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 eight years I represented claimants in ERISA benefit matters both in the internal appeal process and in litigation. The vast majority of my clients were seeking to reverse denials of disability claims. For the last 5 years I have worked as a consultant to other ERISA benefits attorneys. In that capacity I read hundreds of ERISA decisions and court filings each year. Most of these address full and fair review in some way. I must concur that disability claims administrators have become more clever and aggressive in defending against claims. The requirements of full and fair review need to be refreshed to prevent further erosion of claimants' rights to disability benefits and to prevent the promised disability benefits from becoming illusory. "ERISA and its regulations were not intended to be used 'as a smoke screen to shield' the plan from legitimate claims." *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005)(quoting *Richardson v. Cent. States Se. & Sw. Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir.1981)).

COMMENT I: What Time Limits Should Apply to the Claimant's Right to Respond to New Evidence or Rationales?

I am pleased that the EBSA is addressing one of the most common problems with ERISA disability benefit claims – that a claims administrator reviewing an appeal can come up with new support to deny a claim and then slam the door on the claimant by refusing to offer her an opportunity to respond. *Abram v. Cargill* solved this problem temporarily until the decision was reversed. *Midgett Washington Group Int'l LTD Plan*, 561 F.3d 887, 894-96 (8th Cir. 2009).

The horror that some plan administrators have argued would result from permit claimant to respond is not based in reality. It will not lead to an endless or interminable appeal process. It is the claimant who has the greatest interest in the speedy resolution of the appeal, since it is the claimant who is going without benefits, without paying his mortgage, without being able to support his family, and without paying his health insurance premiums or bills. Additionally, the number of claimants who will realistically be able to participate in what the plan administrators predict will be an endless process with multiple iterations is limited by the out-of-pocket costs of doing so.

a) Right to Respond - Imagine a claimant in her fifties who has a potentially life-threatening, chronic and progressive neurological disease that causes weakness, fatigue, pain, and vision problems. She can no longer perform her occupation. Every one of her multiple treating doctors say that she cannot work at any job. The insurer denies her claim for LTD benefits using a stock phrase like, "restrictions and limitations are not supported based on medical documentation submitted." In an attempt to respond to the vague denial, the claimant appeals, submitting medical records, statements from her doctors, herself, her spouse, and her boss, all of which attest to her limitations. The insurer denies her appeal based on quotes from a medical report by a repeat player in the industry as well as a report of a vocational consultant who opines that the claimant can work at some jobs at which she can earn a small fraction of her former wages. She is informed that her opportunities to appeal have been exhausted and she can sue. However, when she receives her claim file, she discovers that the insurer's medical review contains falsehoods and inaccuracies and it is clear the reviewer was not supplied with critical information about some of her conditions. Additionally, the medical reviewer claims to have spoken with one her treating doctors, who agreed that she was capable of working. The claim file also reveals that the vocational consultant was not applying the proper wage threshold to her claim; her plan says that she is disabled if she is unable to earn more than 60% of her former wage. She writes to the insurer explaining that her doctor denies any such conversation with the company's reviewer and explains that the reviewer missed key facts. She adds that the jobs they think she can perform don't pay very much. The insurer explains that the appeal process is closed. Faced with the distortions and falsehoods that a judge might accept as true under the abuse of discretion standard of review, and the possibility that the lengthy litigation process would only result in a remand back to the plan that would elongate the process further, she settles with the insurer for 30 cents on the dollar.

There is nothing special about this fact pattern; it is so common as to be generic. This is how a meritorious claim can be whittled down through sandbagging. Although there is supposedly a right to judicial review, that right is entirely undermined where the claims administrator refuses to entertain any rebuttals and the claimant is facing a lawsuit that is based on a record entirely engineered by the claims administrator. The opportunity to respond to new evidence or rationales before the final decision is crucial.

b) Timing - Meanwhile, I am concerned about the time constraints on the claimant's right to respond. The claimant needs sufficient time to counter reports and rationales that the claims administrator has generated on appeal. As in the

scenario above, claims administrators employ different types of consultants. In order to effectively rebut their reports, the claimant must sometimes find her own experts. Sometimes these professionals are busy. Even the claimant's own physicians are busy and may not be immediately available to formulate a response. For this reason, I believe that a claimant should be provided at least 90 days. This is fair, given that the plans usually take at least this long to make their determinations on appeal. If the claimant does not need this amount of time, he should be able to submit his response and expect a final determination within the period of time left over by the claims administrator.

COMMENT II: Should a Plan be Required to Notify The Claimant of an Internal Limitations Period?

a) Notification of the Internal Limitations Period - First, full and fair review should minimize the possibility that ERISA claims will be buried for reasons that have nothing to do with their merit. Notification of the plan's time limits for filing suit protects the claimant from the loss of benefits because of a mere technicality. Plan fiduciaries should be just as horrified by this possibility as I am.

Next, given that the *Heimeshoff* decision makes it possible for plans to write their own rules about the time limits to bring suit, it is reasonable to require these plans to notify the claimant of such time limits. The agency is correct that the plans are in the best position to know the date. The final denial letter should include this date.

I am particularly concerned about unrepresented claimants in this regard. ERISA contemplates a process that claimants can participate in without legal representation. I have known few claimants who would understand: 1) that they had to go looking for an internal limitations period; 2) where that would be located, or; 3) how to interpret the provision if it could be found. This is further justification for the notification requirement.

b) Reasonable Limitations Period - *Heimeshoff* says nothing about what a "reasonable" limitations period is, but it allows as how there could be an unreasonable one. The agency should intervene here and set the standard for reasonableness, once again, keeping in mind the goal of minimizing the number of claims that are lost due to technicalities. The agency has created other minimum time limits, so the agency is no stranger to this type of rule.

Of course, it would be beyond the imagination of any claimant that the internal limitations period could run before he had completed an appeal process, but there is still confusion around this absurd possibility. Accordingly, I am recommending 2 fixes.

First, the limitations period should not be able to run before the appeal process is complete.

Second, an internal limitations period that is shorter than 2 years after the final appeal denial should be deemed to violate full and fair review. I recently encountered a Kodak plan that created a 90-day limitations period. 90 days in not enough time for a gob-smacked claimant to shop for an attorney who, in turn, will need to collect the claim file and other information before making a decision as to whether a lawsuit is in order. In other words, the plan's notice to the claimant of the date by which she may bring suit is small comfort, where the time will expire before the filing of lawsuit it achievable. And there is some indication that a court could find this 90-day period to be reasonable. *Davidson v. Wal-Mart Associates Health and Welfare Plan*, 305 F. Supp. 2d 1059 (S.D. Iowa 2004) (upholding 45-day contractual limitations period as reasonable).

COMMENT III: Ensuring Independence and Impartiality of Persons Involved with Making the Decision.

I am pleased that the agency is interested in addressing the widespread problem of ERISA disability benefit plans' use of conflicted employees or consultants. However, the regulation could use some refinement in the form of greater specificity.

a) Independence and Impartiality of All Agents in All Fields - The regulation needs to make clear that contractors, agents, outside vendors, and their employees are all covered by the regulation. The disability plans do not directly employ or hire many of the people on whom they rely to deny claims, but all of the people and entities and individuals need to be free of bias or conflict.

A typical example is a disability claim in which surveillance is used against the claimant. The claims administrator will have a contract with a surveillance company who will hire an investigator. Another individual, perhaps, will write the report describing the video. This video and report may be sent to yet another vendor who will contract with a medical reviewer to opine on what the

surveillance shows. This process is fraught with bias and conflict. See e.g. *McKnight-Cameron v. Boston Mut. Life Ins. Co.*, No. 1:13-CV-01774-RLY, 2015 WL 5775524, at *9 (S.D. Ind. Sept. 30, 2015); *Frerichs v. Hartford Life & Acc. Ins. Co.*, 875 F. Supp. 2d 923, 948 (D. Minn. 2012)(noting that the interpretation of surveillance video is inherently subjective).

b) Clarification of "involved." - The agency needs to make clear that what it means to be "involved with making the decision." Insurers and plans regularly take the position that medical and other experts they rely upon are not *making* the decisions but are simply rendering opinions within their expertise so that claims handlers or other committees, who are the delegated decision-makers, can make the decisions. The industry makes this assertion in affidavits and depositions too numerous to count. In my experience, however, these assertions are disingenuous. A medical or vocational expert will make or break the claim, and the claims handler often adopts these opinions without question. This comes out in depositions of the claims handlers. In addition, because of how disability departments are structured there is often a supervisor, who may not make a decision, but may give final approval to that decision. Does this supervisor fall under the regulation? I would expect and argument that she does not.

Given this quandary about who truly makes disability decisions, the agency needs to clarify that independence and impartiality applies to everyone who decides claims or appeals, approves or signs off on those decisions, or renders any opinion that is relied upon in the decision-making process, i.e. anyone who is consulted in the process is considered to be "involved" and is subject to the same standard of objectivity.

COMMENT IV: Explaining Why the Administrator Does not Agree with Other Payers of Disability Benefits

Perhaps the most astounding practice by claims administrators is to entirely discount a favorable Social Security decision in disability benefit denials. The claims administrators doggedly pursue Social Security benefits on behalf of the ERISA claimants, since most ERISA disability benefits are reduced by the amount of these benefits. In many cases plans hire representatives to advocate for claimants before the Social Security Administration, which advocacy entails taking that the position that the claimant is disabled in a way that more severe than almost any LTD plan would require. Once the money-saving Social Security award is obtained (and the plan has perhaps

recouped the benefits), the LTD claim is then denied and the plan does an about face on the disability question. (This inconsistency was described and criticized in *Metropolitan Life v. Glenn*, although the decision does not appear to have changed claims practices very much.)

The explanation for rejecting or ignoring the favorable Social Security decision, if one is attempted, is often boilerplate and goes something like, "*[w]e realize that you obtained a favorable ruling from the Social Security Administration. The SSA's decision is not binding on us. The difference between our decision and SSA's may be driven by the regulations that govern the Social Security system.*" There is no explanation that is pertinent to the specific claim at hand. If the proposed regulation intends to render such an explanation insufficient to satisfy the rule, the agency should clarify this by including language as follows: (A) A discussion of the decision**, that is pertinent to the specific claim or appeal under consideration, . . ."**

To require this level of analysis from plan is to require nothing more than a "deliberate, principled reasoning process," which a plan fiduciary is already obligated to provide. *Glenn v. MetLife*, 461 F.3d 660, 666 (6th Cir. 2006) aff'd sub nom. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008).

COMMENT IV: Effective Date of the Final Regulations

The previous revision of the ERISA claims regulations applied to new claims filed on or after January 1, 2002. Since then there have been cases decided on the "old regs" and other on the "new regs." Insurers and plans have applied one set of standards to some claims and another set to others. This is not ideal. It leads to confusion in the case law and unfairness, especially where the regulations could be seen as clarifications instead of amendments. For example, see *Abram v. Cargill*, 395 F.3d. 882 (8th Cir. 2005) as compared to *Midgett Washington Group Int'l LTD Plan*, 561 F.3d 887, 894-96 (8th Cir. 2009).

I suggest that the agency minimize this patchwork effect by making the final rules apply to all claims "pending on or after" the effective date.

COMMENT V: Deemed Exhaustion Procedure

I commend the agency's effort to set out a procedure for deemed denied claims for those claimants needing to by-pass claims administrators who are committing serious procedural violations. However, some additional clarification is necessary.

a) **Clarifying De Novo Review** - The regulation indicates that a deemed exhausted claim will be decided by the court "without the exercise of discretion by an appropriate fiduciary." The agency should clarify that the court "shall not defer to the decision in any way but shall apply de novo review to all questions whether factual or interpretive." I feel that this added language is needed because some courts applying de novo review will still defer to the claims administrators' factual determinations. See *Pierre v. Connecticut General Life Insurance Co.*, 932 F.2d 1552 (5th Cir.1991). A large swath of the country, in which there are certainly many ERISA claimants, contends with this bizarre variant of de novo review. Without spilling too much ink on how the jurisprudential anomaly came to pass, this variant of de novo review should not be applied where the claim lands in court due to the fault of the claims administrator. I believe this small change will help to carry out what the agency is intending with its regulation.

b) **Supplementing the Record Before the Tribunal -** Where a claim is accepted for review by the court, it is important to remember that the procedural irregularities may have prevented the claimant from including his best evidence in the record. The agency should add some language to the regulation providing that a claimant can supplement the record under this scenario. While some courts applying de novo review might permit this, many would not. Without this addition, a deemed exhausted plaintiff may be worse off than he was before.

c) **Supplementing the Record Re-filed on Remand** – Likewise, the regulations should provide for supplementation of the record on remand. As I understand it, where the court determines that the violation the claimant complained of was di minimis, the claim is remanded to the plan as if it were an appeal. However, a claim that is re-filed with the claims administrator may not have been fully developed and the claimant should be given an opportunity to supplement the record so that the claims administrator has enough evidence on which to decide the merits of the claim. The claims administrator's notice to the claimant should therefore include notice of the right to submit additional information before the claim is re-reviewed.

Thank you kindly for considering my comments,

Sally Mermelstein, Attorney at Law