HARRIS BUCKNER LAW FIRM
34145 PACIFIC COAST HIGHWAY, #314
DANA POINT, CALIFORNIA 92629
VOICE: 949.218-3253
FAX: 949.218.3254

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 the last 15 years, I have represented claimants in ERISA benefit matters in the internal appeal process and (to a smaller degree) in litigation. The majority of my clients seek to reverse denials of disability and life insurance claims. Through the years it has become more evident that disability claims administrators are becoming increasingly shrewd and aggressive in defending against claims. I believe that the requirements of full and fair review need to be revised to prevent further erosion of claimants' rights to disability benefits and to prevent the promised disability benefits from becoming illusory. Due to my busy schedule, I have not had the time to draft my own letter on all the issues. However, I respectfully refer you to Sally Mermelstein's letter for a full analysis as I believe her comments are right on point. With that said, I offer the following:

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

This is an important issue as it is a common problem with ERISA disability benefit claims: claims administrators reviewing often come up with new support to deny a claim and then slam the door on the claimant by refusing to offer him 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).

Plan administrators have argued that permitting claimants to respond would lead to an endless or interminable appeal process. However, this argument is without merit. 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 and who often cannot pay his mortgage, support his family and/or pay 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** – The following fact pattern was offered in Sally Mermelstein's letter, but it truly is a VERY common fact pattern and one I see almost everyday: The claimant is 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 purportedly 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.

   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 - Importantly, the claimant needs adequate time to counter reports and rationales that the claims administrator has created 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. These professionals and 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 a minimum of 90 days.

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

a) Notification of the Internal Limitations Period – To truly achieve a "full and fair review" notification of the plan's time limits for filing suit must be given to the claimant as it protects the claimant from the loss of benefits because of a mere technicality.

Given that the *Heimeshoff* decision allows 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.

This is particularly important when it concerns unrepresented claimants as few claimants 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.

b) Reasonable Limitations Period - *Heimeshoff* says nothing about what a "reasonable" limitations period is. 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. I recommending the following: 1) the limitations period should not be able to run before the appeal process is complete and 2) an internal limitations period that is shorter than 2 years after the final appeal denial should be deemed to violate full and fair review.

Thank you for considering my comments,

Rhonda Harris Buckner, Esq.