: ERISA beneficiaries my file suit where the breach occurred, in their home forum.

Second, forum-selection clauses have a very real chilling effect on claimants' ability to protect their ERISA rights. As an attorney, filing suit in a foreign jurisdiction due to a forum-selection clause is burdensome and expensive. Due to my lack of familiarity with foreign jurisdictions' practices and local rules, I believe it is prudent to retain local counsel. This not only requires finding and retaining capable local counsel familiar with ERISA, but also creates economic disincentives for both me and my client. Even something as simple as appearing *pro hac vice*

increases costs as those fees can be several hundred dollars. The disincentive to handle cases with a foreign forum-selection clause is particularly salient in cases that have lower claim values. Thus, forum- or venue-selection clauses not only interfere with all claimants' "ready access to the Federal courts," but they unfairly prejudice claimants who did not earn much money, leading to a lower claim value, and unfairly harms people who may most need access to the courts to protect their benefits.

Third, forum-selection clauses likely prevent most disabled claimants from attending the proceedings that affect their futures. Recall, a disability claimant involved in a lawsuit had his or her benefits denied. He or she may be destitute, especially after going through a months-long administrative exhaustion before filing suit. Not only may the claimant be unable to afford expensive interstate travel, he or she may be physically or psychologically incapable of traveling and may be homeless or living off the kindness of others. Such a claimant would simply be precluded from participating in his or her own case. Forum-selection clauses may therefore effectively bar claimants from accessing the courts, violating Congress' intent.

Fourth, I have personally met with potential clients whose plan I knew was subject to a forum selection clause. When meeting with such potential clients, I believe I am obligated to inform them of the plan's forum selection clause and the hurdles such a clause would create. I have personally seen potential clients go from hopeful and optimistic about their claim to feeling hopeless at the huge burden they would have to overcome to pursue their case in a foreign jurisdiction.

Fifth, I believe that plan administrators that include forum selection clauses in their disability plans do so knowing it will likely decrease claim incidence. There is no doubt in my mind that if the DOL investigated the motive and effect of such clauses (and I strongly encourage it do so), it would learn that ERISA fiduciaries not only intend that such clauses work exclusively to their benefit, including by reducing claim or lawsuit incidence, but that the clauses do indeed have that effect. This is a clear violation of Congress' intent and the administrators' fiduciary obligations and should not be permitted.

Thus, I recommend that DOL propose a regulation requiring barring the use of venue- or forum-selection clauses in disability plans.

Sincerely,

/s/ Patrick W. Mause

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