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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 am writing with comments to the proposed amendments to 29 CFR 2560, Claims Procedure for Plans Providing Disability benefits.

Basis for Comments

A large part of my legal practice consists of representing claimants and plaintiffs in claims for short-term and long-term disability benefits arising under ERISA plans. I assist claimants in both the pre-litigation claim process itself and litigation in federal court, if necessary. I have represented plaintiffs in ERISA cases in federal court more than 60 times in the Eastern and Western Districts of Kentucky over the past eight years. I have represented many more claimants during the pre-litigation claim process. I have also practiced cases at the Sixth Circuit Court of Appeals.

My firm is one of a very small number that practices ERISA cases in the Eastern District of Kentucky. I believe that many other qualified attorneys are dissuaded from practicing ERISA cases because of, among other reasons, a general perception that the rules are greatly skewed in favor of employers, plans, and insurance companies.

Comments

First, I commend the Department for making improvements to the current regulatory scheme. I agree with many of the Department's observations in its proposed rulemaking commentary and share many of the same concerns.

Second, I would like to address the Department's request for comments regarding the statute of limitations. I believe that this is a very important issue. While one of ERISA's purposes is to

provide uniformity throughout the country with respect to claims for employee benefits, there is a complete lack of uniformity on this principal issue of when a claim must be brought in court. Each state has different rules for statutes of limitation.

For example, my state, Kentucky, has a 10-year statute of limitations for breach of contract claims. It also has a 5-year "catchall" statute of limitations for causes of action created by statutes that do not otherwise mention a statute of limitations. Just across the border in Ohio, courts have used a 15-year "borrowing" statute of limitations for breach of contract claims.

I have practiced a case where suit was not brought until approximately 6 years after a claim was denied. Obviously, it made a huge difference what statute was applied by the courts. My client in Kentucky may have been subjected to a 5-year statute of limitations, while a different claimant just a couple of miles away in Ohio would have had another 9 years to bring suit. This is not only unfair because of the different application of rules, but it is also unfair because claimants often have no idea when a statute of limitations might run.

Additionally, most plans have internal limitations periods that are very difficult for the average claimant to understand. Most of these limitations periods appear in insurance policies and use some variation of language requiring suit to be brought no later than 3 years from when proof of loss was due. My experience is that most claimants do not know what this means. Even the courts have disagreed as to when a claim "accrues" for purposes of a limitations period such as this. One way to provide certainty is to require, at a minimum, that claimants be allowed a standard period of time after receiving a "final" denial of a claim to bring suit. And requiring insurance companies and plans to notify claimants in the denial letters of the date by when suit must be brought would provide certainty to both claimants and plans.

Finally, I would also like to add a few comments on three issues that seem to be recurring problems in claims for benefits:

1. Time limits for deciding claims and "deemed exhaustion"

The current rules require a decision to be made on an appeal of a claim within 45 days, up to a maximum of 90 days if special circumstances requiring additional time exist. In nearly every claim in which I have been involved, claims are not decided within 45 days. I believe that insurance companies routinely take 90 days or more to decide claims without identifying any special circumstances for taking extra time. Sometimes no claim decision is made within 90 days. I recommend that the Department strengthen the language in the regulations to make clear that a failure to exercise discretion during the 90-day period forfeits any deferential review to which an administrator would otherwise be entitled. As it stands now, there is no real repercussion to taking longer than 90 days. Additionally, I would recommend making this a strict rule, not subject to the proposed language involving *de minimis* violations of the regulation or a showing of prejudice by a claimant. My concern is that such language would diminish the purpose of the regulation and simply invite more arguments in litigation by plans and insurance companies that their violations were simply *de minimis* or did not prejudice a claimant.

2. Allowing claimants to respond to new evidence generated by administrators during appeals

I agree with and recommend language allowing claimants to have an opportunity to respond to evidence generated by administrators during appeals. Quite frequently, insurers and administrators generate new paper medical reviews, or even medical examinations, of claimants after an appeal has been submitted. This does not allow a claimant an opportunity to respond to the new information. Allowing claimants a brief period of time to respond to newly generated evidence by plans and insurance companies would be helpful.

3. Avoiding conflicts of interest

Conflicts of interest continue to be an issue in LTD claims. Often, the same medical reviewers appear over and over. The medical review industry is profitable enough that there is an entire market of third-party companies that are paid fees just to transmit medical reports from doctors to insurance companies. The pressure to produce reports that are favorable to the insurance company or employer (i.e. supporting denial of a claim) is real.

There is also pressure on employees of insurance company and plans. I agree that plans and insurance companies should not provide bonuses or incentives to employees to deny claims. However, I would suggest strengthening the enforcement of the regulation to require plans and insurance companies to maintain data on the amounts paid to reviewers and consultants and the number of times those individuals and entities are used. Also, I would recommend clarifying that the regulation applies to third-party medical review companies in the same manner as it would an individual doctor. More often than not, third-party medical review companies are actually the entities that provide reports and have the financial incentive.

Thank you for taking the time to review the regulations and to make changes that will help claimants who have legitimate claims.

Sincerely,

/s/ Phil Fairbanks