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January 18, 2016

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

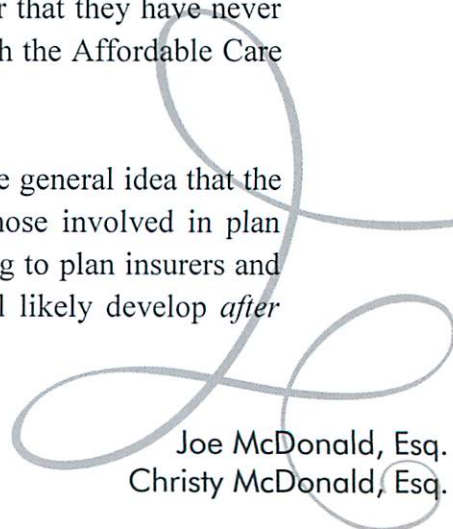
Dear Assistant Secretary Borzi:

I am writing to offer my comments on the proposed changes to regulations which were published in the Federal Register on Wednesday, November 18, 2015. Specifically, on that day you offered a Notice of Proposed Rule Making for the regulation contained at 29 C.F.R. § 2560.503-1. This rule is critically important to American workers and I believe generally that the proposed changes as proposed in the Register are largely beneficial to the workers that I represent.

I have devoted my practice exclusively to the representation of individuals in long-term disability litigation. I accept cases in multiple jurisdictions. Most of the cases that I accept still have administrative appeals that need to be completed. Therefore, I feel that I am well positioned to comment on the proposed changes.

I have handed several hundred long-term disability appeals and I am certain that most of my clients do not understand what they are up against and do not have enough information from insurers or plan administrators to make intelligent assessments. Many of my clients complain about how little information is clearly stated in adverse benefit decisions and many complain bitterly about not having a final response to a report generated by a doctor that they have never seen. Therefore, I support the proposals to bring the regulation in line with the Affordable Care Act.

Before I get into the proposed changes, I would like to offer you the general idea that the rules proposed will not work a hardship on the insurance industry or those involved in plan administration. I suspect that the measures you propose will be cost saving to plan insurers and plan administrators because it will reduce the number of issues that will likely develop *after*



employee benefits litigation commences. I saw your proposals as a clarifying and strengthening measure designed to help both the industry and the beneficiary participants of these plans.

I would like to initiate my comments by discussing the substantive matters in the proposed regulations. I will later move to the non-substantive and more technical features of the proposed regulation.

A. COMMENTS ON SUBSTANTIVE MATTERS IN THE PROPOSED REGULATIONS

I saw that there was a proposal to define the statute of limitations in employee benefits cases. It is remarkable how a statute as significant as ERISA could fail to contain a statute of limitations inside it. Over the years, we have used inconsistent measures to determine the statute of limitation from state to state. In 2013, the Supreme Court’s ruling in *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604, provided some clarification but injected an equal amount of chaos into this important aspect of employee benefits litigation.

ERISA was originally designed to secure the position of American workers and to enhance the likelihood that they would receive the benefits that they were entitled to. Hiding the statute of limitations inside the plan document or positioning it in unusual terms relative to the original “proof of claim” or original “proof of loss”, is dubious and confusing to beneficiaries. There is no harm done in having the plan administrator or insurance company define in their initial adverse benefit decision when the statute of limitations will run. We must consider that the individual receiving the adverse benefit determination may have received the denial after one year of benefits or five years of continuous benefits or fifteen years of continuous payments. Therefore, it becomes too confusing for the individual claimant (and frankly sometimes the attorney) to determine when the plan administrator or insurance company believes the statute of limitations runs. At the time the initial adverse benefit decision is made, the plan administrator is in the best position to advise when a legal action must be filed in a United States District Court. The lifespan of employee benefits cases is not like a tort case or a discrimination case. Without guidance from the plan administrator, the unrepresented claimant will have an impossible time determining when a lawsuit must be filed.

Therefore, I offer the proposed regulation which can be added to the existing regulation at 29 C.F.R. § 2560.503-1(j)(6): (added language is indicated by italics 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'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 or 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 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.

I believe that my offering will go a long way towards eliminating the confusing and difficult calculation of the statute of limitations.

I also note that the regulations proposed new timing on the right to respond to new evidence or rationales generated by the plan administrator. After a claimant submits an administrative appeal, it is not uncommon for the insurance company to either have the claimant examined or to hire a "peer review" physician to analyze the medical records. The report from the IME doctor and/or peer reviewer should be forwarded to the claimant before a final denial is issued. I do not think ERISA was designed to have a "surprise" feature.

Too frequently, claimants (and occasionally their attorneys) are placed at a disadvantage by peer review reports that drop out of the sky when the claim reaches a final denial. I personally had this happen to me in a case in the Southern District of Ohio which was overturned in the Sixth Circuit Court of Appeals. The insurer hired a doctor at the last minute to review an employee's administrative appeal and that physician invalidated all of the testing that the claimant provided without justification and offered a new and creative perspective on how to read a pulmonary function test. See *Niswonger v. PNC Bank Corp. and Affiliates, et al.*, Case No. 13-4282, (6th Cir., May 14, 2015). Regrettably, there was no method or mechanism to contradict these aggressive, unsubstantiated and inappropriate medical opinions by the peer reviewer. Your proposed rule would eliminate that problem and likely would go a long way towards providing clarity. Many District Courts remand cases because the medical evidence is in absolute conflict. Your proposed idea for allowing the claimant to respond to newly developed evidence will go a long way towards eliminating unnecessary remands to the administrator after litigation has been started.

Again, I offer the following potential amendment to the proposed regulation as follows (new language indicated by italics and underlining):

2560.503-1(h)(4)(ii) [proposed regulations]

(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 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 the 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.*

I also saw a proposal to embrace an issue that is vitally important to my clients. I am referring to Independence and Impartiality – Avoiding Conflicts of Interest. When ERISA was developed and signed into law in 1974, I doubt that anyone would understand how sophisticated the insurance industry would become. Historically, insurance companies hired physicians

directly, who would be supportive of their goals. The present paradigm is much more difficult for individual claimants who would like information about the doctors who are opining against disability. Impartiality and independence are vital pillars to the administration of a statute like ERISA. Presently, the insurers or plan administrators contract with peer review clearing houses such as NMR, MMRO, Elite Physicians, University Disability Consortium, etc. These groups act as a (non-fiduciary) go-between for plan administrators and insurers and the physicians are pre-vetted by these groups to participate as experts. I think that your proposed regulation does not go far enough but is a welcome step in the right direction. It would be appropriate in my view if the insurer or plan administrator would disclose how many times it has relied upon the third-party vendor who hired the expert in the past year. It would also be appropriate if the insurance industry or plan administrator could keep track of how many times a particular expert was used to support a denial or approval of benefits. These types of statistics are not unreasonable or unduly burdensome and I believe that independence and impartiality would be enhanced by the disclosure of that information.

I say that your proposal does not go far enough because it does not address a concern that I have. Many of the files that I review are thousands of pages long. They contain years of medical information and it takes me many many hours to go over those files, understand the details and convert the data into a usable resource. **I have noticed that many of the reports generated by peer review physicians and IME doctors are identically formatted.** It seems improbable to me that hundreds of individual physicians all across the country would prepare their reports in the same manner. It has also come to my attention that after reviewing the billing statements for peer reviewers that the actual amount of “physician time” is considerably less than it would take most other people to review a similar amount of data. I believe that the “third party vendors” are completing document review and creating factual narratives before the questions are presented to the reviewing physicians to be answered. I think that any proposed rule should embrace how much time was spent reviewing the file at the third party vendor and how much time individually was spent by the physician (who is often in a different city) who answered the questions that were presented by the plan administrator. In many parts of the country, we are not allowed to obtain any discovery on these issues. It is hard to imagine a scenario where I would ever be able to take a deposition from somebody at University Disability Consortium regarding what activities they performed before the doctor’s report was completed. My concerns were fully developed when I received two identical peer review reports signed by two different physicians. See *Zenadocchio v. BAE Systems Unfunded Welfare Benefit Plan, et al.*, 3:12-cv-00099-TMR (SDOH, March 29, 2013, Judge Thomas M. Rose), (the Court did not understand the depth of the problem but described the situation as “unexplained to a certainty.”)

Towards that end, I offer a proposed regulation which will be helpful to you (added language is italicized and underlined):

In the case of a plan providing disability benefits, the plan and its agents, contractors, or vendors (such as entities who supply consulting experts to plans) must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision or who are consulted in the process of making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, (such as a claims adjudicator, vocational expert, accounting expert, or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

In regard to your proposals on supplementing the administrative record, I would embrace the idea of being able, under certain circumstances, to advise the plan administrator of a development such as a Social Security award and/or some other offset such as a verdict or settlement after the record is closed. There is no method for doing this. Frankly, I have invented my own method for dealing with this problem and defense counsel either tolerates it or simply “goes ballistic.” I file a “Notice of Social Security Award” anytime litigation is commenced in a District Court.

Given the way that these insurance policies work, I believe that the claimant should be given an opportunity at any point to notify the plan administrator or any District Court judge about a positive Social Security ruling. I am aware that plan administrators attempt to distance themselves from the Social Security Act but they do so in the clumsiest way. It must be remembered that every policy or plan that exists in America has an offset for benefits paid under the Social Security Act. It has always seemed clear to me that these policies embrace the standards inside the Social security Act when they count the benefits as an offset. In sum, while the Social Security Administration has some rules that are different, when a claimant is below the age of 50, the Social Security Act uses no special rules that enhance the likelihood of a different outcome under a long-term disability policy. The Social Security Act always embraces the idea that the claimant would be disabled from all occupations in the United States. Recently, a judge in the Western District of Pennsylvania found it improper that Prudential could distance itself from the Social Security standards which were actually more difficult than the standard offered by Prudential in the administration of its “own occupation” policy. See *Strott v. Dimensional Investment, LLC Health & Welfare Plan, et al.*, Case No. 2:13-cv-01245 (WDPA, March 23, 2015, Judge Cercone). I believe that it is important and vital to the process to be able to disclose your Social Security victory even after administrative appeals are exhausted.

B. TECHNICAL MATTERS IN THE PROPOSED REGULATIONS

Claimants have a right to see what is in their files after receiving an adverse benefit decision. Many claimants contact my office and are aware of their right to get a copy of their file but simply do not know what words to use when making the request. I believe that if we referred to it as a “claim file” the import of 29 C.F.R. § 2560.503-1(g)(1)(xii)(C) would go much farther.

I also wanted to talk about venue selection and how it is being used improperly by some plan administrators. Many plan administrators are using the themes developed in *Heimeshoff* to generate new and exciting limitations on where and when they can be sued. The United States has a very mobile economy. Workers are continuously repositioned from assignment to assignment and location to location. Some workers move to places where it is cheaper to live after they become disabled and are no longer able to work. Thus, in our mobile society it seems inappropriate that a plan administrator will drag each claimant back to a specific location or in a specific court. The DOL should consider a regulation that prevents plan administrators from selecting far flung places as the only jurisdictions where they will be sued.

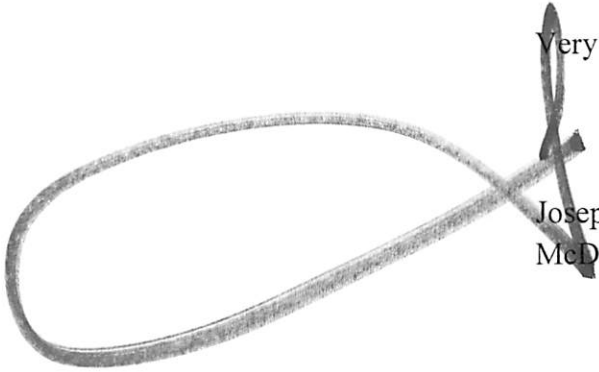
Finally the rule at 29 C.F.R. § 2560.503-1 needs to be amended to eliminate abusive conduct being perpetuated by insurers who refuse to finish an appellate review within the 90 day period described in the regulation. The DOL should consider a rule which removes the possibility of deferential review if the decision to approve or deny benefits occurs after the 90 day period defined in the regulations. Such a rule will ensure that the administrative process does not drag on indefinitely.

I hope that these comments are helpful to you as you begin the rule making process.

If you have any questions or concerns relative to my comments, please do not hesitate to contact me at my office. I will make myself available for discussion with you.

I consider the proposed changes to be necessary and in the best interest of my clients who continuously inspire me with their determination. The reasons why individuals become disabled are as vast as one can imagine. My clients range from 30 years old to 60 years old. They arrive at my office with degenerative conditions, autoimmune conditions or metastatic diseases. Anything we can do to make the rules work for these disabled workers will be a step in the right direction and will bring us closer to the original intent of the Employee Retirement Income Security Act.

Very truly yours,

A large, stylized handwritten signature in dark ink, consisting of a large loop followed by a vertical stroke that crosses the loop.

Joseph P. McDonald
McDonald & McDonald Co., L.P.A.

JPM/ksw