

## **Comment on a proposed regulation**

Re: Claims Procedure Regulations for Plans Providing Disability Benefits  
RIN No.: 1210-AB39  
Regulation: 29 C.F.R. §2560.503-1

To: Phillis C. Borzi,  
Assistant Secretary Employee Benefits Security Administration

Dear Assistant Secretary Borzi:

I represent claimants in ERISA benefit matters and have done so for more than 10 years. Most of my clients are disability claimants; some claims also involve life insurance waiver premium benefits; occasionally, we have a straight life insurance claim. My partner and I have represented hundreds of claimants all over the country in administrative appeals and in litigation.

### I. Independence/ Impartiality

The proposed regulation is very much a step in the right direction regarding the need for independence and impartiality of claims adjudicators and medical experts, but it is not enough. What this regulation fails to recognize, at least in regards to medical experts, is that most insurers and third-party administrators obtain medical experts from outside services and the services, in my experience, commonly use their internal quality assurance or quality review processes to alter or change doctor's opinions. That is, the so called independent medical experts are provided information and sent a set of questions; they answer the questions; the service which provides them reformats the questions and the answers - - and frequently changes the answers. To insure independence of such medical experts, it is necessary not only that the administrative record include the final report that is attributed to the medical expert, but also that the administrative record include the questions presented, any templates, and all communications between the service (or directly by the insurer) and the medical expert, including drafts of reports, so that true independence can be assessed. Frankly, on those rare occasions (because in litigation ERISA cases rarely allow comprehensive discovery) that I have been allowed to "drill in" to the background of medical reports I have found that they have been rewritten by services. The problem is

compounded by the plan/insurers/third-party administrations claim that since they never saw the communications between the services and the doctor, and that they do not have possession, custody, or control over those documents, they therefore cannot include them in the administrative record. Generally, these facts come to light only when there is robust discovery - - which will never happen in ERISA cases. I have learned most of these facts because we also represent plaintiffs in insurance bad faith case where realistic discovery is permitted.

Therefore, to strengthen the new regulation regarding independence and impartiality, the regulation should also require that to insure independence and impartiality of medical experts, all communications sent to or from the medical expert, from whatever source, on the claim, and all drafts of the report must be obtained and included in the claim file and that when applicable, the contract between the insurer or third-party administrator and the service and the contract between the service (or insurer) and the doctor also be included in the claim file. Otherwise, the medical expert report is presumed to be not independent and should be accorded no weight.

## 2. Social Security Administration, etc. Decisions

The requirement in the proposed regulations that adverse benefit determinations in disability benefit claims will have to include the basis for disagreeing with any disability determinations by the Social Security Administration, is also a definite step in the right direction. Even in circuit courts which the standard requires consideration of Social Security determinations, such as the Ninth Circuit, court routinely disregard inconsistent SSA determinations. For example, in one of my recent cases, *Barnett v. Southern California Edison Long Term Disability Plan*, 2015 U.S. at Lexis 21179 (9th Cir. Dec 7, 2015), a panel of the Ninth Circuit gave short shrift to my argument that the plan administrator gave no weight to a contrary SSA determination (although you cannot ascertain this from the decision), neither the denial letter or the appeal denial letter ever mentioned the contrary SSA decision; the defendant argued that because two of seven reviewing doctors listed the SSA information in their medical reviews - - without addressing it - - that that was sufficient. Clearly that was not. This proposed regulation obviously would have to avoid such unfair practices in the future.

### 3. Internal Rules

The proposed change in regulations regarding addressing specific internal rules guidelines, protocols, etc., is a step in the right direction, but is not strong enough. The reality is that almost invariably insurers and third-party administrators claim in rendering decisions on disability appeals that they do not rely upon rules, guidelines, protocols or standards. There is an inherent tension between consistent adjudication of claims and not having rules, guidelines and protocols or standards upon which an insurer relies upon. These insurers and third-party administrators have numerous people making determinations, often in different parts of the country. There is simply no way they are not utilizing rules, guidelines, protocols or standards, but disclosing them. The rule should be that all rules, guidelines, protocols, standards, or other similar criteria utilized by the claim administrators to train, supervise or evaluate personnel making benefit decisions must be disclosed with the claim file or it will be presumed that the decision was not made consistent with other claim decisions. I realize that insurers and third-party administrators claim that these are confidential business records and it would prejudice them to disclose them publically. That is simply not true: UNUM widely discloses its claims standards because it was ordered to do so by numerous state departments of insurance: Reliance Standard has disclosed its claim standards to me; Standard never discloses its claim standards in ERISA cases, but does so in bad faith cases. The reality is that all of these insurance companies and third-party administrators have standards and criteria; of the major carriers, few routinely disclose them. All should be obligated to disclose them.

### 4. Reviewing New Evidence

The proposed regulation regarding granting claimants the right to review and respond to new evidence or rationales developed by the plan during the pendency of the appeal is also very much needed. It is not uncommon in my experience for the rationales and the reasons to change from denial letter to appeal denial letter without any explanation. A classic example of this is in one of my cases, *Boxell v. The Plan for Group Insurance of Verizon Communications, Inc.*, 51 F. Supp. 3d759, 776 (N.D. 2014) in which the court concluded that in the course of its communications regarding its claims decision and its claims processing, the claims administrator not only “moved the target” it actually “hid

the target”, deliberately obscuring its standards, rationale, and reasons. In my experience, this is simply not unusual and deprives claimants of a full and fair appeal.

One of the concerns that I have about commenting on appeal medical reviews is that the regulation should also impose reasonable timelines on the plan. Here is what we frequently encounter: We submit appeals; 45 days pass and the plan exercises its right to an extension without giving any explanation; 45 days more passes and the plan provides its appeal medical review for comment - - obviously intending by doing so to “restart the clock” for its final decision. This sequence happens all the time in our claims, especially with certain insurance carriers. In order to avoid this state of affairs, the regulation should provide that the decision maker must solicit and obtain the medical report on appeal within 45 days of receiving the appeal, which time can be extended by a tolling agreement with the claimant; otherwise, any medical review on appeal may not be considered in the decision making process and it will be presumed that there is no medical grounds to deny the claim.

Here is an example of the problem from a current case:

1. By letter dated August 26, 2014, plan terminated Claimant’s LTD benefits.
2. By letter dated January 5, 2015, we timely appealed the August 26, 2014 termination of LTD benefits.
3. By letter dated January 8, 2015, plan acknowledged receipt of claimant’s appeal.
4. By letter dated January 27, 2015, we supplemented the appeal with additional medical records.
5. By letter dated February 18, 2015, plan informed us that it may need an additional 45 days to render its decision on claimant’s appeal from the termination of LTD benefits, but it did not notify us of any additional time needed.

6. By letter dated March 19, 2015, we submitted updated medical evidence.
7. By letter dated April 8, 2015, we asked that plan make its decision on the appeal or at least provide a projected decision date.
8. By letter dated April 15, 2015, plan notified us that it was awaiting clarification of a medical review.
9. By letter dated May 22, 2015, we wrote that plan had had claimant's appeal for 117 days, well in excess of the maximum 90 day time to decide the appeal; that plan commonly fails to timely decide appeals and thus violates the Regulations. We asked plan to decide the appeal by June 5, 2015.
10. On June 5, 2015, plan provided us with a peer review report to which it asked claimant's physician to respond, giving until July 3, 2015, to do so.
11. By letter dated June 15, 2015, we responded to the peer review.
12. By letter dated June 24, 2015, we sent claimant's physician's response to Plan.
13. By letter dated July 6, 2015, we requested a status update of claimant's appeal.
14. Plan responded on July 7, 2015, that it was reviewing claimant's physician response.
15. By letter dated July 14, 2015, we requested a decision in claimant's appeal, as plan had had the appeal for 190 days.

16. By letter dated July 22, 2015, plan asked for records from the another physician who was referenced in claimant's doctor's June 24, 2015, submission.
17. By letter dated July 23, 2015, we provided the requested records and we asked why the records were being requested a month after Plan received claimant's doctor's response. We gave plan until July 30, 2015, to decide the appeal.
18. As we were preparing to file suit, we received a letter dated August 11, 2015, from plan's representative, which represented that plan wanted claimant to submit to an IME on August 19, 2015, with an IME doctor who is an admitted liar and a fraud, having been disciplined by the California Workers' Compensation Board for fraudulent billing, so we refused and filed suit nine months after the appeal was submitted.

As a practical matter to avoid such circumstances, regulations have to protect against the claims decision maker "gaming" the system in such a fashion.

Thank you for your consideration of my comments.

Very Truly Yours,  
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