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January 19, 2016

By Email (e-ORI@dol.gov) and Mail

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room M-5655
U.S. Department 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 comment on the Employee Benefits Security Administration's ("EBSA") proposed amendments to claims procedure regulation for plans providing disability benefits under the Employee Retirement Income Security Act of 1974 ("ERISA").

For over twenty years, my law practice has focused exclusively on the representation of insurance policyholders, including, in particular, disability benefit claimants in pre-litigation administrative appeals and ERISA litigation.

I applaud the EBSA's stated purpose to "improve the current procedural protections for workers who become disabled and make claims for disability benefits from an employee benefit plan." Robust procedural protections are particularly important in light of the few *substantive* rights and protections afforded plan participants and beneficiaries. In this regard, the expansive scope of ERISA preemption of state laws designed to protect insureds against insurance company abuse, coupled with the lack of meaningful remedies available under ERISA, largely immunizes insurance companies from all liability resulting from their actions—even if they wrongfully, intentionally or maliciously deny benefits. For nearly twenty years, courts throughout the country have thus decried the injustices ERISA has come to inflict upon those it was designed to protect:

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This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.

Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 53 (D. Mass. 1997).

[ERISA and its remedial provisions] have become virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a “regulatory vacuum” in which virtually all state law remedies are preempted but very few federal substitutes are provided.

. . . .

The unavailability of extracontractual damages has effects that are perverse . . . it creates strong incentives for HMOs to deny claims in bad faith or otherwise “stiff” participants. ERISA preempts the state tort of bad-faith claim denial, so that if an HMO wrongly denies a participant’s claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith.

DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 456, 459 (3d Cir. 2003) (internal citation omitted).

[T]he injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end.

Cicio v. Does, 321 F.3d 83, 106 (2d Cir. 2003) (Calabressi, J., dissenting in part).

In its Executive Summary, the EBSA has noted the “volume and constancy” of ERISA disability litigation. This is because the disability insurance industry has taken advantage of ERISA preemption to its great financial benefit and to the detriment of countless disabled insureds. Indeed, in a confidential memorandum written by a Provident Life (now Unum Group) senior executive, the nation’s largest disability insurer revealed its creation of an ERISA “task force” to take advantage of the protections afforded the insurance industry under ERISA in stark financial terms:

A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we

settled for \$7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million.

(Memorandum from Jeff McCall to IDC Management Group (Oct. 2, 1995) (attached as Exhibit 1).

No doubt, the EBSA will have received many comments critical of the proposed amendments from the disability insurance industry. Their comments and criticisms should be viewed in the context of the limited nature of the amendments themselves. ERISA itself is broken; these proposed amendments are quite modest procedural protections for vulnerable insureds who, in the end, will still be left to navigate a system that is inherently unbalanced against them.

I. The regulations should require the claims administrator to advise claimants of the date of the running of any applicable limitations period

Heimeshoff v. Hartford Life & Acc. Ins. Co., 134 S. Ct. 604, 616, 187 L. Ed. 2d 529 (2013) 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.” Setting aside that most disability claimants will not have experience navigating a limitations period, the holding from *Heimeshoff* is counterintuitive; 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 predictably has created much confusion. This confusion is confounded by 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 will understandably assume that “the period for which the insurer is liable” lasts as long as his or her disability, even though some courts deny this argument. *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 typically not equipped to evaluate these provisions to determine the running of an internal limitations period.

The EBSA should require plan administrators to calculate the internal limitations period and inform claimants of any potential expiration. As observed by the EBSA, plan administrators are in a better position to know the date of the expiration of the limitations period and are generally better equipped to answer this question than a claimant. One 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).

It is far from novel to require insurers to advise their insureds of applicable limitations periods. 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, coverage, *time limits* or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant.

Cal. Code Regs. tit. 10, § 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.

Cal. Code Regs. tit. 10, § 2695.7(f).

Failure to advise insureds of the applicable limitations period estops insurers from asserting such a defense. *Spray, Gould & Bowers v. Associated Internat. Ins. Co.*, 71 Cal. App. 4th 1260, 1269-73 (1999).

I recommend an amendment to the regulations governing the manner and content of notification of benefit determinations on review. *See* 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. This amendment addresses conflicting court views on when claims “accrue” because 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. The *Heimeshoff* decision itself suggests the importance to promulgate further regulation in this area. *See Heimeshoff*, 134 S. Ct. at 616.

Accordingly, I propose amending the proposed regulation by adding a section as follows and renumbering accordingly (added language is indicated in bold):

29 C.F.R. § 2560.503-1 (j) (proposed regulation)

(6) 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 or enforceable 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 no 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.**

II. Reasonable temporal limits may be placed on the proposed requirement that claimants be given an opportunity to review and respond to new evidence generated by the claims administrator on appeal

The purpose of 29 C.F.R. § 2560.503-1 is to provide disability claimants with the information needed for a meaningful review of their denial of benefits so the determinative issues may be addressed. When information is properly disclosed by the claims administrator, it allows a claimant to address the accuracy and reliability of that evidence to ensure “a meaningful dialogue” between the parties. *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997)

The EBSA’s proposed amendment at 2560.503-1(h)(4)(ii) is necessary to promote a “a meaningful dialogue.” This amendment raises the question of temporal limits on a claimant’s

opportunity to respond to new evidence. The following suggestion places reasonable limits on both claimants and plan administrators. Claimants should have up to 75 days to respond to new evidence or rationales provided by plan administrators. A motivated claimant with a less complicated medical condition or injury may submit well before the 75-day deadline, but many claimants have disabilities that require testing or examination by specialists, including neuropsychologists or vocational consultants. In these cases, sometimes even more time will be required. If more time is required by the claimant, the plan administrator should grant a reasonable extension of time for the claimant to respond.

Moreover, consistent with the tolling recommendation above, the period for the decision on review to be completed should be tolled during this 75-day period. When the claimant has responded, the plan administrator should be allowed whatever time was left under the existing regulations or 30 days, whichever is longer, to issue its determination on review. This rule should apply whether the new information is a new “rationale” or new “evidence.”

Accordingly, I suggest the following amendment to the proposed regulation (added language is indicated in bold):

29 C.F.R. § 2560.503-1(h)(4)(ii) (proposed regulation)

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 on 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 claimant before the decision on appeal is issued and the claimant must be afforded up to 75 days to respond. In instances where a greater response time may be necessary, the plan administrator shall grant a reasonable extension of time for the claimant 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;** and

III. The proposed regulations should be clarified to require the claims administrator to advise claimants of their right to request their claim file

The proposed regulation at 29 C.F.R. § 2560.503-1(g)(1)(vii)(C) is a positive amendment to the regulations. However, the amendment should include the phrase “claim file,” which is a plain language term used in the insurance industry to designate all information relating to a claimant’s benefit claim and a defined term under the proposed amendments. In my experience, claimants without the benefit of counsel may be unaware that they are permitted access to their entire file and may only request a specific type of record, such as medical records. My suggested clarification will

confirm for a claimant unfamiliar with ERISA that the plan administrator may disclose all relevant documents.

I suggest the following amendment to the proposed regulation (added language is in bold):

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.

IV. The regulations should require the claims administrator to advise claimants of their right to retain an attorney for any internal appeal

Many ERISA claimants are unaware that they have a right to be represented by counsel in pre-litigation appeals to the plan administrator. Speaking from experience, in the past year alone two of my clients were told by separate plan administrators that claimants are *prohibited* from retaining an attorney during the administrative appeals process. In both cases, this misinformation ultimately delayed the appeal submission and may have prejudiced each client's case.

Regulation 2560.503-1(j)(4) currently requires any notification of an adverse determination of a benefit determination on review to disclose the right to bring an action under ERISA, which implies the assistance of an attorney to file suit. However, 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 these important proposed regulations.

Very truly yours,



Terrence J. Coleman

TJC:js
Enclosure

EXHIBIT 1

PRIVILEGED

Provident Internal Memorandum

*Jeff,
looks good. See
comment on last page.
Ken D.
10/4/95*

To: IDC Management Group
Glenn Felton

From: Jeff McCall

Date: October 2, 1995

Re: ERISA

A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for \$7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million.

In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. Accordingly, I have attached a rough draft of questions that should be asked in our claim investigation process. I recommend that it be used for all claims. The key for determining the applicability of ERISA is whether or not the employer "sponsors" or "endorses" the plan. If the employer pays the premium, the policy would usually, but not always, be considered to be governed by ERISA. Salary allotment or payroll deduction arrangements, by themselves, do not necessarily mean that a policy is subject to ERISA. While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.

Another requirement needed in order to take advantage of the protection offered by ERISA, is to establish a formal appeal process for ERISA situations. When we deny a claim, we must include language in our letter that informs the claimant of the right to appeal our decision within 60 days. I have attached a copy of sample language. The appeal must be in writing and should be reviewed by a panel specifically established to review ERISA appeals. I recommend that the panel be composed of Chris Kinback, Bob Parks, Becky Absher, Tom Timpanaro and me.

We will be modifying the salary allotment agreements used at the point of sale to include endorsement language.

I am interested in any comments or feedback you may have on this issue.

JM:ajr

*Paul
Dinglers*

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