BOLT KEENLEY KIM LLP

1010 Grayson Street, Suite Three
Berkeley CA 94710

T: 510 225 0696
F: 510 225 1095

bkim@bkkllp.com
www.bkkllp.com

January 19, 2016

By Email (e-ORI@dol.gov) and Electronic Submission (http://www.regulations/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:

I write to provide comments on the Department of Labor's ("DOL") proposed regulations for amending the claims procedure regulations applicable to disability benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"). I am keenly interested in the content of these proposed regulations because I am an attorney whose practice for the past 10 years has been primarily focused on the representation of claimants in ERISA-governed disability benefit disputes. Moreover, a key focus of my law firm, Bolt Keenley Kim LLP, is the representation of insurance policyholders, including disability benefit claimants, in pre-litigation internal appeals and litigation under ERISA. The issues addressed by the proposed regulations are issues that I must deal with on a daily basis representing claimants in ERISA matters. Below are my comments to the proposed regulations, with proposed revisions to the proposed regulations highlighted and underlined.

I. The Regulations Should Require the Claims Administrator to Inform Claimants of the Date(s) When Any Applicable Limitations Period Runs

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 & Acc. Ins Co.*, 134 U.S. 604 (2013). This is a crucial area for regulation as the *Heimeshoff* decision

has created confusion and much litigation, due to the uncertainty of the scope of the *Heimeshoff* decision. *Heimeshoff* held that "[a]bsent a controlling statute to the contrary, a participant and a plan may agree by contract to a particular limitations period, even one that starts to run before the cause of action accrues, as long as the period is reasonable."

This holding from *Heimeshoff* is counterintuitive and places unreasonable burdens on claimants to decipher the limitations periods crafted by claim administrators. As should be self-evident, no claimant ever considers that a deadline to file suit to recover benefits would be running while his or her appeal is pending.

The *Heimeshoff* decision has created much confusion because the Supreme Court failed to appreciate the inherently confusing nature of the boilerplate "proof of loss" language inserted into most group disability plans by insurers. For example, Unum Life Insurance Company of America inserts the following two provisions relating to the contractual statute of limitations into many of its group policies:

> No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No action shall be brought after the expiration of *three years after the time written proof of loss is required* to be furnished.
>
> . . .
>
> Written proof of loss must be furnished . . . in the case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days *after the termination of the period for which the insurer is liable* and, in the case of claim for any other loss, within 90 days after the date of such loss.

(emphasis added). A layperson would assume the "the period for which the insurer is liable" lasts as long as his or her disability, yet surprisingly some courts deny this argument and common sense. *See, e.g., McArthur v. Unum Life Ins. Co. of Am.*, 45 F. Supp. 3d 1303, 1307 (N.D. Ala. 2014); *Kirkland v. Guardian Life Ins. Co. of Am.*, No. 3:06–cv–107, 2008 WL 1990340, at *10–11 (M.D. Ga. May 5, 2008) (deciding the "period for which the insurer is liable" is the interval between a plan's scheduled benefit payments rather than the total period that an insurer may potentially be liable for payment). A disability benefit claimant is simply not equipped to evaluate these provisions to determine the running of an internal limitations period.

The DOL can alleviate the ambiguity and confusion caused by *Heimeschoff* by creating standards for what is a reasonable plan-based limitations provision, in the same way that the DOL used its regulatory power to create timing deadlines for the claims process in prior versions of the regulations. Since *Heimeshoff* left open the illogical possibility that an internal limitations period could run before the appeals process is complete (even in cases where exhaustion is mandatory), the DOL is in a good position to clarify that such an approach would violate full and fair review required by 29 U.S.C. §1133.

Additionally, because contractual limitations periods are plan terms, the claimant should receive notice about the limitations period from the plan just as is the case with other plan terms. As the DOL correctly points out in the preamble to these proposed regulations, plan administrators are in a better position to know the date of the expiration of the limitations period and should not be hiding the ball from claimants if the plan administrator is functioning as a true fiduciary. Surprisingly, even though plan and claim administrators are supposed to serve as fiduciaries to claimants, in my experience, administrators routinely refuse to clarify the relevant limitations period, even when our office requests clarity on the limitations period for a claimant's claim.

As a result, I propose an amendment to the regulations (see below) 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. The proposed alteration takes into account 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. This proposed rule 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 beneficial for both claimants and plan administrators, reducing uncertainty and unnecessary transaction costs for all parties.

Insurers are already required under certain state insurance laws to advise their insureds of applicable limitations periods in non-ERISA claims. California, for example, has long required the following as part of its Fair Claims Settlement Practices Regulations:

> Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverages, *time limits* or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant.
>
> 10 CCR §2695.4(a), emphasis added.
>
> Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately.

10 CCR §2695.7(f)

Under California law, the failure to advise insureds of the applicable limitations period estops insurers from asserting such a defense. *Spray, Gould & Bowers v. Associated International Ins. Co.* (1999) 71 Cal.App.4th 1260, 1269-1273. This standard takes into account the common sense notion that plan administrators and insurers, as the drafters of these boilerplate "proof of loss" language, should be required to explain the implications of that language in plain English.

Moreover, at least one federal court has interpreted the existing regulations to require notice of the expiration of a limitations period. *Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis, No*. 4:12CV53 HEA, 2014 WL 562557, at *4 (E.D. Mo. Feb. 13, 2014), *aff'd sub nom. Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 790 F.3d 799 (8th Cir. 2015)("[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of [ERISA] following an adverse benefit determination on review." 29 C.F.R. § 2560.503–1(g)(iv)). This is a minority perspective. Here, the DOL should do more than interpret its own rules; it should re-write them to remove any ambiguity.

I therefore 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.
>
> **(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.

(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).

II. The Proposed Regulations Should Require the Claims Administrators to Inform Claimants of Their Right to Request Their Claim File

The regulation concerning notice of the right to request relevant documents contained in 29 C.F.R. §2560.503-1(g)(1)(vii)(C) [proposed regulation] is an improvement since it was formerly missing from the regulation. However, it would be more helpful to claimants to use the words "claim file," which is plain language and is consistent with the amendment at 29 C.F.R. §2560.503-1(h)(4)(i) [proposed regulation]. Attorneys understand the language of (g)(1)(vii)(C), but lay persons, who are the actual participants and often not represented, may not realize what rights are given here.

As a result, I suggest the following amendment to the proposed regulation (added language is underlined and bolded):

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 entire 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.

///

///

///

III. The Proposed Regulations Should Require the Claims Administrator to Advise Claimants of Their Right to Retain an Attorney for Any Internal Appeal

Often ERISA claimants who have been wrongly denied disability benefits do not realize that they have the right to be represented in the administrative appeal process. In my practice, I have been contacted by claimants who said they believed that the internal appeal process was an "informal" process and filed an internal appeal without realizing the importance of submitting additional evidence to establish their claim. I have found that claims administrators all too eager to deny appeals from self-represented claimants shortly after receiving the appeal, knowing that once an internal appeal is denied it is virtually impossible to introduce relevant evidence in litigation. In some cases, I have seen claims administrators deny appeals from self-represented claimants within days of the appeal, saying that no new information has been submitted.

29 C.F.R. section 2560.503-1(j)(4) currently requires any notice of an adverse determination of a benefit determination on review to inform the claimant of the right to bring an action under ERISA. This only implies the assistance of an attorney to file suit and does not underline the right to retain counsel to submit an internal appeal. Therefore, to clarify that a claimant may obtain legal assistance to assist with a pre-litigation appeal, 2560.503-1(g)(1) should be amended to require a plan administrator to inform a claimant of his or her right to "retain an attorney to represent you on appeal" from an adverse benefit determination.

Thank you for the opportunity to comment upon the proposed regulations.

Sincerely,

/s/ Brian H. Kim

Brian H. Kim
BOLT KEENLEY KIM LLP