

# PUBLIC SUBMISSION

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**Docket:** EBSA-2015-0017  
Claims Procedure for Plans Providing Disability Benefits

**Comment On:** EBSA-2015-0017-0001  
Claims Procedure for Plans Providing Disability Benefits

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## General Comment

Please see attached

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## Attachments

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I represent disabled claimants seeking benefits under group and individual disability insurance policies, and am writing in support of the proposed regulations at:

<https://www.federalregister.gov/articles/2015/11/18/2015-29295/claims-procedure-for-plans-providing-disability-benefits>.

I am unaware of any rampant or systemic abuse by insurance companies reviewing claims under individual disability insurance policies. On the other hand, rampant and systemic abuse by insurance companies reviewing claims under group disability insurance policies is the rule. Ironically, ERISA, which was intended to benefit employees, has led to the disparate treatment. The primary culprit is discretionary clauses that grant an insurance company or administrator the unrestricted authority to determine eligibility for benefits and to interpret terms and provisions of the policy, contract or certificate.

Discretionary clauses place the employee at a disadvantage in any disagreement over the meaning of the insurance contract, usurp the role of the courts in deciding a matter of law, that is, the meaning of the contract, and exacerbate the insurer's inherent conflict of interests in being both the entity that pays and decides what does or does not need to be paid. In other words, the insurance company profits increase when it denies and terminates claims. As noted by the Supreme Court in *Metlife v. Glenn*, 554 U.S. 105, 128 S.Ct. 2343 (2008), where an insurer both determines whether an employee is eligible for benefits and pays those benefits out of its own pocket, there is a conflict of interest. This conflict would be greatly mitigated by prohibiting discretionary clauses.

Discretionary clauses are unjust and contrary State laws because the deferential standard of review is opposed to the common law doctrine that ambiguities in insurance contracts are to be construed in favor of the insured. Moreover, discretionary clauses in insurance contracts are also misleading because policyholders may not understand from reading these clauses that they are giving up the right to a neutral, merits-based review of the insurer's decisions and the meaning of the policy, and that the insurer as a practical matter could proceed with essentially absolute discretion as to what the policy means.

A disability or health insurance policy is a contract. The interpretation of a contract is a matter of law and ordinarily questions of law are for the judiciary to decide. In a court action on a contract, such as when an insured sues an insurer, a court looks at the question of law *de novo*, i.e., without regard for how the contract might have been initially interpreted by the insurer. However, when a discretionary clause is present, it largely usurps the role of the courts because they are required to give strong deference to the insurer's interpretation of the contract and will only overturn the insurer's view if the court finds the insurer's decision was arbitrary and capricious. This leads insurers to deny and terminate claims that they know should be approved.

Insurance companies' widespread abuse due to discretionary clauses prompted regulatory authorities to take action. In 2002, the National Association of Insurance Commissioners (the "NAIC") issued a model act entitled "Prohibition on the Use of Discretionary Clauses" (the "Model Act"). When an insurance company issues a group disability policy, a discretionary clause grants the insurer or administrator the authority to determine eligibility for benefits and to interpret terms and provisions of the policy. The purpose of the Model Act is to prohibit clauses that purport to reserve discretion to the insurer to interpret the terms of a disability insurance policy.

The abuse of discretionary authority by the insurance industry became so widespread that the media covered the issue. On October 13, 2002, NBC Dateline did an expose called "Benefit of the Doubt".[1] The story described how Unum Provident, the largest disability insurance provider, had systematically manipulated and created evidence in order to create excuses to deny and terminate disability claims. On November 20, 2002, CBS 60 Minutes also did an expose on Unum called "Did Insurer Cheat Disabled Clients?"[2] The 60 Minutes piece detailed how Unum forced doctors to manufacture evidence as a means to deny and terminate disability claims.

The abuses by Unum resulted in the U.S. Department of Labor and 49 State Insurance Departments bringing an action against Unum that resulted in a regulatory settlement agreement. Among other things, Unum was forced to reassess hundreds of thousands of disability claims that it had denied or terminated. Since that time, a blind eye has been turned to the continued abuses by insurers of group disability policies subject to ERISA.

In what is already a contract of adhesion, i.e., one that a consumer has no choice but to accept, discretionary clauses skew the balance of power even further in favor of the insurer. In other words, the subscriber is at a severe disadvantage in any contest over questions of coverage, eligibility and interpretations and applications of the provisions of the contract for the simple reason that the insurer included a discretionary clause in the contract. However, if discretionary clauses are prohibited, then the courts apply the de novo standard of review, and are free to substitute their own judgment for that of the insurer. If a matter comes to court, the consumer faces a more level playing field, and is better protected.

What is perhaps most affected by the differing standards of review is the mindset of the insurers. Under the "arbitrary and capricious" standard of review, insurers believe that they can refuse to pay benefits regardless of the evidence employees submit, as long as the insurers pay their doctors to manufacture contradictory evidence. Insurers cannot do so if de novo standard of review applies, where a court determines which side's conflicting evidence is better. In other words, simply requiring a level playing field would end most of the insurance industry's abuse of disabled employees. My experience has shown that whenever a court rules that a de novo standard of review applies, the insurer immediately seeks

to settle the case, which is a tacit admission that the insurer knew its decision was wrong.

**Conclusion:**

The proposed regulations should be implemented, but an outright ban on discretionary clauses is needed.

[1] The transcript can be found at:

<http://www.chattanooga.com/2002/10/15/27804/Transcript-Of-Dateline-Story-On-UnumProvident.aspx>.

[2] The transcript can be found at: [http://www.cbsnews.com/2100-18560\\_162-529376.html](http://www.cbsnews.com/2100-18560_162-529376.html).