December 4, 2017

Dear Committee:

I am writing in effort to provide addition clarity to your consideration of the proposed ERISA regulations. I have represented disability claimants in ERISA-based disability cases for over twenty years. It is my only practice area for which I have represented many hundreds of claimants.

Disability Insurance Economic Model

Before discussing the problems with the ERISA appeals procedures, it is important to understand the disability insurance benefit model. Disability insurers employ actuaries to provide detailed estimates based on complicated alogrithms to determine the probability of disability for individuals from particularized pools. They use these estimates to set premiums which are designed to render a profit. While collecting premiums on the pools of insureds prior to claims being made (which increase with average insured's age), the disability insurers invest these monies (called "the float") to earn additional income. Finally, when it is time to pay claims, the insurers will deny many claims which results in a windfall to the insurer when insureds fail to appeal or do so unsuccessfully. For this reason, it is extraordinarily clear that the disability insurers have created a system which profits them even before undertaking questionable claims review activities.

Additional Evidence Submitted with Claim Denials Following Claimant Appeal

Under the ERISA framework, disability insurers are "gaming" the system in various ways. Following appeal filed by disability claimants for denial of disability coverage, most disability insurers will add new physician reviews in their final claims decision. This unsavory practice is called "sandbagging" by the claimant's bar. The insurers will then attempt to bar any response by claimants in an effort to restrict the contents of the claim file in order to prove that they were "reasonable" in their review efforts under the applicable ERISA judicial standard of review.

Numerous court decisions have decided the impropriety of disability insurers engaging in sandbagging. An administrator is bound by its initial decision and cannot later assert a new rationale as this is "sandbagging" by post-hoc justifications. *Winebarger v. Liberty Life Assur. Co. of Boston*, 571 F.Supp.2d. 716,726 (W.D.Va. 2008). An insurer cannot close the record to the insured but keep it open for itself. *Russo v. Hartford Life and Accid. Ins. Co.*, 2002 WL 32138296 (S.D.Cal.2/2/02) citing *Killian v. Healthsource Provident Adminstrators, Inc.*, 162 F.3d 514 (6th Cir. 1998); *See Also*, *Toppins v. The Hartford Life and Accident Ins. Co.*, 657 F.Supp.2d 1107 (W.D. Missouri 9/24/06).

The disability insurers will protest the new protections afforded by the proposed regulations as they will no longer be able to garner an advantage by their sandbagging conduct. They will argue that this increases cost and time invested into the claims review. Unfortunately, the disability insurers have brought this upon themselves by their own improper conduct. There was no reason why they could not review claimant appeals and decide the case without generating new evidence on which to deny the claims. Instead, they will now claim undue burden. Such a claim should be seen as self-serving and meritless since, if the insurers had followed ERISA as intended, their costs would contained. Their position only reveals their real intention of denying disability claims by any means possible.

Manipulation of Appeals Decision Deadlines

It is very common for disability insurers to manipulate the appeal deadlines in order to gain additional time to create sandbagging denials. In order to defeat this practice, deemed exhaustion must be asserted by claimants so that they can avail themselves of relief in the courts from this unlawful practice. Many times, courts will excuse this poor conduct and remand the case back to the administrator which does little more than provide the disability insurer with even more time to create a more effective claim denial.

An recent example of improper insurer manipulation of the appeals deadlines led to a rebuke of this activity in *Wiley v. Prudential Ins. Co.,* 201 F.Supp.3d 176 (D.D.C. 2016)(a case litigated by this counsel).

Disability Insurer Conflict of Interest

The disability insurers often are affected by overt conflicts of interests. A glaring example is Unum's current practice of awarding bonus compensation in the form of cash and stock/stock options to its medical review personnel based on company performance. The medical reviewers are required to own a significant amount of Unum stock as part of their employment. Therefore, the interest of the reviewers is clearly affected by Unum's profitability. To this end, claims departments do not create cash flow to the company in the form of premiums. Rather, they restrict outflow of expenses in the form of paid claims. Therefore, denying claims insures to the company's benefit, which, in turn, results in bonuses to the claims personnel in both cash, stock/stock options, and increase stock price for stock already held.

Moreover, as a penalty for failing to conform to Unum's claims review expectations, the medical personnel suffer restriction on the sale of their stock and stock options should their employment be terminated. This "carrot and stick" approach to dealing with claims personnel creates an important and unavoidable conflict of interest in claims review. This is only one example of such practices by the disability insurers in this regard.

The disability insurers will not disclose these activities to this Committee and hope it does not find out about such conduct. Unfortunately, the profit seeking motives of the disability

insurers can never be underestimated. In the end, it is only the claimants that suffer.

Conclusion

Thank you for taking the time to review my concerns regarding the new regulations and why they are so necessary to protect claimant rights in a system that clearly favors disability insurance interests.

Respectfully,

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