By e-mail to: e-ORI@dol.gov
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:

This letter contains my comments 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 I am an attorney whose practice is focused on the representation of claimants in ERISA-governed disability benefit disputes. I have

My first comment addresses the vital issue of Statute of Limitations, which I have seen become a deadly landmine for unsuspecting beneficiaries, and I offer some suggested changes to the regulation to provide more clarity and avoid surprises to both claimants and claims administrators. My next comment relates to an issue I have encountered on numerous occasions, where claims administrators sandbag or change their rationales on review, leaving the beneficiary unable to respond to the new evidence and/or rationale. This practice is widespread and not in keeping with the fiduciary role of the claims administrator. Both of these comments relate to where I believe the DOL should make a substantive change in the proposed regulations.

Comment on Notice for Applicable Statute of Limitations
The DOL has invited comment in 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.

For instance, I have had several clients who have been receiving benefits for several years before being denied and cut-off by the claims administrator. Since most Plan terms state the Statute of Limitations runs from 3 years of the proof of loss (which is usually 180 days after the disability began), the Statute of Limitations has long run by the time the final denial has been issued. Being familiar with the status of the law, I have been able to file suit promptly after the administrative appeals were exhausted, but many individuals who have been on-claim for a substantial amount of time are unrepresented and wholly unfamiliar with this law. Under the *Heimeshoff* decision, many will likely lose meaningful rights to court.

To avoid this confusion, 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.
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> **(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]
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> (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.**

Thank you for taking the time to review my comments and your efforts to improve the rules governing employee disability benefit plans.

Sincerely,

Hudson T. Ellis
Attorney at Law