

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

Testimony of
Mark DeBofsky
Daley, DeBofsky & Bryant
55 W. Monroe St., Suite 2440
Chicago, Illinois 60603
(312) 372-5200
mdebofsky@ddbchicago.com
www.ddbchicago.com

August 28, 2012

Executive Summary:

I am an experienced practitioner in the field of representing claimants in disability benefit disputes. In my practice, I have encountered a number of problems with ERISA claims and litigation that need to be examined by the Department of Labor:

- ERISA claimants are denied the last word in claim appeals, which permits insurers and plan administrators to “sandbag” them with newly developed evidence they are unable to rebut in court.
- ERISA claimants are subjected to confusing and inconsistent limitations periods within which to bring suit.
- Insurers and plan administrators have become too reliant on medical opinions from physicians who never examine the claimants but merely rely on medical file reviews; and treating doctor opinions are given neither the weight nor consideration they deserve.
- ERISA has been transformed into a quasi-administrative law regime lacking due process protections, contrary to Supreme Court directives on the meaning and scope of what constitutes a civil action.
- Insurers have unfairly reduced their contractual obligations by improperly offsetting dependent Social Security benefits and Veterans disability benefits from the long-term disability benefits paid to claimants.
- Without a damages remedy insurers lack sufficient incentives to engage in good faith claims practices.

These issues are explored in more detail below.

Introduction

I am an attorney in private practice in Chicago, Illinois, whose practice is concentrated in the representation of individuals claiming entitlement to disability benefits under private disability insurance policies. Our firm’s practice also encompasses Social Security disability claims; and I myself have handled over 1,200 such claims in addition to having represented

hundreds of disability insurance claimants. Most of my cases involve benefits governed by ERISA; and in addition to representing claimants both in the claims process and in litigation, I have also written extensively on topics relating to disability benefits and I have given public testimony on several occasions in relation to disability benefits:

United States Senate, Committee on Finance, September 28, 2010, Hearing on “Do Private Disability Policies Provide the Protection They Promise?” (available at <http://finance.senate.gov/hearings/hearing/?id=1c1bd578-5056-a032-5237-4dd9283e52ed>)

National Association of Insurance Commissioners, Consumer Protections & Innovations Working Group, December 4, 2008, Testimony: “Disability Insurance Claims Handling Best Practices

ERISA Advisory Committee, United States Department of Labor, July 7, 2005, Hearing on Communications Issues in ERISA Benefit Claims

National Association of Insurance Commissioners, Committee on Consumer Protection, December 8, 2003. Testimony: “Why Discretionary Clauses in Disability Insurance Policies Must Be Prohibited.”

United States Department of Labor, Hearing on Proposed Amendments to ERISA Claim Processing Regulations, Washington, D.C., February 19, 1999

I would like to thank you for inviting me to testify at this hearing; and I appreciate having the opportunity to call your attention to several problems I have seen recur repeatedly in the course of my practice and which I believe could be remedied by regulation and/or legislation. I have already proposed to the Secretary of Labor much of what follows; however, no action has been taken since the measures discussed below were suggested more than three years ago.

1. Who Gets the Last Word in the Claim Review Process

The majority of courts that have addressed the issue of who gets the last word in claim appeals have concluded that there is no obligation for benefit plans to share with claimants the evidence compiled during the course of claim appeals until after the appeal is decided. The most recent such ruling is *Midgett v. Wash. Group Int'l Long Term Disability Term*, 561 F. 3d 887 (8th Cir. 2009). Following the issuance of that ruling, the Secretary unsuccessfully sought rehearing.

Permitting plan administrators (primarily insurance companies) to withhold evidence is essentially a grant of a license to “sandbag” the claimant since most courts still adhere to an administrative law paradigm for adjudicating ERISA claims which does not allow claimants the opportunity in litigation to augment the claim record with additional evidence challenging the evidence utilized by the plan administrator. Claimants are also only rarely allowed to even cross-examine the makers of the adverse evidence. This runs afoul of the very essence of the “full and fair review” requirement espoused by 29 U.S.C. § 1133 and which was best described

in *Grossmuller v. Int'l Union, United Auto. Aerospace & Agric. Implement Workers of Am., U.A.W., Local 813*, 715 F.2d 853, 858 n.5 (3d Cir. 1983): “[T]he persistent core requirements of review intended to be full and fair include knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision.”

I therefore suggest that 29 C.F.R. § 2560.503-1(h)(2) be amended to include a new requirement: (v) *Provide for a review that allows the claimant the opportunity to review and address the accuracy and reliability of all evidence utilized in the appeal, including all evidence obtained or reviewed after the submission of each appeal.*

2. Confusion Regarding Statutes of Limitations

A spate of recent appellate rulings shows uncertainty and confusion as to when limitations periods accrue, toll, and exhaust. Since courts have all but mandated “administrative exhaustion” prior to permitting a claimant to bring suit in ERISA claims (*See, e.g., Powell v. AT&T Communications, Inc.*, 938 F.2d 823, 826 (7th Cir. 1991)), claimants should not be at peril of exhausting the time within which they are allowed to bring suit while their pre-suit claim appeals are pending.

Indeed, in both *Abena v. Metropolitan Life Ins.Co.*, 544 F.3d 880 (7th Cir. 2008) and *Burke v. Pricewaterhousecoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2nd Cir. 2009), the limitations period was held to have accrued prior to the exhaustion of pre-suit appeals, and that period was not tolled by the appeal. *White v. Sun Life Assur.Co. of Canada*, 488 F.3d 240 (4th Cir. 2007), held, however, that the limitations period was tolled during the course of the claim appeal.

Given the uncertainty resulting from these cases, it would be beneficial to have a regulation that is clear and leaves no doubt as to the parties’ rights.

Therefore, I suggest that the existing regulation, 29 C.F.R. § 2560.503-1(j), be amended to provide as follows: 29 C.F.R. § 2560.503-1(j)(6): *A statement that all applicable limitations periods are tolled during all claim appeals. The claim administrator must also include in its final denial notification a statement setting forth the date calculated by the claim administrator on which the relevant limitations period expires; and no civil action commenced after the conclusion of the claim appeals may be challenged as untimely so long as it is brought prior to such date.*

3. Treating Doctor Opinions

In *Black & Decker v. Nord*, 538 U.S. 822 (2003), the Supreme Court rejected an argument that plan administrators should give deference to opinions rendered by treating doctors in the same limited manner in which the Social Security Administrations defers to treating doctor opinions in accordance with the criteria listed in 20 C.F.R. § 404.1527(d). However, the Court

stated:

If the Secretary of Labor found it meet to adopt a treating physician rule by regulation, courts would examine that determination with appropriate deference. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 81 L. Ed. 2d 694, 104 S. Ct. 2778 (1984). The Secretary has not chosen that course, however, and an *amicus* brief reflecting the position of the Department of Labor opposes adoption of such a rule for disability determinations under plans covered by ERISA. See Brief for United States as *Amicus Curiae* 7-27.

538 U.S. at 832. Given that invitation by the Supreme Court, the Department of Labor should reconsider its prior opposition to a treating physician rule and adopt the same rule as that utilized by the Social Security Administration given the superior information usually possessed by the treating doctor.

The reason why circumstances have changed is that *Nord* has triggered a regime in which insurers have come to heavily rely on reports from physicians who have not even examined the claimant; and despite evidence suggesting the financial bias of the doctors and the vendors hired to retain such doctors, courts give such opinions equal if not greater weight than opinions rendered by treating doctors. Several recent rulings have questioned insurers' financial ties to such organizations - *Wright v. Raytheon Co. Short Term Disability Plan*, 2008 U.S. Dist. LEXIS 81951 (D. Ariz. September 17, 2008) (describing the financial relationship between Network Medical Review/Elite Physicians and Metropolitan Life Insurance Company). *Also see, Solomon v. MetLife*, 2009 U.S. Dist. LEXIS 51507 (S.D. N.Y. June 18, 2009) (pointing out that one reviewer, whom the insurer characterized as "independent," derived 99% of her income in the years 2002-2004 from paper medical reviews for third parties, 58% to 63%, or over \$ 100,000, of which was derived from reviews for MetLife). Another case reported that one frequently-retained medical consultant had found an absence of disability in 193 out of 202 cases she reviewed over a two year period. *Caplan v. CNA Financial Corp.*, 544 F. Supp. 2d 984 (N.D. Cal. 2008). Yet another insurer utilized a file reviewer so frequently that a court characterized him as a "man with a mission - to deny claims." *Gunn v. Reliance Standard Life Insur. Co.*, CV-04-01852 FMC, 2005 WL 2901792 (C.D. Cal. 10/31/2005).

Given the continued existence of a deferential standard of review where the courts defer to insurers' conclusions unless they can be deemed unreasonable, giving deference to the insureds' treating physicians is the only way to have greater assurance that the claims process is producing accurate claims decisions, a goal the Supreme Court recently characterized as paramount in ERISA. *MetLife v. Glenn*, 128 S.Ct. 2343 (2008). Indeed, the Court demanded that plan administrators utilize "higher-than-marketplace quality standards" to meet that goal. 128 S.Ct. at 2343. However, cases such as *Davis v. Unum*, 444 F.3d 569, 575 (7th Cir. 2006) encourage insurers to utilize such biased resources based on findings such as the one made by that court:

When an administrator, like Unum here, opts to investigate a claim by obtaining an expert medical opinion--independent of its own lay opinion and that of the

claimant's doctors--the administrator is going to pay a doctor one way or another. *See Wallace v. Reliance Standard Life Ins. Co.*, 318 F.3d 723, 724 (7th Cir. 2003). Thus, whether the administrator retains in-house doctors (arguably reducing overhead costs for the benefit of the plan's participants and beneficiaries) or pays for freelance doctors makes no difference in this conflict analysis. Paying for a legitimate and valuable service in order to evaluate a claim thoroughly does not create a review-altering conflict.

Particularly in view of what has since been learned about the claim operations of multiple insurers suggesting abuses in their reliance on non-examining physicians (*see, e.g., Willcox v. Liberty Life Assur.Co. of Boston*, 552 F.3d 693 (8th Cir. 2009); *Alfano v. Cigna Life Ins.Co. of N.Y.*, 2009 U.S.Dist.LEXIS 7688 (S.D.N.Y. January 30, 2009); *Gordon v. Northwest Airlines, Inc. and Life Ins.Co. of North America*, 2009 U.S.Dist.LEXIS 22217 (D.Minn. March 18, 2009)), the Seventh Circuit's viewpoint appears questionable. *See, McCauley v. First Unum Life Ins.Co.*, 551 F.3d 126 (2nd Cir. 2008); J. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315 (Spring 2007). Thus, thoughtful guidance from the Department of Labor as to consideration of opinions rendered by treating physicians is not only desirable, but is also necessary to insure greater transparency and accuracy in the claims process. The Secretary could either incorporate the Social Security treating physician rule into the existing ERISA regulations or create a new regulation with similar qualifications.

4. Deferential Court Review/Administrative Law Paradigm/Remands of Claims

The ERISA statute is silent as to the standard of review that courts are to apply when they adjudicate benefit claims; however, in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court permitted benefit plans to incorporate provisions reserving discretion to interpret plans and determine benefit eligibility that triggered a deferential standard of review. Insurers quickly recognized the advantage of that standard which requires claimants to prove the plan administrator abused its discretion by showing the insurer's decision was not just wrong, but unreasonable. Insurers rushed to put such language in their policies; and while several states have reacted by enacting laws and issuing rulings prohibiting such clauses consistent with a model law promulgated by the National Association of Insurance Commissioners (NAIC, Prohibition On The Use Of Discretionary Clauses Model Act (#42) (September 2004)), a majority of jurisdictions still permit the inclusion of discretionary clauses in insurance policies. And the result has been a series of court rulings since *Bruch* that have transformed ERISA litigation into a quasi-administrative law regime contrary to a series of Supreme Court rulings questioning the propriety of such procedures.

In both *Chandler v. Roudebush*, 425 U.S. 840 (1976) and *United States v. First City National Bank*, 386 U.S. 361 (1967), the Supreme Court held that where Congress establishes the right to bring a civil action, such claims are to be plenary trial proceedings and not administrative-type reviews. That proposition was recently reaffirmed in *Kappos v. Hyatt*, ___U.S. ___, 132 S. Ct. 1690 (2012), where the Supreme Court ruled the right of a patent claimant to challenge a patent's denial by bringing a civil against the director of the Patent and Trademark

Office invoked the right to trial permitting the introduction of new evidence and cross-examination of witnesses. The Court's ruling is consistent with Rule 2 of the Federal Rules of Civil Procedure, which states there is only one form of "civil action;" and all civil actions are to be governed by all provisions of the Federal Rules of Civil Procedure. Yet ERISA cases continue to be treated as proceedings limited to a court's review of an "administrative" record.

Although the Seventh Circuit recognized a right to trial in ERISA cases adjudicated under the *de novo* standard in *Krolnik v. Prudential Ins.Co.*, 570 F.3d 841 (7th Cir. 2009), the First, Ninth and Tenth Circuits still adhere to conducting *de novo* hearings as record review proceedings. See, *Orndorf v. Paul Revere Life Insur.Co.*, 404 F.3d 510 (1st Cir. 2005), *Kearney v. Standard Insurance Company*, 175 F.3d 1084 (9th Cir. 1999), and *Jewell v. Life Ins.Co. of North America*, 508 F.3d 1303 (10th Cir. 2007). Such record review proceedings result in a wholesale denial of basic due process rights ordinarily accorded litigants under the Federal Rules of Civil Procedure such as the right to take discovery and engage in trials with examination and cross-examination of witnesses, which are crucial rights in view of the importance of disability benefits and the Supreme Court's emphasis on accurate claim decisions and insurers' obligation to employer "higher-than-marketplace quality standards" in their adjudication of claims. See, *Metropolitan Life Ins.Co. v. Glenn*, 554 U.S. 105, 115 (2008).

The routine practice of remanding claims to insurers found to have acted arbitrarily and capriciously is also offensive to Constitutional rights. The practice of remanding ERISA disability benefit claims derived from Social Security law, an area governed by administrative law. However, unlike Sentences 4 and 6 of 42 U.S.C. §405(g), which explicitly permit remands as part of judicial reviews of Social Security disability claim denials, the ERISA statute lacks any authority permitting remands. Consequently, remands of ERISA civil actions fail to fully adjudicate the parties' rights and afford appropriate judicial remedies that finally resolve a civil action as required by Article III of the United States Constitution. According to *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 241 (1937), which involved a dispute over disability benefits, the Court reiterated the principal that Article III demands the issuance of a final judgment disposing of the dispute. ERISA authorizes a civil action pursuant to 29 U.S.C. § 1132(a)(1)(B) "to recover benefits due ... under the terms of [a] plan." Either the claimant is entitled to recover the benefits or the denial must be upheld under that provision. Remands are extra-statutory, unconstitutional, and must be disallowed.

5. Social Security Dependent Benefits and Veterans Disability Benefits Offsets

Over the past fifteen years, disability insurers have aggressively expanded the list of offsets that reduce the disability benefits paid to insureds. One such offset that is now commonly enumerated in group disability policies is an offset of dependent Social Security benefits in addition to offsets of Social Security benefits paid to the insured. The Social Security Administration not only pays benefits to the disabled wage earner, but also pays a benefit to the disabled wage earner's dependents in certain circumstances. Dependents of disabled wage earners are entitled to receive monthly payments until they reach the age of 18 or graduate from high school solely on account of their dependency and support from the wage earner. In addition, disabled children who become disabled prior to reaching adulthood are entitled to

benefits as adults under their disabled parent's social security number.

Offsets of dependent Social Security benefits are unfair and can impose a hardship on disability benefit recipients. First, Social Security dependent benefits are restricted benefits. Unlike Social Security disability payments, which may be used for any purpose, dependent benefits are restricted and may only be used for the dependent's care and support. Thus, in cases where dependent benefits are offset, the claimant is not receiving 60% (or the contractually-defined percentage) of their pre-disability earnings – they are receiving substantially less than that if their benefits are reduced not only by the primary Social Security disability benefit, but by the dependent benefits as well, since the claimant does not have full access to those benefits to purchase necessities such as medicine or durable medical supplies the disabled parent requires. Consequently, group disability insurance recipients with children receive disparate treatment in relation to recipients who do not have children.

This issue was obviously the reason why the NAIC several years ago promulgated a model law that was adopted by most, if not all, states that prohibit disability insurers from offsetting cost-of-living increases paid by Social Security. If COLA increases were offsettable, the promised benefit would, over time, diminish to next to nothing and the claimant would not be receiving the contractual benefit of 60% of pre-disability income.

Second, permitting offsets of dependent benefits creates anomalous circumstances. A Social Security disability recipient who is also receiving disability insurance benefits may be divorced and lose custody of the dependent and the right to take a dependent tax deduction, See, *Hackner v. Long Term Disability Plan*, 2003 U.S. App. LEXIS 23605 (7th Cir. Ill., Nov. 17, 2003)(unpublished). A disability insurance recipient who adopted a grandchild due to the incarceration of the child's parents recently contacted our office and complaining that Social Security began paying dependent benefits to the grandchild and the insurance carrier promptly reduced its payments to the grandfather by the amount of the dependent benefits, a situation that strongly suggests unfairness and inequity. And while the dependent benefits and ensuing offsets would, in most instances terminate when the dependent turns 18 or graduates from high school, if the child is disabled, the offset could potentially continue through the full duration of the long-term disability benefit payments, depriving claimants of thousands of dollars in benefits due them.

In addition to court rulings permitting Social Security dependent offsets, insurers' efforts to deduct Veterans' benefits have also been problematic. In *High v. E-Systems, Inc.*, 459 F.3d 573 (5th Cir. 2006), the court permitted the offset as a matter of the insurer's discretionary authority to interpret its policy under ERISA even though the policy lacked an explicit provision permitting such offsets. However, another court recently ruled that Veterans' benefits are different than Social Security benefits – they do not necessarily replace earnings losses but are paid to compensate the veteran for wounds received or illnesses suffered while in active service. See, *Riley v. Sun Life and Health Ins.Co.*, 657 F.3d 739 (8th Cir. 2011). However, a dissenting opinion in *Riley* would have found the insurer could offset VA benefits based on the insurer's interpretive discretion; and when a petition for rehearing was filed, several other appellate judges agreed. The key point made in the *Riley* ruling is that VA benefits are not income replacement

benefits, but are instead paid to compensate the service member for wounds suffered or illnesses incurred while in service to their country. For that reason alone, such offsets should be flatly banned.

6. Damages

ERISA has been interpreted as a law that permits limited remedies and therefore bars the recovery of damages no matter how egregious the insurer's conduct and no consideration is given to the harm suffered as a consequence of the unjustified denial of benefits. There has been no better statement as to the need for a damages remedy in ERISA than in the opinion authored by Judge Spencer Letts in *Dishman v. Unum*, 1997 WL 906146 (C.D.Cal. May 9, 1997). After overturning Unum's benefit denial, the court added a "Further Opinion" which included the following language:

UNUM's unscrupulous conduct in this action may be closer to the norm of insurance company practice than the Court has previously suspected. This case reveals that for benefit plans funded and administered by insurance companies, there is no practical or legal deterrent to unscrupulous claims practices. Absent such deterrents, the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.

* * *

As this case demonstrates, the reform of shifting the attorney's fee to the insurer is not enough to deter this type of conduct. UNUM's bad faith acts placed pressure on the Dishmans because they were deprived of monthly income which they needed to live. A lump sum benefit after a lawsuit, even with interest and free from legal expense, did nothing to alleviate the pressure upon them at the time the claim was denied and during the entire course of the litigation. UNUM was not deterred by the prospect of paying the Dishmans' attorneys' fees, because it had every reason to believe that the economic straits in which it had placed the Dishmans would force a favorable settlement long before any substantial fees had been accumulated.

It is still the Court's view that bad faith tort liability under state law is so extreme and unpredictable that it would detrimentally disturb the ERISA balance. However, without any statutory or other legal deterrent it is entirely predictable that insurers will go overboard to minimize claims.

That viewpoint makes it obvious that damages remedies need to be made available to claimants as a deterrent against bad faith conduct.

Conclusion

The current state of the law involving disability benefit disputes adjudicated under ERISA is dire. Disability benefits are a key economic safety net for workers whose careers are disrupted by injury or illness and are no longer able to support themselves and their families. When insurers fail to pay benefits to meritorious claimants, those individuals often drain the resources of their families and often become public aid recipients. And the tragedy is magnified because ERISA, which offered the promise of more protection, has resulted in far less protection for disabled individuals. Insurers argue that the current state of the law reduces costs; however, that rationale is no justification for a system that gives greater deference to insurance adjusters than to federal administrative law judges. Modestly higher premiums are a legitimate tradeoff for the assurance that an insurance policy is a promise of protection rather than a worthless piece of paper.

The ways in which ERISA can be amended to live up to its promise are not unduly complex although one possibility would be to exclude insured disability benefits from ERISA altogether leaving claimants with the existing protections of already well-established state laws, rights, and remedies. Another proposal is to amend the ERISA statute to preclude deferential review and mandate the same plenary proceedings as are utilized in all other civil actions, including trial by jury as guaranteed by the Seventh Amendment to the U.S Constitution. Finally, ERISA's remedies need to be broadened in order to deter the bad faith conduct described by Professor Langbein in his Northwestern Law Review article and by Judge Letts in *Dishman*.