From: Robert Perez
Sent: Friday, December 08, 2017 5:54 PM
To: EBSA, E-ORI - EBSA
Subject: 1210-AB39

Office of Regulations and Interpretations,
Employee Benefits Security Administration
Room M-5655
U.S. Dept. of Labor
200 Constitution Avenue NW
Washington D.C. 20210

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

Dear Deputy Assistant Secretary Hauser:

This is to oppose modifying or further delaying the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) that are now scheduled to go into effect on April 1, 2018.

Our firm represents many individuals in ERISA matters particularly in disability claims. With 35 years of experience in over 20 of them focused on ERISA, we are qualified to comment on the issues regarding the claims regulations.

Want to take an opportunity to comment on the re-examination noting that the claims raised by the insurance industry are not new or novel. This is simply an attempt to revisit the issue without a reasonable basis for doing so. We have found that although the stated intent of ERISA by Congress was to assist employees obtain benefits, much of the early case law has been pro insurance company. The Department of Labor's regulations have limited the one-sided nature of the claims process with an insurance company by disabled individual. Many of these individuals are so financially stressed that they are in jeopardy of losing their house, their car, and making drastic choices about medical care that is desperately needed to return them to functioning.

Costs Will Not Increase

The industry claims if the final rules go into effect there will be an increase in costs that will increase premiums resulting in less access to disability benefits. The claim of increased costs is overblown and inaccurate. The claims regulations fundamentally require the opportunity for the claimant to respond to last-minute attempts by the disability carrier to justify the denial without an opportunity for the claimant employee to respond. This is fundamentally unfair.

At the time when the industry previously made these comments and they were rejected before the final adoption of the rules. The Department concluded that costs would not outweigh the benefits. This is truly accurate. It is intuitively obvious that the burdens on the claimant for delay and subsequent denial

without a fair opportunity have the claim paid outweighs the requirement that the insurance company review additional material submitted after the claimant has an opportunity to review it.

Having done ERISA claims prior to 2002, the clarity that was added with those regulations assisted in opening the process and assuring claimant had more due process in the ERISA appeal. We refer to the department to the Bureau of Labor Statistics. https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm.The data show an increase in employer-based disability insurance. The problem with the argument of the insurance industry is that it looks at the costs that are incurred without regard to the costs of litigation that might be prevented by a more open fair process.

The Department has also asked for data about whether disability premiums increased in response to the adoption of statutory bans on discretionary language clauses in disability policies by some states. Unfortunately, I cannot really address that because I practice in Ohio that has not considered this issue. But intuitively, if a federal judge is required to examine the evidence and make a determination without regard to a claims adjuster's prior judgment, it should encourage the claims administrators make a more careful review and determination. As one federal judge said during a hearing, "I do not know why I must defer to claims adjuster who is had no training in due process or legal analysis." This is an accurate insight. Nowhere in the statute does this arbitrary and capricious standard exist. It is unfortunate that the courts have grafted this onto determinations by a claims adjuster who obviously, does not understand their fiduciary duties that a true trustee would. It is well-established in the insurance industry that the underwriting and rate setting should be separate and apart from the claims process.

The Benefits Outweigh the Costs

Whatever the cost of the final rules, are outweighed by the more open and fair claims process that would result at should be reflected in diminished litigation and shifting the cost of the claims process onto the courts. Currently we are involved in litigation because an insurance company refused to make a simple claims determination in an ERISA matter, and filed a court action to have a federal judge make the determination when a simple reading of the insurance policy should have resulted in the claim paid. Undoubtedly, the insurance industry has not factored in the costs to the public and the taxpayer of the increase in litigation that occurs because of unfair claims handling. We have seen a change in the attitudes of the federal judiciary from deferring to claims adjusters if there's any reason at all stated in the denial to actually doing an analysis to determine whether there are substantial reliable evidence supporting the denial. Enhancing the regulations to open the process would be step in the right direction to assist accurate claims determinations. The ERISA process is already tilted in favor of the claims adjuster who generally have no idea that they are supposed be acting as fiduciaries. No doubt they cannot spell fiduciary let alone act as one.

Innumerable times, I have been told by clients that they cannot believe that I disability insurance plan and to which they paid for many years is now not going to pay them when they need it. The lack of understanding of the insurance claims process is fundamentally denying claimants without attorneys from having their claims paid. Although, the claims currently say that the insurance company is supposed to tell them what is needed to perfect their claim, this never happens. Most recently, the attempts of the insurance company to satisfy this requirement, results in a laundry list of things that could possibly be presented such as MRIs, lab tests and other documents that do not give direction to the claimants whatsoever. Even if the rates increase, many times the employee is paying for the disability policy many times without any contribution on the part of the employer. A slight increase in

the rates, would certainly be acceptable to many claimants who find themselves not being paid in a time of need.

Requiring the Plan to Discuss the Basis for Disagreement with Social Security Decisions or Other Contrary Opinions is Not Costly.

The insurance claims adjuster's consideration of the Social Security decision and the award that is deducted from the risk payments to be paid by the insurance company is truly sad. Current consideration of many of these claims adjusters is that we realize that you have Social Security and we've considered that, but the rules are different. This is the not the type of consideration that is contemplated by the Department of Labor. In fact, there has been a shift in the courts at least within the Sixth Circuit Court of Appeals where the decisions are now recognizing the fact that is incongruous for disability carrier to deny payment when in fact, the amount that they pay the claimant, is reduced by Social Security disability payments and the adjuster simply disregards the Social Security commissioner's determination. Nonetheless, this is what is seen. Even more absurd is the fact that any of the insurance carriers sure that the claimant gets a non-attorney assisting with Social Security disability claim to assure that insurance company has to pay less than they would if the claimant did not receive Social Security. Because these non-attorney representatives, do not have any ethical constraints, they discharge the client when the insurance company tells the non-attorney representatives that they are not going to be paying the claim anymore therefore, they are not going to pay for the Social Security representation. The claimant is left high and dry in the middle of the Social Security disability process. It's truly inequitable, yet this is way these "fiduciaries" act.

It is doubtful that there any costs incurred with properly investigating the claim and if there are, these are concomitant with the payment that the insurance company is receiving from the premiums. This is the essence of the job of the insurance adjuster. Insurance adjuster should be required to fully explain why there disagreeing with favorable Social Security decision. Simply stating that the standards are different, is inadequate and this is what we see constantly in the denial letters rather than any thorough analysis of why the decision is different when the Social Security Administration usually has a more stringent definition of disability, has awarded benefits.

The Deemed Exhausted Rule is Not Costly

The industry is concerned that attorneys representing claimants will file quickly and often is ridiculous. In the few times we've had to file a deemed exhausted claim in court, it is after insurance company has denied sometimes six letters requesting that they make a decision and the insurance company ignored all of these letters. Any attorney who is constantly in federal court and seeing the same judges over and over would never run to court and file suit saying "gotcha" because that judge will be very unhappy with the attorney, and the attorney's reputation will be diminished. As any attorney who is credible will tell you, their reputation with the judge is more important than any particular claim. We have never had a disability claimant hire us to do litigation on an hourly basis because they simply can't afford it. Therefore, carefully analyzing the claims and handling thoroughly throughout the process is the key to success as is attempting everything before filing suit. Further, a court will only award attorney fees for litigation where the plaintiff has achieved some degree of success on the merits. *Hardt v. Reliance Standard Life Ins. Co*., 560 U.S. 242, 255 (2010). The court's award of attorney's fees is discretionary, and among the factors is culpability of the parties, and filing a suit without attempting to exhaust all non-judicial interventions is key to showing the insurance companies culpability. Therefore, it is only when

there is absolute stonewalling on the part of the insurance company that we choose to file a deemed exhausted case.

Providing the Right to Review and Respond to New Evidence or Rationale From the Plan During the Appeal Review is Not Costly.

It is essential that claimants be given the opportunity respond to the higher paper reviewers. These insurance company physicians have some of the most ridiculous reasons for recommending the claim not be paid. The most popular is "the medical records do not support the disability." This is a rote reason. It is totally inadequate when the treating physician who has had clinical experience and sometimes years of treating the patient, as stated that the claimant cannot perform their own occupation. An opportunity for a treating physician to respond to this opinion without any factual basis is fundamental to a full and fair review required under the statute. The true reason why the insurance industry is concerned about this is that it would show clearly to the courts, the inadequacy of the paper reviewer physician's opinion. Having read these opinions for more than 20 years, I can attest to the fact that most of them are insubstantial. Recently, I had insurance company all me and tell me that their paper reviewer stated that the claimant's objective evidence of a functional capacity evaluation that showed she was disabled had some inconsistencies with the medical records. The insurance adjuster wanted my client who had taken two functional capacity evaluations at her expense take a third functional capacity evaluation. We responded, tell me what the inconsistency is, and we will have a treating physician explain the medical record. Insurance company declined to have clarification of this inconsistency that was never articulated even after repeated requests to tell us the nature of the inconsistency. Claimant's denial stated that claimant refused to take a functional capacity evaluation when, there was no provision in the insurance policy that allowed the insurance company to request this. The insurance carrier could have done an actual independent medical exam where a physician does a clinical examination of the patient. Instead it decided to deny the claim based upon a paper reviewer's determination that there was some inconsistency in the medical records regarding the actual functional capacity evaluations that were performed on the claimant. If this rule were in effect, there would've been an opportunity for a treating physician to explain the perceived inconsistency. This is even more inexcusable because medical records are not written by physicians to support disability claims but rather to treat the patient. More onerous is the fact that many of these paper reviewers call the treating physician who is in the middle of their day seeing patients and asked some questions about the claimant/patient and the treating physician does not have access to the medical records. Many times, when the treating physician sees the comments that are attributed to them in these telephone calls they are outraged. The treating physician many times states that this is a total misrepresentation of the content of the call. An opportunity for the treating physician to respond to the paper reviewer's representations of this call is essential. For years we've been requesting the opportunity to respond to the paper reviewers never has an insurance company agreed to it. The reason is clear, the insurance company does not want an accurate criticism of their higher paper reviewer's conclusory opinion. The additional costs that would be incurred would be the cost of sending a facsimile to the attorney then reading the response that probably would be faxed as well. How can this cost be compared to unfair denial?

Other Provisions

The Impartiality Rule

Concern about a rule requiring that the consulting experts be impartial is feckless. In our experience, are virtually no impartial physician reviewers. Sometimes the bias is so obvious that the requirement that they be impartial would merely show how inadequate the reviewer's review was. Many of the paper reviewers now put in the boilerplate stating that they have no interest in the matter and they are impartial when it is clearly not the case. The fear that the insurance industry has is that they will be required to move outside of the stable of hired reviewers who have developed a cottage industry of doing paper reviews for insurance companies and required to get medical specialists who have expertise is understandable but certainly not excusable. These current insurance company paper reviewers are so well known in the court system, that doing computer research will produce many decisions. Some judges make a finding of fact that the paper reviewer is a "frequent flyer" in making disability denials.

The Rule Requiring Disclosure of any Internal Limitations Period

Requirement that time limitations in the contract be stated to the claimant simply a matter of hitting a keystroke or two to produce a computer-generated paragraph in the denial letter. Since most of the denial letters are full of boilerplate language before the two or three sentence denial is standard operating procedure for the insurance companies and that there should be no cost. It is simply, fulfillment of a fiduciary duty to inform claimant to the time limit for filing suit. As the Sixth Circuit has required this notification, seems to appear and more and more denial letters. *Moyer v. Metro. Life Ins. Co*., 762 F. 3 503, 505 (6th Cir. 2014). Certainly, requiring it across-the-board could be no more costly – just another computer generated clause.

The Rule Requiring Disclosure of Internal Guidelines

Disclosure of internal guidelines or certification that none exist, is also something that should not cost anything more than adding a few keystrokes. After doing so many years of disability claims, sometimes our knowledge of the contents of the companies claims manual is greater than that of the claims adjuster. Requiring a claims administrator to reference the claims manual might require the adjuster to actually read their manual. This would have a salutary effect.

In conclusion, further delay of these rules is unwarranted. These regulations are necessary to assist the employee claimants to whom the insurance company as a fiduciary obligation. They will enhance the overall process, reduce unnecessary litigation and provide a framework within which the claims adjuster should work to assure "full and fair review" that is required under the statute. Please enact them on the scheduled date.

Sincerely yours,

Robert Armand Perez Sr.
Perez Law Firm Co. LPA
6921 Fox Hill
Cincinnati, OH 45236-4905
Tel: 513-891-8777
Fax: 513-891-0317
Email: rperez@cinci.rr.com
Web site: perezfirm.com