

**2012 ERISA ADVISORY COUNCIL
HEARING ON MANAGING DISABILITY RISKS IN
AN ENVIRONMENT OF INDIVIDUAL RESPONSIBILITY**

Testimony of
Mala M. Rafik
Rosenfeld Rafik & Sullivan, P.C.
(617) 723-7470
mmr@rosenfeld.com
www.rosenfeld.com

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I. Introduction

I am an attorney in private practice in Boston, Massachusetts. My practice is focused on representing individuals who are chronically ill and disabled in private disability and health insurance claims. My firm also represents individuals in private life and long-term care insurance claims as well as Social Security disability and Veteran's disability benefit claims. The vast majority of my cases involve claims governed by ERISA. In addition, I speak extensively on matters relating to health, disability and life benefits nationally.

Thank you for inviting me to testify at this hearing. I am particularly grateful for the opportunity to address several issues that I have seen in my practice, which could use the benefit of Department of Labor review or legislative amendments to ERISA. Some of the issues I will be discussing are being addressed with some success on the state level, but national efforts are desperately needed to ensure an even playing field for some of the most vulnerable members of our society.

II. Summary

I have been representing individuals who are chronically ill and disabled in disability benefit claims under ERISA since 1998. During that time, I have witnessed the transformation of a law that Congress enacted to protect employees into a shield to protect insurance companies who fail to provide the fair and principled reviews required of them by statute and regulation. Without having to face the likelihood of a trial by jury or the possibility of damages, insurance companies are free to deny claims with impunity. The worst any insurance company faces if they improperly deny coverage is an order to pay the benefits that should have been paid in the first place. Interest on unpaid benefits is not guaranteed, even though claimants have lost the use of money rightfully due them under the terms of their policy. Attorney's fees are also discretionary. After years of fighting wrongful terminations, many of my clients have faced foreclosure of their homes, bankruptcy, the inability to support their families, the loss of health insurance coverage and many more direct damages for which they will never, under ERISA, be compensated. Many of these problems have to be addressed by Congress. However, there are several issues that arise during the ERISA-mandated internal appeals process and in litigation that should be addressed by the Department of Labor.

- ERISA claimants are provided with inadequate guidance during the internal appeals process as to information required to be submitted to perfect their claims, as well as the impact of the appeals process on the subsequent litigation.
- Insurers rely upon new medical and vocational information developed on appeal to deny claims, but refuse to provide this information to claimants, who then have no mechanism to challenge the evidence in court.
- There is no clarity as to the limitations period for filing suit.
- Unjustified restrictions in policies providing limited benefits for individuals suffering from mental illness or self-reported conditions are often manipulated to limit benefits for individuals suffering from conditions not subject to either policy limitation.
- Insurers routinely seek to offset child Social Security benefits, severance and pension benefits from the long-term disability benefits owed to claimants.
- There is no incentive, without the threat of damages, for insurers to provide the full and fair review of benefit claims contemplated by ERISA's regulations.

In addition to the above, many claimants filing for benefits are terminated from employment, thereby losing their employee benefits, including much needed health insurance coverage. For those found disabled under the Social Security Regulations,, Medicare benefits are available, but only 29 months after the individual's date of disability. COBRA benefits are often available, but cost-prohibitive, particularly for an individual living on disability benefits, which often only pays sixty percent of their salary. The ability to pay for COBRA coverage is further diminished for those facing the denial or termination of their disability benefits. Claimants are placed in a no-win situation – unable to access the health care to treat their illness and hopefully return to work, and unable to access the regular care and treatment required by disability insurance policies in order to contractually prove eligibility for benefits. These barriers only serve to perpetuate a system in which individuals suffering from disabilities are no longer able to care for themselves, and are forced to rely upon public assistance to survive. The resolution to many of these issues is simple: allow individuals covered under ERISA-governed policies the same access to the judicial system permitted virtually every other plaintiff in this country.

III. Issues for Department of Labor Consideration.

A. A biased internal process.

In most circumstances, there is no trial in ERISA cases. Courts review the paper record created during the internal appeals process, without taking testimony or new evidence, and more importantly, without ever meeting, or hearing from, the individual at the center of the dispute. The record is compiled by the insurance company who, for the most part, is responsible for both determining benefit eligibility and paying claims. Although claimants are informed, pursuant to regulation, that they may submit any information supporting their entitlement to benefits during the appeals process, claimants are not informed that if they fail to do so, they will forever be barred from submitting that information to a court for its review. Such a concept is unfathomable to any individual with even a passing familiarity with the legal system. And, yet, it is the reality for ERISA-insureds. As a result, countless unrepresented claimants simply write their insurance company a letter informing the company of their desire to appeal, without appreciating that

failing to submit every last piece of evidence supporting their claim, and then some, will limit their ability to prevail in litigation. Often times, insurers compound this problem by verbally informing claimants that all they have to do to appeal is to write a letter expressing their dissatisfaction with the process. This is a common refrain among the clients who come to our office.

Even if claimants know enough to submit additional information with their appeals, insurers routinely obtain new medical and vocational reviews on appeal which are not provided to claimants for their review and response prior to the conclusion of the appeals process. This is true whether or not claimants are represented by counsel. While existing regulation requires the disclosure of all information used to deny a claim prior to the filing of an appeal, a gap exists that permits insurers to shore-up their original denial with new information that is not required to be disclosed to claimants. This leaves individuals without the means to respond to the insurer's appellate reviews, and ensures a biased record in litigation. Unfortunately, the majority of courts to review this issue have sided with the insurer in the face of no regulation requiring insurers to provide claimants with the opportunity to review and to respond to all information generated during the internal process, including without limitation, information generated on appeal. *See e.g., Midgett v. Wash. Group Int'l Long Term Disability Term*, 561 F.3d 887 (8th Cir. 2009). 29 U.S.C. § 1133 requires a full and fair review of benefit claims. It contemplates an even playing field. Without an amendment to ERISA's regulations requiring insurers to provide an opportunity to respond to appellate reviews, the full and fair review requirement is frustrated, and the uneven playing field that has resulted over the last 38 years, will continue.

B. A lack of clarity regarding the limitations periods for benefit claims.

A significant amount of ERISA litigation in the past decade has centered around the limitations period for benefit denial claims. There is simply no consistency nationwide as to when the limitations period for ERISA benefits claims accrue and exhaust. Some courts have held that limitations periods accrue at the conclusion of the internal appeals process – a determination that makes abundant sense. *See e.g. Jeffries v. Trustees of Northrop Grumman Savings & Inv. Plan*, 169 F.Supp.2d 1380 (M.D.Ga.2001) (citing *Radford v. General Dynamics Corp.*, 151 F.3d 396(5th Cir. 1988). Others begin the limitations period at the date of the first notification that benefits have been denied or terminated. *See e.g. Chepilko v. Cigna Group Ins.*, 2012 WL 2421536 (S.D.N.Y. June 27, 2012). While unreasonable in the face of internal appeals processes that can last twelve to eighteen months or longer, the most egregious decisions are those that hold that the limitations period runs before the conclusion of the internal appeals process. *See e.g., Burke v. Pricewaterhousecoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2nd Cir. 2009). This uncertainty has led to viable claims being dismissed without judicial review and litigation being filed prior to the conclusion of the internal appeals process. Both scenarios defy Congress' goals of access of the courts for ERISA claimants and achieving a prompt and inexpensive resolution of disputes.

Allowing for clear boundaries as to the event that triggers the accrual of the limitations period, i.e., the date the insurer issues its final decision on appeal, as well as a clear statement that all limitation periods, contractual or otherwise, are tolled during the appeals process will

conserve judicial resources, ensure that claimants have access to the courts, and provide clarity for both parties.

C. The misuse of mental health and self-reported symptoms limitations by insurers.

Virtually all ERISA disability policies contain a two-year limitation on claims where the insured suffers from a psychiatric condition. The legality of such provisions have been uniformly upheld under ERISA and the Americans with Disabilities Act (“ADA”), with the exception of two cases in the District of Massachusetts, *Fletcher v. Tufts University*, 367 F.Supp.2d 99 (D.Mass. April 15, 2005) and *Iwata v. Intel Corp.*, 349 F.Supp.2d 135 (D.Mass. Dec. 8, 2004), which, in denying motions to dismiss, found that the provision may constitute discrimination under the ADA. Both cases were settled prior to a final determination as to the substantive issues. Massachusetts currently has legislation pending to require parity in disability policies – similar to the parity required by state and federal law in health insurance policies. However, federal regulation is required to ensure that policies treat individuals suffering from mental and physical illnesses equitably. Any concerns regarding increased cost raised by insurers are easily addressed through the claims process. As insurers adjudicate claims for physical illnesses, they can adjudicate claims based on mental illness. The same principles apply.

Further compounding the inequity presented by the mental illness limitation, insurers have routinely utilized such provisions to limit benefits for insureds suffering from physical conditions, by re-characterizing their illnesses as mental in nature, or by using secondary, non-disabling diagnoses of depression to limit coverage. *See e.g., Morgan v. The Prudential Ins. Co. of America*, 755 F.Supp.2d 639 (E.D.Pa. 2010)(court rejected Prudential’s attempt to use the mental illness limitation to limit benefits for a claimant suffering from Fibromyalgia); *Kuhn v. Prudential*, 551 F.Supp.2d 413, 432 (E.D.Pa.2008) (abuse of discretion where “Defendant improperly attempted to ‘pigeon hole’ Plaintiff into a mental health limitation without properly considering her diagnosis, during the coverage period, of Dibromyalgia-like symptoms that over time was confirmed by the consensus of Plaintiff’s treating doctors.”) These provisions become a loophole for insurers to justify early termination of benefits, leaving individuals who are still unable to work without the safety net promised to them by their insurance contract.

In the last decade, insurers have begun further limiting benefits for specific medical conditions (i.e., Chronic Fatigue Syndrome, Fibromyalgia, Lyme disease) or for specific types of illnesses, for example, illnesses based on self-reported or subjective symptoms. This limitation appears, superficially, to seek to capture illnesses such as Chronic Fatigue Syndrome and Fibromyalgia, which are often difficult to prove through traditional medical tests. Unfortunately, however, such limitations are written so broadly, and so often misused, that any number of diagnoses are caught up in their web. A common such provision limits payment of benefits for “disabilities, due to a sickness or injury, which are primarily based on self-reported symptoms” to a specified number of months, most often 24. “Self-reported symptoms” is defined as “manifestations of your condition which you tell your doctor such as pain or fatigue that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine.” This provision is extraordinarily broad; for the most part, virtually all disabilities include pain and/or fatigue as a disabling symptom. We have seen this provision used to limit

claims where insureds suffer from debilitating migraines, severe back problems, Multiple Sclerosis, and in one instance, a brain tumor. It is deeply unfair to punish claimants suffering from illnesses that medical science is not yet able to objectively verify by limiting their coverage under disability policies. Regulation requiring parity in the provision of benefits regardless of diagnosis is required to fix this inequality.

D. Improper offsetting for Social Security dependent benefits, pension benefits and third party recoveries.

Standard disability policies provide insureds with 60% of their predisability earnings, minus certain offsets articulated in the policy. Offset provisions have garnered favor as the years have passed, leaving claimants with less than the 60% of income promised to them by their disability and more restrictions on the income they do receive. Such provisions are defended by insurers as existing to avoid a double recovery for the same loss. *See, e.g., Hall v. Life Ins. Co. of N. America*, 317 F.3d 773, 775 (7th Cir.2003) (discussing reasons for income offset provisions). Common offsets include Social Security Disability Income (“SSDI”) benefits, Social Security retirement benefits, pension benefits, severance payments, sick pay, Veteran’s benefits and third party settlements – many of which neither compensate for the same loss, nor derive from the same claim. Certainly, third party settlements and severance pay have no relation to disability benefits paid under disability policies. However, even more egregious is the offset of pension benefits, including 401K benefits, and the offset of dependent Social Security benefits.

1. Pension benefits.

Pension benefits are a routine offset to disability benefits, even if the pension is received for reasons other than an individual’s disability. For many insureds, pension plans provide the only source of income when benefits are denied and financial situations, dire. However, choosing to take an early retirement only provides a windfall for the insurer, who, under many policies, is permitted to offset pension benefits. More outrageous however, is the recent decision in *Day v. AT & T Disability Income Plan*, 685 F.3d 848 (9th Cir. 2012), where the insurer was permitted to offset the claimant’s accrued pension benefits that were rolled over from the employer’s plan to an individual retirement account. There, the insurer received the benefit of an offset, even though the individual never received a dime of the money.

2. Social Security dependent benefits.

When the Social Security Administration (“SSA”) deems an insured to be disabled under its guidelines, benefits are also paid to the individual’s dependents under the age of 18 until they reach 18 or until they graduate from High School. However, these benefits are heavily restricted under federal regulation; the money must be spent on the dependent’s care and support. Nonetheless, the ability of insurers to offset the amount paid for the care of dependents by the SSA has been upheld by many courts faced with the issue. *See, e.g., Fortune v. Group Long Term Disability Plan for Employees of Keyspan Corp.*, 588 F.Supp.2d 339, 341–42 (E.D.N.Y.2008), *aff’d*, 391 Fed.Appx. 74, 80 (2d Cir.2010); *Hackner v. Long Term Disability Plan for Employees of the Havi Group LP*, 2002 WL 31803674, *13 (N.D. Ill. Dec. 12, 2002),

aff'd in part, reversed in part on other grounds, 81 Fed. Appx. 589 (7th Cir. 2003); *Mayhew v. Hartford Life & Accident Ins. Co.*, 2011 WL 5024648, at *5-7 (N.D.Cal. Oct. 21, 2011). Because of the restriction placed on the use of dependent benefits by the federal government, disabled insureds with children effectively receive less than their insurance policy provides for coverage. This is especially true in families where the children are living outside the disabled parents' home, but the offset is still applied by the insurance company.

Massachusetts currently has legislation pending to ban the offset of Social Security dependent benefits. Regulation is needed on the federal level to ensure that claimants receive the full benefit promised by their policies.

3. Severance benefits.

Severance benefits received by employees terminated from employment following their date of disability are also determined to be an offset under many disability plans. Severance benefits neither compensate employees for loss of income, nor compensate them for the same loss that caused the disability. To the contrary, severance benefits reward employees for their years of service to a company. Allowing this money to be offset under disability policies both disincentivizes employers from offering severance payments to disabled employees and rewards insurers. Such income belongs to the employees who worked loyally for an employer. To relate the receipt of a severance to a disability and deprive a recipient of this income simply because they are disabled and receiving benefits under an ERISA-governed policy is not logical or reasonable.

E. Damages

Considered an equitable statute, ERISA remedies have been limited by the courts to payment for the actual cost incurred for the benefit in dispute. Put another way, claimants are only entitled to recover what they have lost: their disability benefits. Remedies such as consequential damages (for lost wages or pain and suffering) or punitive damages (to punish outrageous conduct) that are traditionally available to consumers in under non-ERISA policies (such as individual policies or government-sponsored plans) are not available to participants in ERISA plans. Without the ability to hold an insurer liable for the losses it causes due to its unfair conduct creates a system that sanctions insurers who wrongfully deny coverage and limits access to the courts by claimants seeking to obtain remedies for actions that virtually every other plaintiff in every other type of case is able to obtain. As a result, the courts and Congress have provided insurers with what amounts to immunity from legitimate claims raised by the very individuals the statute was written to protect. There is no justification for providing private insurance companies who both administer and pay claims for benefits the same level of deference afforded an independent Administrative Law Judge and the same level of protection afforded the Social Security Administration.

IV. The Interplay between the Receipt of Disability Benefits and Employment.

A. The lack of real job protection.

While many individuals are under the impression that the receipt of disability benefits grants employees a right to job-protected leave, often nothing could be further from the truth. Although employers are free to design their leave or disability plans in such a way, there is no legal requirement to do so. Legal obligations that govern an employer's management of employees who are not able to perform their jobs because of illness or disability and who require leaves of absence are generally found under the ADA, the Family Medical Leave Act ("FMLA") and state law. In addition, COBRA provides employees with the right to continuing medical coverage.

The requirements of the FMLA are relatively straightforward. An employee with a "serious health condition" who is eligible for coverage under the FMLA has a right to be restored to the same position or a position "equivalent" to the one they held prior to their leave, if the employee returns to work before expiration of the traditional twelve weeks (or twenty-six weeks for certain military leave situations) of FMLA leave (this period may be extended voluntarily by the employer). Job protection no longer exists at the end of the FMLA period; an employee's only other option for job protection is the ADA. However, whether, and the extent to which, the ADA provides comfort for disabled employees seeking job (and as a corollary, continued coverage under the employer's welfare benefit plans) security is not contained in the statute, and as a result, has been the subject of considerable litigation.

The ADA prohibits employers from "discriminat[ing] against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." Although the ADA does not provide an express right to reinstatement to a job upon conclusion of a disability leave, the ADA's anti-discrimination, anti-retaliation, and reasonable accommodation requirements often provide a basis for employees claiming rights to reinstatement. For example, where employers have permanently replaced employees on disability leave based upon the need to operate the business, employees often have claimed that such actions are actually a pretext for discrimination on the basis of disability and/or retaliation for claims of discrimination.

In addition, permitting the use of accrued paid, unpaid leave or extended leave is a form of reasonable accommodation when it is necessitated by an employee's disability. However, the ADA does not define how long is too long before an extended leave is no longer protected under the ADA. What the case law does state is that indefinite leave is not generally a reasonable accommodation protected under the statute. Unfortunately, for many employees suffering from a serious medical illness that causes a disability, whether temporary or otherwise, a return to work date may be uncertain and accommodation unknown. For those individuals, job protection is rarely available once an employee's FMLA period has expired, as the ADA generally requires that employees provide employers with a reasonable estimated return to work date in order for such an accommodation to not be considered an undue burden.

In reality, many disabled employees find themselves in the position of having to choose between their employment and the benefits that come with it, and the disability benefits to which they are entitled. If unable to return to work within twelve weeks, and uncertain about a date they can return, employees are often terminated from employment. As a consequence of this termination, employees lose many of the benefits they need to help keep them and their families afloat: health, dental, life and pension benefits. Without the coverage provided by these benefits and with the loss of the security of employment, the bridge to a return to work promised by disability policies is meaningless. Disabled former employees are left to fend for themselves, or to seek public assistance.

B. The loss of collateral benefits.

A separate, but related problem befalls employees whose employment status, and receipt of employee benefits, is linked to their receipt of disability benefits. Specifically, many employers with generous extended leave policies permit employees to remain on the employer's benefit plans (including health insurance plans) as long as they are considered disabled under the terms of the disability plan. As a result, employees whose disability benefits are wrongly terminated by insurance companies suffer a compounded loss: the loss of their employment and their employee benefits. Even if benefits are reinstated, it is difficult to guarantee the reinstatement to employment and employee benefits lost as a result of the unlawful denial of coverage. And, because damages are not available under ERISA, employees are forced to bear the burden of this loss, even though other employees covered under the same plan receive the benefits.

V. Conclusion

Insurers justify the state of the current system – the lack of damages, clauses limiting benefits on the basis of diagnosis or the nature of one's disability, preemption of state law -- as necessary to reduce costs and to ensure that disability policies are not cost-prohibitive and available to all employees. However, every single day, my clients state that they would rather pay more for a policy that actually provides benefits, than a minimal amount for a policy that offers no protection at the most desperate time in their lives. Our firm sees every day the devastation imposed upon working families as a result of chronic illness and the failure of insurers to live up to the promises contained in the policies they have sold to employers. Until the system is fundamentally altered, this devastation, and the financial impact on individuals, families, and our society will continue to grow. At a very basic level, we must provide ERISA claimants with the same access to the courts and to the rights and remedies available to any other individual wronged by a third party in our legal system. The rights to compensation for their actual losses and to a jury trial are basic privileges of our society to which ERISA claimants should be entitled. Deferential review should be prohibited. And, discrimination based on the nature of one's illness should be unlawful. Individuals who are chronically ill and disabled deserve very these essential protections.