No. 20-1464

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

RHONDA OVIST,
Plaintiff-Appellant,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
UNUM GROUP
Defendants-Appellees.

On Appeal from a Final Judgment of the United States District Court
For the District of Massachusetts

BRIEF OF THE SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF NEITHER PARTY

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TABLE OF CONTENTS

TABLE OF AUTHORITIES i

QUESTION PRESENTED 1

SECRETARY'S INTEREST 1

STATEMENT OF THE CASE 1

A. The Long-Term Disability Policy 1

B. The Claims Procedure 3

C. The District Court Proceedings 5

SUMMARY OF ARGUMENT 7

ARGUMENT 8

The Burden Should Shift to the Plan to Prove a Benefit Limitation Applies Once the Participant Presents a Prima Facie Case of Coverage 8

A. Federal Common Law Supports Burden Shifting when Applying Benefit Limitations 8

1. Federal Common Law Based on Insurance Cases Requires Insurers to Prove Limitations 10

2. General Principles on Burdens of Proof Support Burden Shifting 15

B. Courts That Reject A Federal Common Law Based On Insurance Law Provide No Sound Basis to Differentiate Exclusions And Limitations 20

TABLE OF CONTENTS-(continued)

C. The Court Need Not Reach the Question 23

CONCLUSION 25

COMBINED CERTIFICATIONS

TABLE OF AUTHORITIES

Federal Cases:

Abatie v. Alta Health & Life Ins. Co.,
458 F.3d 955 (9th Cir. 2006) 19

Andover Newton Theological Sch., Inc. v. Cont'l Cas. Co.,
964 F.2d 1237 (1st Cir. 1992) 23

Arruda v. Zurich Am. Ins.,
951 F.3d 12 (1st Cir. 2020) 24

B & T Masonry Const. Co. v. Pub. Serv. Mut. Ins. Co.,
382 F.3d 36 (1st Cir. 2004) 10

Black & Decker Disability Plan v. Nord,
538 U.S. 822 (2003) 9, 16

Boyd v. Sysco Corp.,
No. 4:13-cv-00599-RBH, 2015 WL 7737966 (D.S.C. Dec. 1, 2015) 17

Chavez v. Standard Ins. Co.,
No. 3:18-CV-2013-N, 2020 WL 1873547 (N.D. Tex. Mar. 10, 2020) 14

Clark v. Metro. Life Ins. Co.,
67 F.3d 299 (6th Cir. 1995) 12

Cleary v. Knapp Shoes, Inc.,
924 F. Supp. 309 (D. Mass. 1996) 9, 12

Critchlow v. First UNUM Life Ins. Co. of Am.,
378 F.3d 246 (2d Cir. 2004) 6, 9, 10, 16

Deal v. Prudential Ins. Co. of Am.,
263 F. Supp. 2d 1138 (N.D. Ill. 2003) 14

Federal Cases-(continued):

Dowdy v. Metro. Life. Ins. Co.,
890 F.3d 802 (9th Cir. 2018) 10

Dutkewych v. Standard Ins. Co.,
781 F.3d 623 (1st Cir. 2015)..24

Easthampton Cong. Church v. Church Mut. Ins. Co.,
916 F.3d 86 (1st Cir. 2019)..10

Erie Ins. Grp. v. Sear Corp.,
102 F.3d 889 (7th Cir. 1996) 12

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101 (1989)...8, 19

Fought v. UNUM Life Ins. Co. of Am.,
379 F.3d 997 (10th Cir. 2004) 11

Gent v. CUNA Mut. Ins. Soc'y,
611 F.3d 79 (1st Cir. 2010).. 11, 18, 23

Glista v. Unum Life Ins. Co. of Am.,
378 F.3d 113 (1st Cir. 2004)... 10, 11, 17

Gobeille v. Liberty Mut. Ins. Co.,
136 S. Ct. 936 (2016)...1

Hoffman v. Life Ins. Co. of N. Am.,
No. EDCV 13-2011-JGB(SP), 2014 WL 7525482 (C.D. Cal. Dec. 29, 2014)
aff'd, 669 F. App'x 399 (9th Cir. 2016)... 18, 21

Horton v. Reliance Standard Life Ins. Co.,
141 F.3d 1038 (11th Cir. 1998) 10

Hughes v. Boston Mut. Life Ins. Co.,
26 F.3d 264 (1st Cir. 1994)..9

Federal Cases-(continued):

Int’l Bhd. of Teamsters v. United States,
431 U.S. 324 (1977) 15, 16

Kamerer v. Unum Life Ins. Co. of Am.,
334 F. Supp. 3d 411 (D. Mass. 2018) 6, 13, 14, 24

Koppers Co., Inc. v. Aetna Cas. And Sur. Co.,
98 F.3d 1440 (3d Cir. 1996) 12

Lavery v. Restoration Hardware Long Term Disability Benefits Plan,
937 F.3d 71 (1st Cir. 2019) 14

Loucka v. Lincoln Nat’l Life Ins. Co.,
334 F. Supp. 3d 1 (D.D.C. 2018) 21, 22

McAlister v. Liberty Life Ins., Co.,
647 F. App’x 539 (6th Cir. 2016) 13, 14

McCartha v. Nat’l City Corp.,
419 F.3d 437 (6th Cir. 2004) 13

McDonnell v. First Unum Life Ins. Co.,
No. 10 CV 8140 RPP, 2013 WL 3975941 (S.D.N.Y. Aug. 5, 2013) 22

McGee v. Equicor-Equitable HCA Corp.,
953 F.2d 1192 (10th Cir. 1992) 10

Metro. Life Ins. Co. v. Glenn,
554 U.S. 105 (2008) 11

Mt. Airy Ins. Co. v. Greenbaum,
127 F.3d 15 (1st Cir. 1997) 10

Newby Int’l, Inc. v. Nautilus Ins. Co.,
112 F. App’x 397 (6th Cir. 2004) 11

Okuno v. Reliance Standard Life Ins. Co.,
836 F.3d 600 (6th Cir. 2016) .... passim

Federal Cases-(continued):

Owens v. Rollins, Inc.,
No. 1:08-CV-287, 2010 WL 3843765 (E.D. Tenn. Sep. 27, 2010)....................14

Penzer v. Transp. Ins. Co.,
545 F.3d 1303 (11th Cir. 2008) 12

Pilot Life Ins. Co. v Dedeaux,
481 U.S. 41 (1987)...9

Ringwald v. Prudential Ins. Co. of Am.,
754 F. Supp. 2d 1047 (E.D. Mo. 2010) 22

Rush Prudential HMO, Inc. v. Moran,
536 U.S. 355 (2002)...1, 24

Seaman v. Mem'l Sloan Kettering Cancer Ctr.,
08-CV-3618 (JGK), 2010 WL 785298 (S.D.N.Y. Mar. 9, 2010),
aff'd sub nom. Seaman v. First Unum Life Ins. Co., 487 F.App'x 670 (2d Cir. 2012).. .... 18, 21

Sec'y of Labor v. Fitzsimmons,
805 F.2d 682 (7th Cir. 1986) (en banc) 1

Sentry Ins. v. R.J. Weber Co.,
2 F.3d 554 (5th Cir. 1993) 12

Silva v. Metro. Life Ins. Co.,
762 F.3d 711 (8th Cir. 2014) 17

Stamp v. Metro. Life Ins. Co.,
531 F.3d 84 (1st Cir. 2008)...9

Williams v. Grp. Long Term Disability Ins.,
No. 07 C, 6022, 2009 WL 500626 (N.D. Ill. Feb. 27, 2009) 14

State Cases:

Baugher v. Hartford Fire Ins. Co.,
522 P.2d 401 (Kan. 1974) 12

Children's Friend & Serv. v. St. Paul Fire & Marine Ins. Co.,
893 A.2d 222 (R.I. 2006) 10

Gen. Acc. Ins. Co. of Am. v. Am. Nat'l Fireproofing, Inc.,
716 A.2d 751 (R.I. 1998) 12

Harman v. Nw. Mut. Life Ins. Co.,
429 P.2d 849 (Idaho 1967)..12

Highlands Ins. Co. v. Aerovox Inc.,
676 N.E.2d 801 (Mass. 1997) 10

Rich v. Dyna Tech., Inc.,
204 N.W 2d 867 (Iowa 1973) 12

Federal Statutes:

Employee Retirement Income Security Act of 1974,
as amended, 29 U.S.C. § 1001 et. seq.:

Section 2, 29 U.S.C. § 1001 1

Section 102(a), 29 U.S.C. § 1022(a).. 16, 17

Section 102(b), 29 U.S.C. § 1022(b) 16

Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)............................... 1, 5, 9, 19

Section 503, 29 U.S.C. § 1133 ....1, 11

Section 712(a), 29 U.S.C. § 1185a 18

State Statutes:

Tex. Ins. Code § 554.002 12

Miscellaneous:

Fed. R. App. P. 29(a)(2) 1

29 C.F.R. § 2560.503-1 .... 11, 17, 19

29 C.F.R. § 2590.712 .... 17, 19

Claims Proc. for Plans Providing Disability Benefits,
81 Fed. Reg. 92316 (Dec. 19, 2016) 17, 18

5 Charles Alan Wright & Arthur R. Miller, Fed. Prac. & Proc. Civ. § 1271
(3d ed. 2020) 11, 12

2 McCormick on Evid. § 337 (8th ed. 2020) 15, 16

McCormick on Evid. § 337 (2d ed. 1972) 15, 16, 17

McCormick on Evid. § 343 (2d ed. 1972) 15, 16, 17

17A Couch on Ins. § 254:11 (3d ed. 2020) 10, 13

17A Couch on Ins. § 254:12 (3d ed. 2020) 10, 13

17A Couch on Ins. § 254:13 (3d ed. 2020) 21

Rest. of the Law of Liab. Ins. § 32 (Am. Law Inst. 2019) 15

QUESTION PRESENTED

Whether a plan covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"), has the burden to prove that a limitation on benefits applies when the participant has made a prima facie case of coverage.

SECRETARY'S INTEREST

The Secretary of Labor bears primary responsibility for interpreting and enforcing Title I of ERISA. Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 691 (7th Cir. 1986) (en banc). In this role, the Secretary has a substantial interest in ensuring that plan participants receive their contractually-defined benefits and a full and fair review of their benefit claims. See 29 U.S.C. §§ 1132(a)(1)(B), 1133. He also has a strong interest in uniform enforcement of ERISA across the nation. See Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943–44 (2016); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 385 (2002). The Secretary files this amicus brief pursuant to Federal Rule of Appellate Procedure 29(a)(2).

STATEMENT OF THE CASE

A. The Long-Term Disability Policy

Plaintiff-Appellant Rhonda Ovist was a participant in an ERISA-covered long-term disability plan sponsored by her employer, Rollins College, and funded by a group insurance policy ("Policy") issued by Defendants-Appellees Unum Life

Insurance Company of America and Unum Group (collectively, "Unum"). JA11.[1] Unum also acted as the claims administrator for the Plan. Id.

Under the Policy, a participant is "disabled" when she is "*limited* from performing the *material and substantial duties* of [her] *regular occupation* due to [her] sickness or injury" and she has a "20% or more loss in [her] *indexed monthly earnings* due to the same sickness or injury." JA12 (alterations original). The Policy, however, limited benefits in particular circumstances: "The lifetime cumulative maximum benefit period *for all disabilities due to mental illness and disabilities based primarily on self-reported symptoms* is 24 months." Id. "Self-reported symptoms" ("SRS") is in turn defined as "the *manifestations* of your condition which you tell your physician, *that are not verifiable using tests, procedures, or clinical examination standardly accepted in the practice of medicine.* Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy." Id.

[1] The opinion at issue here was a magistrate's report and recommendation dated February 21, 2020, which was adopted by the district court on March 27, 2020. Ovist v. Unum Life Ins. Co. of Am., 4:17-cv-40113, 2020 WL 1931958 (D. Mass. Mar. 27, 2020).

B. The Claims Procedure

Ovist worked for Rollins College as a professor when she became disabled due to fibromyalgia, chronic fatigue syndrome, opioid dependence and withdrawal symptoms, chronic sinus infections, Chlamydophila pneumonia, and cytomegalovirus disease. JA13. Her symptoms included extreme fatigue, chronic pain, difficulties with concentration and memory, and cognitive issues. Id.

Ovist filed a claim for disability benefits to begin June 1, 2011. Id. After a physician consultant for Unum reviewed Ovist's medical records and opined that she was disabled, Unum approved benefits based on symptoms of her chronic fatigue syndrome. Id. Unum also notified her that her benefits would end on June 29, 2013, because of the 24-month SRS limitation. Id. Throughout the period Ovist received benefits, Unum required her to provide documentation of her disability. JA14. On September 14, 2012, the Social Security Administration found Ovist to be disabled. Id.

On June 11, 2013, Unum informed Ovist that it would pay benefits while review was ongoing, but that the SRS limitation was still effective. Id. Nevertheless, on July 22, 2013, Unum extended the end date of Ovist's benefits from June 29, 2013, to June 20, 2014, based on the opinion of an Unum physician consultant. JA15. Unum continued to review Ovist's claim and, on September 5, 2014, informed her that her benefits would continue until October 27, 2026,

subject to continued documentation. Id. On December 30, 2014, a nurse consultant for Unum reviewed Ovist's records and concluded that no diagnostic findings "equate[d] to the level of her impairment." Id. Ovist's primary care physician wrote that her symptoms were attributed to fibromyalgia and chronic fatigue syndrome, but another Unum physician consultant opined that her diagnoses could not be confirmed by clinical signs or diagnostic findings. Id.

On February 17, 2015, Unum closed Ovist's claim due to the exhaustion of benefits under the SRS limitation. JA16. Ovist's physician provided a letter stating that her disability was attributable to chronic fatigue and immune deficiency syndrome and suspected mold exposure. Id. Upon receipt of the letter, Unum continued its review, but concluded on April 17, 2015, that her limitations were not diagnostically verifiable, based on analyses by its physician and nurse consultants and an independent reviewer. Id. On July 2, 2015, Ovist submitted more information about mold exposure, which an Unum physician consultant and independent physician determined were not associated with her symptoms. Id.

Ovist then filed an administrative appeal on or about July 15, 2015, and Unum permitted Ovist to submit additional evidence until December 15, 2015. JA16-17. On September 24 and 25, 2015, Ovist underwent a Cardiopulmonary Exercise Test ("CPET"), a two-day test designed to measure physical functionality, the results of which Ovist posited to be objective evidence of disabling symptoms.

Br. of Pl.-Appellant 23, Aug. 19, 2020, Doc. 00117630789. According to Ovist, Unum rejected the CPET results because they were not contemporaneous with her benefit termination date in February 2015. Id. at 37. Unum also submitted the appeal to an independent medical reviewer, who did not dispute Ovist's argument that the trigger-point test used by her treating physician was a recognized tool for diagnosing fibromyalgia. JA17, 21. But the reviewer nevertheless concluded that Ovist's limitations were not verifiable by examinations or diagnostic testing. JA17. On January 27, 2016, Unum denied Ovist's appeal. JA17. Unum conceded that Ovist's limitations rendered her unable to work, but because her symptoms were not objectively verifiable, the SRS limitation applied and the maximum benefit period for Ovist's claim was twenty-four months. Id.

C. The District Court Proceedings

Ovist filed a suit for benefits under ERISA section 502(a)(1)(B) in the District Court of Massachusetts on August 2, 2017. JA17; 29 U.S.C. § 1132(a)(1)(B). The parties submitted cross-motions for summary judgment based on the administrative record. JA17. The court applied a deferential standard of review because the Policy granted Unum discretion in interpreting and applying plan provisions. JA18.

Before reaching the merits, the court held that Ovist, as the plaintiff, bore the burden to prove she was entitled to benefits beyond what she received. JA19-20.

Ovist had argued that Unum has the burden to prove that the SRS limitation applies, citing to the general rule in insurance law that, where an insurer defends its benefits denial based on an exclusion clause, it has the burden to prove the clause applies. JA19 (citing Critchlow v. First UNUM Life Ins. Co. of Am., 378 F.3d 246, 256 (2d Cir. 2004)). The district court, however, distinguished the SRS limitation from an exclusion because, "[t]hough Unum did limit Ovist's benefits, it did not exclude her from them." JA20. It also reasoned that burden shifting was not appropriate when Unum notified Ovist throughout the claim administration process that the SRS limitation applied, distinguishing this case from Kamerer v. Unum Life Ins. Co. of Am., 334 F. Supp. 3d 411, 428 (D. Mass. 2018), where an insurer had not relied on a limitation until late in the claims process. Id.

On the merits, the district court determined that Unum's interpretation and application of the SRS limitation was not arbitrary and capricious. JA24. Unum did not dispute that Ovist's conditions rendered her disabled under the Policy. JA20. The court accepted Ovist's argument that her fibromyalgia was objectively diagnosed using the trigger-point test, but concluded that the disabling symptoms associated with her diagnosis, e.g., pain and fatigue, were self-reported and not verified by clinical tests. JA22-23. The court did not discuss the CPET results that Ovist had submitted. Br. of Pl.-Appellant 45. The district court found that Unum appropriately applied the 24-month SRS limitation, granted summary judgment in

favor of Unum, and denied Ovist's claim for disability benefits beyond what she received. JA26.

SUMMARY OF ARGUMENT

This case involves the proper allocation of burdens when proving whether a benefits limitation applies for insured benefits under ERISA. When a participant presents a prima facie case for coverage and the plan seeks to limit her benefits based on plan language, the plan should bear the burden of proving the limitation. This comports with the general common law rule that the burden shifts to the insurer to prove an exclusion applies. For purposes of burden shifting, there is no basis under the common law to distinguish a benefit limitation from an exclusion—both operate by barring, whether in whole or in part, a participant from receiving benefits for which she is otherwise eligible. The district court erred by rejecting burden shifting, holding instead that an ERISA plan participant has the burden to prove how a limitation does not bar her from eligibility for benefits. If necessary to reach this burden question, this Court should correct the lower court's error by requiring the plan to prove benefit limitations, which more appropriately aligns with the common law for insurance and conforms with general principles governing the allocation of burdens.

The Sixth Circuit has already weighed in on the issue in Okuno v. Reliance Standard Life Ins. Co., 836 F.3d 600, 609 (6th Cir. 2016), where it placed on the

plan the burden of proving a one-year mental health limitation in an ERISA long-term disability plan. While this Court may decline to reach this question, this brief proposes a framework for approaching the issue, a framework in which the burden lies with the plan to prove limitations. Should the Court reach the question, the Secretary urges the Court to adopt the proposed framework, resolve the split in the district courts, and agree with the Sixth Circuit.

ARGUMENT

The Burden Should Shift to the Plan to Prove a Benefit Limitation Applies Once the Participant Presents a Prima Facie Case of Coverage

When reviewing a denial of ERISA benefits based on a limitation to coverage, the burden should shift to the plan to prove the limitation applies, just as the burden shifts for exclusions. Such a rule accords with a federal common law rule for ERISA based on the common law for insurance cases as well as the general principles for burden shifting.

A. Federal Common Law Supports Burden Shifting when Applying Benefit Limitations.

"ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989) (internal quotation marks and citations omitted). When a plan denies a participant's claim for benefits, ERISA provides the participant with a federal

cause of action under section 502(a)(1)(B). 29 U.S.C. § 1132(a)(1)(B). The statute, however, does not address the burdens of the parties to such an action. See id.; Cleary v. Knapp Shoes, Inc., 924 F. Supp. 309, 315 (D. Mass. 1996). Rather, when Congress passed ERISA, it expected that courts "would develop a federal common law of rights and obligations under ERISA-regulated plans." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 831 (2003) (quoting Pilot Life Ins. Co. v Dedeaux, 481 U.S. 41, 56 (1987) (internal quotation marks omitted)). Particularly when reviewing a plan administrator's denial of benefits, courts look to the federal common law. Stamp v. Metro. Life Ins. Co., 531 F.3d 84, 88 (1st Cir. 2008).

In interpreting plan terms, courts recognize that federal common law may draw from state law in "embody[ing] common-sense canons of contract interpretation," as long as doing so is consistent with ERISA. Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264, 268 (1st Cir. 1994). When an ERISA plan offers benefits that are insured—either fully-insured by an insurance company or self-insured by the employer—a court may look to insurance law to inform federal common law under ERISA for reviewing benefit denials. See Critchlow, 378 F.3d at 256 (incorporating insurance principles "into the federal common law governing ERISA-regulated plans").

1. Federal Common Law Based on Insurance Cases Requires Insurers to Prove Limitations.

In ERISA cases, the principle is well settled and undisputed that the plan has the burden to show the applicability of an exclusion, once the claimant has presented a prima facie case that she is covered and thus entitled to benefits under the plan terms. See, e.g., Dowdy v. Metro. Life. Ins. Co., 890 F.3d 802, 810 (9th Cir. 2018); Critchlow, 378 F.3d at 256-57; Glista v. Unum Life Ins. Co. of Am., 378 F.3d 113, 131 (1st Cir. 2004); Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038, 1040 (11th Cir. 1998); McGee v. Equicor-Equitable HCA Corp., 953 F.2d 1192, 1205 (10th Cir. 1992). The ERISA rule mirrors an established rule in insurance cases. See, e.g., B & T Masonry Const. Co. v. Pub. Serv. Mut. Ins. Co., 382 F.3d 36, 39 (1st Cir. 2004); Mt. Airy Ins. Co. v. Greenbaum, 127 F.3d 15, 19 (1st Cir. 1997); see also Highlands Ins. Co. v. Aerovox Inc., 676 N.E.2d 801, 804 (Mass. 1997); Children's Friend & Serv. v. St. Paul Fire & Marine Ins. Co., 893 A.2d 222, 229-30 (R.I. 2006); 17A Couch on Insurance §§ 254:11-12 (3d ed. 2019). "As a general matter, in Massachusetts, the insured bears the initial burden of showing that the case involves a generally covered risk under the policy." Easthampton Cong. Church v. Church Mut. Ins. Co., 916 F.3d 86, 91-92 (1st Cir. 2019) (internal citations and quotation marks omitted). "Where, as is here, the parties do not dispute that the incident was a generally covered risk, the burden shifts such that the insurer must demonstrate that an exclusion precludes coverage.

‘And if the insurer satisfies that burden, the burden shifts back to the insureds to show an exception to the exclusion holds sway.’” Id. (citation omitted).

While courts generally accept without question the “basic rule” that an ERISA plan has the burden to prove an exclusion in denying coverage, some courts have also explained their reasons for shifting the burden for exclusions—reasons that apply equally to burden shifting for limitations. McGee, 953 F.2d at 1205 (cited by Gent v. CUNA Mut. Ins. Soc’y, 611 F.3d 79, 83 (1st Cir. 2010)). For example, this Court has explained that the background insurance rule shifting the burden for exclusions is “reinforced here by ERISA’s statutory command that the administrator articulate specific reasons for a denial of benefits.” Glista, 378 F.3d at 131 (citing 29 U.S.C. § 1133). This “statutory command” that plans explain their adverse benefit decisions applies to denials based on both exclusions *and* limitations. See 29 C.F.R. § 2560.503-1(g)(1).

Courts also categorize insurers’ claims of exclusions as affirmative defenses to coverage. See, e.g., Fought v. UNUM Life Ins. Co. of Am., 379 F.3d 997, 1007 (10th Cir. 2004) (ERISA plan exclusion is affirmative defense), abrogated on other grounds by Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 116 (2008); Newby Int’l, Inc. v. Nautilus Ins. Co., 112 F. App’x 397, 406 (6th Cir. 2004) (insurance policy exclusion waived if not pleaded); see also 5 Charles Alan Wright & Arthur R. Miller, Fed. Prac. & Proc. Civ. § 1271 (3d ed. 2020) (listing among affirmative

defenses recognized by federal courts "the claim by an insurer that the loss suffered by the insured was excepted by the policy's terms"). "A[n ERISA] plan administrator attempting to establish an exclusion from coverage has the burden to establish by a preponderance of the evidence that a covered employee's illness or medical condition is excludable." Clark v. Metro. Life Ins. Co., 67 F.3d 299, 299 (6th Cir. 1995); see also Cleary, 924 F. Supp. at 315 (adopting Clark). Applying a limitation, similar to applying a policy exclusion, is an affirmative defense that aids the plan by reducing its liability for benefits. In this vein, a duration-based limitation, such as the 24-month SRS limitation at issue here, operates similarly to an oft-used affirmative defense—a statute of limitations—by cabining to a defined time period the potential liability of a plan.

Since the rationale for placing the burden on insurers to prove exclusions applies equally to limitations, many courts have understandably placed the burden to prove limitations on the insurers.[2] Notably, under insurance law, the burden shifts to prove "the applicability of policy exclusions *and limitations*" alike. See

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[2] E.g., Penzer v. Transp. Ins. Co., 545 F.3d 1303, 1309 (11th Cir. 2008); Erie Ins. Grp. v. Sear Corp., 102 F.3d 889, 898 (7th Cir. 1996); Koppers Co., Inc. v. Aetna Cas. And Sur. Co., 98 F.3d 1440, 1446 (3d Cir. 1996); Sentry Ins. v. R.J. Weber Co., 2 F.3d 554, 556 (5th Cir. 1993) (interpreting Tex. Ins. Code § 554.002); Harman v. Nw. Mut. Life Ins. Co., 429 P.2d 849, 850-51 (Idaho 1967); Rich v. Dyna Tech., Inc., 204 N.W 2d 867, 871 (Iowa 1973); Baugher v. Hartford Fire Ins. Co., 522 P.2d 401, 409 (Kan. 1974); Gen. Acc. Ins. Co. of Am. v. Am. Nat'l Fireproofing, Inc., 716 A.2d 751, 757 (R.I. 1998).

17A Couch on Ins. § 254:12 (emphasis added). Consistent with these authorities, the Sixth Circuit, the only circuit to opine directly on the issue under ERISA, has endorsed burden shifting for the plan to prove the applicability of a limitation. Okuno v. Reliance Standard Life Ins. Co., 836 F.3d 600, 609 (6th Cir. 2016). The Sixth Circuit examined an ERISA-covered long-term disability policy that limited benefits to one year for disabilities caused or contributed to by mental or nervous disorders. Id. at 603. In discussing the parties' respective burdens of proof, the court held, "Reliance [the plan administrator] bears the burden to show that the exclusion on which it based denial of benefits, the Mental and Nervous Disorder Limitation, applies in this case." Id. at 609. Notably, the Sixth Circuit treated the limitation as an "exclusion," and accordingly assigned the burden of proof to the plan. Id. (citing McCartha v. Nat'l City Corp., 419 F.3d 437, 443 (6th Cir. 2004), holding that "[a]n ERISA plan, not the participant, has the burden of proving an exclusion applies to deny benefits"); see also McAlister, 647 F. App'x 539, 545 n.6 (6th Cir. 2016) (shifting the burden when reviewing the application of a 24-month mental illness limitation in a long-term disability policy).

Other district courts have found as the Sixth Circuit did, including another court in this circuit. In Kamerer v. Unum Life Insurance Company of America, the participant had sufficiently proved her disability so "[i]f Unum wants to then reduce her benefits, it seems appropriate that they should demonstrate why Ms.

Kamerer is not entitled to those benefits." 334 F. Supp. 3d at 428. The court bolstered its conclusion by noting that Unum cited the limiting clause for the first time after several years of having paid benefits. Id. Other federal courts have similarly determined that the burden to prove the applicability of a policy limitation rests with the plan. E.g., Owens v. Rollins, Inc., No. 1:08-CV-287, 2010 WL 3843765, at *2 (E.D. Tenn. Sep. 27, 2010); Williams v. Grp. Long Term Disability Ins., No. 07 C 6022, 2009 WL 500626, at *7 (N.D. Ill. Feb. 27, 2009); Deal v. Prudential Ins. Co. of Am., 263 F. Supp. 2d 1138, 1143 (N.D. Ill. 2003); see also Chavez v. Standard Ins. Co., No. 3:18-CV-2013-N, 2020 WL 1873547, at *3 (N.D. Tex. Mar. 10, 2020). All of these courts adopted a federal common law that accords with the common law for insurance requiring insurers to prove limitations.[3]

[3] This burden shifting framework would apply generally to ERISA cases in which the plan denies benefits based on a limitation, whether reviewed under de novo or abuse of discretion standards. Cf. McAlister v. Liberty Life Assur. Co. of Boston, 647 F. App'x at 545 n.6 (distinguishing the question of which party bears the burden of proof from the question of the applicable standard of review). Even under a deferential standard of review, courts have shifted the burden to the plan to prove exclusions and limitations. See Lavery v. Restoration Hardware Long Term Disability Benefits Plan, 937 F.3d 71, 78-81 (1st Cir. 2019) (holding that the plan administrator's denial of benefits based on an exclusion was arbitrary and capricious); Okuno, 836 F.3d at 607, 609 (shifting the burden to the plan to prove a benefits limitation while employing deferential review).

2. General Principles on Burdens of Proof Support Burden Shifting.

The background principles for allocating burdens of proof also support burden shifting when proving the application of a policy limitation. "The [burdens'] allocation, either initially or ultimately, will depend upon the weight that is given to any one or more of several factors, including: (1) the natural tendency to place the burdens on the party desiring change, (2) special policy considerations such as those disfavoring certain defenses, (3) convenience, (4) fairness, and (5) the judicial estimate of the probabilities." Allocating the Burdens of Proof, 2 McCormick on Evid. § 337 (8th ed. 2020); see also Int'l Bhd. of Teamsters v. United States, 431 U.S. 324, 359 n.45 (1977) (citing McCormick on Evid. §§ 337, 343 (2d ed. 1972)). Several of these factors are relevant when allocating the burden to prove a policy limitation applies.

First, when a limitation furthers the plan's interest by limiting its liability, the "natural tendency" would be to allocate the burden of proof to the insurer. 2 McCormick on Evid. § 337. The structure of insurance policies itself leans toward burden shifting, because policies typically provide a broad grant of coverage, with an enumerated set of exclusions and limitations. E.g., Rest. of the Law of Liab. Ins. § 32. "Each exclusion represents an insurer's efforts to identify a class of claims that differs in some material way from the broad class of claims that are covered by the policy." Id. Burden shifting is appropriate, therefore, because "[i]t

is the insurer that has identified the excluded classes of claims and will benefit from being able to place a specific claim into an excluded class." Id.

Second, notions of fairness weigh in favor of burden shifting because the plan is in the better position to interpret and apply exclusionary terms.[4] 2 McCormick on Evid. § 337 ("[F]airness usually requires that the adversary give notice of the particular exception upon which it relies and therefore that it bear the burden of pleading."). Employers as plan sponsors have "large leeway to design disability and other welfare plans as they see fit." Black & Decker Disability Plan, 538 U.S. at 833. ERISA requires that plans be clear in disclosing participant rights and obligations, particularly "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits," so that participants understand the extent of their benefits. 29 U.S.C. § 1022(a)-(b); see Critchlow, 378 F.3d at 256. It would thus be unfair for a participant who has established that she is covered by a plan to then lose that coverage because she cannot also prove a limitation does not apply.

Third, "presumptions shifting the burden of proof are often created to reflect judicial evaluations of probabilities and to conform with a party's superior access to the proof." Int'l Bhd. of Teamsters, 431 U.S. at 359 n.45 (citing McCormick on

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[4] The Secretary does not take a position on the principles governing plan interpretation or on the application of plan terms to the facts of any particular case, including this one.

Evid. §§ 337, 343 (2d ed. 1972)). In cases such as this one, where participants must demonstrate coverage under a long-term disability policy, the probability is that exceptions are not common or well-understood by the disabled participants. See Silva v. Metro. Life Ins. Co., 762 F.3d 711, 721 (8th Cir. 2014) (describing a plan "nearly 100 pages long and contain[ing] technical language unlikely to be read or understood by 'the average plan participant'" (quoting 29 U.S.C. § 1022(a)). The regulation governing claims administration reflects this reality. In cases where benefits are denied based on "a medical necessity or experimental treatment or similar exclusion or limit," the plan must provide an explanation for the determination, "applying the terms of the plan to the claimant's medical circumstances," as well as all supporting evidence. See 29 C.F.R. § 2560.503-1(g)(1)(vii)(B); Glista, 378 F.3d at 131 (burden shifting "reinforced here by ERISA's statutory command that the administrator articulate specific reasons for a denial of benefits"). In making their determinations, plans can access experts and the entire record, including internal review mechanisms, and they know the exclusions contained in long or complicated policies. See Boyd v. Sysco Corp., No. 4:13-cv-00599-RBH, 2015 WL 7737966, at *18 (D.S.C. Dec. 1, 2015) (finding plan administrators erred in failing to disclose an internal guideline that explained exclusions related to substance use disorders); Preamble, Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316, 92318

(Dec. 19, 2016) ("[D]isability claims processing involves more human involvement [than for medical claims], with reviewers studying pages of materials and consulting with varied professionals on claims that involve a more complex, multi-layered analysis"). Because of the likelihood that plans have more access to information about the application of limitations, courts should place the burden on plans to prove a limitation.

Fourth, burden shifting is also in accord with policies animating ERISA. As an example, in the group health plan context, plans have an obligation to explain and support their denial of benefits based on limitations related to mental health and substance use disorder benefits under the Mental Health and Addiction Equity Act ("MHPAEA") and implementing regulations.[5] 29 C.F.R. § 2590.712(d). MHPAEA requires parity in the provision of benefits for medical-surgical conditions compared to benefits for mental health and substance use disorders. 29 U.S.C. § 1185a. It specifically regulates various limitations that may exist with regard to health benefits. Id. (addressing aggregate lifetime limits, annual limits,

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[5] While MHPAEA does not apply to disability plans, many of the limitations under which a plan pays benefits for only a limited period are based on disabilities arising from mental health conditions. See, e.g., Okuno, 836 F.3d at 603; Gent, 611 F.3d at 81; Hoffman v. Life Ins. Co. of N. Am., 13-CV-2011 (JGB) (SP), 2014 WL 7525482, at *2 (C.D. Cal. Dec. 29, 2014), aff'd, 669 F. App'x 399 (9th Cir. 2016); Seaman v. Mem'l Sloan Kettering Cancer Ctr., 08-CV-3618 (JGK), 2010 WL 785298, at *5 (S.D.N.Y. Mar. 9, 2010), aff'd sub nom. Seaman v. First Unum Life Ins. Co., 487 F. App'x 670 (2d Cir. 2012).

financial requirements, and treatment limitations). Under MHPAEA's regulations, the plan must make available its criteria for determining medical necessity, and provide its reasoning for any denial of benefits. 29 C.F.R. § 2590.712(d)(1)-(2) (incorporating disclosure requirements of ERISA claims regulation, 29 C.F.R. § 2560.503-1). Again, it is the plan, not the participant, who must support how a limitation on benefits applies when administering a claim. Given the disclosure requirements under both the claims and MHPAEA regulations, plan administrators are well-positioned based on their knowledge and experience to bear the burden in federal courts to prove the application of any limitation on benefits.

Lastly, ERISA's purpose of protecting plan participants also plays a factor. The Supreme Court has rejected readings of ERISA that would afford less protection to participants than before its enactment. See Firestone Tire & Rubber Co., 489 U.S. at 113-14. Courts are mindful of this in creating rules to govern judicial review of benefit determinations. See e.g., id. at 115 (determining that a de novo standard of review is the default for cases under 29 U.S.C. § 1132(a)(1)(B), in part because a default arbitrary and capricious standard would be less protective of participants); Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 972-73 (9th Cir. 2006) (determining whether a district court could consider new evidence not contained in the administrative record). Since a burden-shifting framework for limitations applies to insurance policies generally, a contrary rule

for ERISA-covered plans essentially subjects ERISA participants to a higher burden to obtain benefits, compared to a claimant who has an identical insurance policy not covered by ERISA. Applying a burden-shifting framework for proving limitations in ERISA plans more closely accords with the general rule in insurance law and thereby does not render ERISA less protective for participants.

B. Courts That Reject A Federal Common Law Based On Insurance Law Provide No Sound Basis To Differentiate Exclusions And Limitations.

Despite the established principle that the burden shifts to the plan to prove an exclusion in denying a participant's benefits, the district court here held that the burden does not shift because "limitations of benefits provisions are different than exclusion clauses." JA19. The district court, however, failed to recognize that, conceptually and in practice, it is difficult to draw a principled distinction between exclusions and limitations for purposes of burden shifting. Indeed, exclusions and limitations often operate in the same way—to deny a category of otherwise-available benefits in order to limit the insurer's liability. It is a distinction without a difference.

The district court's decision here cannot be reconciled with Okuno and similar authorities in the insurance law context that make no such distinction. In distinguishing exclusions from limitations and holding that the participant bears the burden to prove the latter, the district court relied on the reasoning of two

district court decisions. JA19; see Seaman, 2010 WL 785298, at *10; Hoffman, 2014 WL 7525482, at *5. In Seaman, the district court determined that the claimant's disability was "not a condition that is excluded from coverage" since the insurer paid twenty-four months of benefits. 2010 WL 785298, at *10. It reasoned that the claimant had better access to her own medical records, which provide the factual basis for determining whether the limitation applied. Id. at *11. Similarly, in Hoffman, the court explained that a two-year limit for disability benefits based on mental illness was not an exclusion, which are "total denials from coverage." 2014 WL 7525482, at *5. The court placed the burden of proof on the claimant, citing the general rule that the plaintiff bears the burden of proof and explaining that he has better access to his medical records and history. Id. at *6.[6] Other district courts have similarly rejected a burden-shifting framework in applying benefit limitations, reasoning that limitations, which often appear in the benefits (rather than the exclusions) section of a policy, define the scope of coverage, which plaintiffs must affirmatively demonstrate. E.g., Loucka v. Lincoln Nat'l Life Ins. Co., 334 F. Supp. 3d 1, 10 (D.D.C. 2018); McDonnell v.

[6] The Hoffman case dealt with whether the plaintiff's bipolar disorder was exempt from his policy's mental illness limitation. 2014 WL 7525482, at *6. There is some authority for placing the burden of proving an exemption to an exclusion on the claimant. See 17A Couch on Ins. § 254:13 (exceptions to exclusions); Hoffman, 669 F. App'x at 400. The Secretary does not take a position on which party carries the burden of showing whether an exemption to an exclusion applies.

First Unum Life Ins. Co., No. 10 CV 8140 RPP, 2013 WL 3975941, at *14-15 (S.D.N.Y. Aug. 5, 2013); Ringwald v. Prudential Ins. Co. of Am., 754 F. Supp. 2d 1047, 1056-57 (E.D. Mo. 2010).

Thus, courts that foreclose burden shifting to prove limitations have done so by categorically distinguishing limitations from exclusions, without explaining why their rationale does not apply to both. For example, it is just as true in applying exclusions that the claimant has better access to his own medical history, but courts have consistently placed the burden on the plan to show an exclusion applies. It is also true that the plan drafts a limitation, just as it drafts an exclusion, in an effort to cabin its responsibility for paying benefits. Moreover, as in this case, the plan's application of a limitation, like its application of an exclusion, often relies on its own internal policies and reviewers for an evaluation of the claimant's proffered medical history.

To be sure, the Secretary acknowledges that there may be closer cases in which it may be difficult to determine whether a particular condition should be characterized as an exclusion or limitation, for which the insurer bears the burden, or an initial term of coverage, for which the insured bears the burden—for example, where a limitation is built into (or intertwined with) the terms of coverage. Because the SRS limitation here is viewed as a limitation under any approach, the Secretary does not take a position on what approach should be

adopted generally. But, importantly, that interpretive question provides no basis for distinguishing *between* exclusions and limitations for purposes of burden shifting. Cf. Andover Newton Theological Sch., Inc. v. Cont'l Cas. Co., 964 F.2d 1237, 1243 (1st Cir. 1992) (about distinguishing terms of coverage from exclusions, "If an insurer were able to distribute provisions limiting liability throughout a policy, with the expectation that its shouldering of the burden of proof would be limited to the single section entitled, 'Exclusions,' this would create considerable incentive to obfuscation and subterfuge."). Indeed, limitations that do not result in a total denial of benefits will generally be easier to distinguish from terms of coverage than an exclusion will be. The district court erred in holding that the SRS limitation is a limitation that the participant must prove does not apply.

C. The Court Need Not Reach the Question.

On several prior occasions, this Court has acknowledged the dispute over who has the burden to prove the applicability of a limiting clause, but has declined to take a position. In Gent v. CUNA Mutual Insurance Society, in dicta, this Court recognized that a mental illness limitation "might appear to operate much like an exclusion," but the plan participant also had the obligation to establish the cause of her disability to continue receiving benefits. 611 F.3d 79, 83 (1st Cir. 2010). The district court in Gent, like the district court here, had imposed the burden directly

on the participant. Id. This Court determined, however, that the burden matters only when one or both parties fail to produce evidence, or when competing evidence is in equipoise and, in Gent, the plan administrator had stronger evidence that the limitation applied "whether it bore the burden of proof or not." Id. This Court similarly found for the plan without deciding how to allocate the burden of proof in Dutkewych v. Standard Ins. Co., 781 F.3d 623, 634 (1st Cir. 2015), and most recently in Arruda v. Zurich Am. Ins., 951 F.3d 12, 20 n.4 (1st Cir. 2020).

This Court could again decide that the burden of proof for applying the SRS limitation is not outcome determinative in this case and thus decline to decide the issue. On the other hand, after the Sixth Circuit's decision in Okuno, 836 F.3d at 609, a circuit split would arise if the district court is affirmed on the burden-shifting issue. Moreover, there remains a continued split among district courts, including an intra-circuit split between the district court here and the Kamerer court. Compare JA19-20, with Kamerer, 334 F. Supp. 3d at 428. Indeed, any ruling on the allocation of burdens would implicate more than just this case. Thus, if this Court reaches the issue of which party must prove a benefits limitation, the Secretary urges this Court to adopt the burden-shifting framework presented herein, which aligns with the Sixth Circuit's decision in Okuno, 836 F.3d at 609. Doing so would protect participants' contractual rights to benefits and further uniformity in ERISA enforcement. See Rush Prudential HMO, Inc., 536 U.S. at

393-94 ("[T]he exclusivity and uniformity of ERISA's enforcement scheme remains paramount.").

CONCLUSION

For the foregoing reasons, if the Court reaches the question presented, it should adopt a burden-shifting framework for plans to prove the applicability of a limitation on benefits once a participant presents a prima facie case for coverage.

Dated: August 21, 2020

Respectfully submitted,

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COMBINED CERTIFICATIONS

I hereby certify that the attached brief complies with Fed R. App. P. 29(a)(4)-(5) because it has been prepared in proportionately-spaced typeface using Microsoft Word in 14-point Times New Roman, and excluding the parts of the document exempted by Fed. R. App. P. 32(f), it contains 5,982 words.

I further certify that on August 21, 2020, I electronically filed the foregoing document with the United States Court of Appeals for the First Circuit by using the CM/ECF system. I certify that the following parties or their counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system:

Jonathan Feigenbaum, Counsel for Plaintiff-Appellant

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Dated: August 21, 2020

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