SINCLAIR WILLIAMS LLC
ATTORNEYS & COUNSELORS
2100-A SouthBridge Parkway, Suite 336 • Birmingham, Alabama 35209
P: 205.868.0818 • F: 205.868.0894
www.SinclairWilliams.com

January 18, 2016

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 request your consideration of the following comments on the proposed amendments to the claims procedure regulations applicable to disability benefit plans. For the past 15 years, I have represented claimants pursuing disability benefits provided through ERISA-governed plans. I review in any given year a minimum of three hundred to four hundred ERISA-governed claims and in some years that number has reached above eight hundred claim reviews.

I limit my comments to two areas of primary concern as it relates to the proposed changes in procedure and disclosure. Before addressing those two areas of concern I wish to express my appreciation for the EBSA's work to improve transparency and provide clarification in the regulations. Overall, the proposed changes will offer consumers, the industry and ultimately the courts better insight into the proper interpretation of the regulations. The proposed clarifications also reflect thoughtful consideration of recent U.S. Supreme Court opinions that described what that court thought the proper role a decision maker should play in the administrative scheme. My 'areas of concern' therefore are not to be taken as criticism. Instead I would ask they be considered suggestions for further clarification of the regulations.

1. § 2560.503-1(g)(1)(vii)(B) *Improvements to Basic Disclosure Requirements.*

Effective January 20, 2001, the Department of Labor improved disclosure requirements to require not simply the materials "relied upon" in making a determination but to further require production of all "relevant" documents as that term is now defined within § 2560.503-1(m)(8). Prior to this change, administrators could avoid production of materials supportive of the claim

for benefits by asserting those supportive documents were not "relied upon" in denying the claim.

The proposed language within the additional paragraph (g)(1)(vii)(B) uses the same "relied upon" language which was problematic in the pre-2001 regulations. It has been my experience over the course of several thousand claims the most common response we receive from claims administrators is to argue they did not "rely upon" their internal regulations, protocols, rules or standards in denying the claim and thus there is no need to produce them. This, of course, begs the question whether or not the administrators violated their own rules, guidelines, protocols and standards by ignoring them.

As it currently stands, the amendment would seem to offer two alternatives: (A) provide the "internal rules, guidelines, protocols, standards or other similar criteria of the plan *relied upon*" or (B) state there are no such documents. Thus it may appear claimants will get either (A) or (B). However, consider the scenario where the administrator violated their own internal rules in denying the claim. Rather than disclosing that violation by producing the rule or stating no such rule exists, the administrator may simply choose (C): state that in denying the claim the administrator did not "rely" upon their internal rules. We would propose the following clarification:

RECOMMENDATION:

Current:

> (B) 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.

Proposed:

> **(B) The "relevant" (as defined by ¶ (m)(8)(iii) and (iv) of this section) internal rules, guidelines, protocols, standards or other similar criteria of the plan, plan administrator, claims administrator or other entity making the adverse determination.**

There should not be much objection to this clarification from the industry involved in the administration of these claims given that many are beginning to recognize the importance of full disclosure of internal rules contained in documents such as claims manuals. Indeed, one of the largest disability insurers has begun providing its claims manual upon written request to disability claimants. The relevant provision of Unum Group's Claims Manual is attached.

2. § 2560.603-1(h)(4)(ii) and (iii) *Right to review and respond to new information before final decision.*

Out of the thousands of claims that I have reviewed over the course of my practice, less than five percent (5%) of the claimants sought advice prior to filing a claim. Ninety-five percent (95%) of claimants who sought assistance with ERISA claims did so only *after* the initial denial. This provides a very limited time period for the claimant's attorney to become familiar with the case and to submit additional evidence.

This narrow window of time is exacerbated with what the ERISA plaintiffs' bar refers to as "sandbagging" where a claims administrator discloses for the first time new medical opinions in the final (appellate) denial. The new regulation would assist claimants in being fully informed on the basis for the final denial and in providing them with the opportunity to respond *if* the claimants are given the right to "toll" the time for a determination when presented with new evidence.

RECOMMENDATION:

> **If the plan or claims administrator generates new evidence during the appeal of an adverse benefit determination, then that administrator is required to "give the claimant a reasonable opportunity to respond . . ." by providing the claimant (at the claimant's discretion) the right to temporarily "toll" his claim review.**

Oftentimes the "new evidence" generated during the appeal phase of a disability claim is medical evidence generated by insurance company physicians who are employees of the company or by insurance company "paper" doctors who provide medical records reviews through third party service companies dedicated to the insurance industry. While it may be that the insurance companies may demand quick turnaround from their captive physicians, such is not possible for a claimant.

The claimants are not able to insist on their attending physicians' responses within a few days' notice or even a few weeks' notice. If the administrators of the claim generate new medical evidence on appeal, claimants should be given a right *at their discretion* to trigger the tolling provisions under the regulation and inform the administrator that the clock for making the determination will not begin to run again until such time as the claimant is able to procure a rebuttal for the new evidence.

Once the claimant submits that rebuttal to the administrators' new evidence, the "clock" would continue on the time period for making a determination, thus giving the administrator the same amount of time they had left prior to the "tolling" of the claim decision window. Such a proposal is in line with the majority of jurisdictions which have dealt with the timing issue and the administrators' attempts to generate additional evidence during the appellate phase. *See Abatie v. Alta Health & Life Ins. Co., et al.*, 458 F.3d 955, 973-974 (9th Cir. Cal. 2006) (*en banc*) (an administrator's stating of a last minute reliance on a new ground for denial of benefits must

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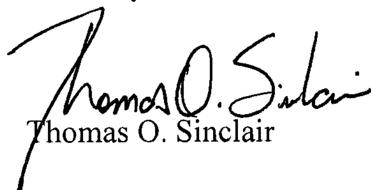
be considered as part of the administrator's failing to adhere to the ERISA and Plan's procedures: "an administrator must provide . . . adequate notice of the reasons for denial . . .and must provide a "full and fair review" of the participant's claim . . . When an administrator tacks on a new reason for denying benefits in a final decision, thereby precluding the plan participant from responding to that rationale for the denial at the administrative level, the administrator violates ERISA's procedures." . . . "Accordingly, an administrator that adds, in its final decision, a new reason for denial, a maneuver that has the effect of insulating the rationale from review, contravenes the purpose of ERISA. This procedural violation must be weighed by the district court in deciding whether [the administrator] abused its discretion"); *Jebian v. Hewlett-Packard Company*, 349 F.3d 1098 (9th Cir. 2003) (a contrary rule would allow claimants, who are entitled to sue once a claim had been "deemed denied," to be "sandbagged" by a rationale the plan administrator adduces only after suit has commenced); *Conley v. Pitney Bowes*, 176 F.3d 1044 (8th Cir. 1999) (Refusing to consider insurer's post hoc rationales in claim litigation); *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005) (Evidence of independent medical examination acquired during last stage of appeal could not be relied upon by claim administrator as supporting its claim decision. "There can hardly be a meaningful dialogue between the claimant and the Plan administrators if evidence is revealed only after a final decision." The claimant should have been permitted to review and respond to the report).

By providing claimants the right to "toll" the claim decision window or take a timeout when the claims administrator hits them with new evidence at the eleventh hour, the Department can alleviate not only the lack of meaningful dialogue referenced by the courts, it will also alleviate stress on the attending physicians across the country by providing them more time to respond.

We greatly appreciate the opportunity to provide commentary on the proposed clarifications and stand ready to respond to any questions or concerns you may have with our recommendations.

Sincerely,



Thomas O. Sinclair

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