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DO PRIVATE LONG-TERM DISABILITY POLICIES PROVIDE THE PROTECTION THEY PROMISE?

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

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DO PRIVATE LONG-TERM DISABILITY POLICIES PROVIDE THE PROTECTION THEY PROMISE?

TUESDAY, SEPTEMBER 28, 2010

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:09 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Carper, Grassley, and Snowe.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Claire Green, Congressional Fellow; Alan Cohen, Chief Counselor for Social Security and Senior Budget Analyst; Tom Klouda, Professional Staff Member; Jen Rigger, Congressional Fellow; and Jack McGills, Intern. Republican Staff: Steve Robinson, Chief Social Security Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Black's Law Dictionary defines "insurance" as "a contract whereby one party undertakes to compensate the other for loss." Thus, an insurance policy is only good if the insurance company actually compensates the consumer when there is a loss.

Today we will look at long-term disability insurance. We will consider cases where insurance companies are failing to live up to their side of the bargain, and we will hear ideas about how to fix it.

We will learn about plans offered to employees through their employers. This occurs under ERISA, the Employee Retirement Income and Security Act. And we will compare what happens under ERISA with what happens under Social Security.

Abusive insurance company tactics start with having doctors with conflicts of interest review claims. Many of these doctors are employed either by the insurance company or by the companies that do a lot of business with the insurance company. These arrangements make it far too easy for the doctors to deny claims, terminate claims, or reject appeals.

Consider the case of Charles Tucker. Charles's neurologist diagnosed him with multiple sclerosis. Charles's doctor said that the disease "basically disabled him from performing his occupation." Ten other doctors agreed.

Charles filed a claim with his long-term disability insurance company, Standard Insurance Company. Meanwhile, a doctor who worked for Standard put a medical report in Charles's file. The company doctor never met Charles. The company doctor never examined him. Even so, the company doctor concluded that "the diagnosis of multiple sclerosis is not supported, and the patient could return to a sedentary work activity."

When Charles found out about this report, he was, understandably, quite upset. He contacted the news media, who contacted the insurer. Only then did Standard approve Charles's claim.

Or consider the case of Rocky Whitten. Rocky suffered a broken neck. As a result, Rocky had severe headaches, memory loss, pain, and significantly reduced vision from all the medicines that he had to take. Rocky's doctor said that he was permanently disabled.

But Rocky's insurance company, The Hartford, hired a private investigator. The private investigator put Rocky under video surveillance, and that private investigator took videos of Rocky getting in and out of a van, reading a magazine, and dipping corn chips into salsa at a restaurant.

So The Hartford sent Rocky a letter telling him that he was, "physically capable of performing full-time sedentary occupations," and The Hartford terminated his benefits.

Rocky appealed the decision through The Hartford's internal appeals program, but the company's internal appeals program turned him down. Soon, his finances became desperate. Rocky and his attorney prepared to sue The Hartford, and Rocky reached out to the news media. The media called the company and, miraculously, The Hartford paid Rocky's back benefits and reinstated his monthly benefits.

Abuses like these are not uncommon. Thousands of cases clog the district courts. Many claimants end up in desperate straits. Some lose their homes, their savings, and even their spouses or custody of their children.

How do the insurance companies get away with these abuses? Unfortunately, loopholes in the law permit them.

First, ERISA preempts State insurance measures to address these abuses. That means that claimants cannot get jury trials, pretrial discovery, or the right to submit evidence to the court. And claimants cannot receive punitive or consequential damages.

Second, companies can include what is called a discretionary clause in their insurance plan document. In most States, these clauses mean that it is not enough for a claimant to prove that the company's reasoning is weak when it decides to deny benefits. To win the case, the claimant has to prove that the company's reasoning is arbitrary or capricious. That is a significantly higher standard.

It is time to close these loopholes. It is time to end the abuses. An insurance policy is only good if the insurance company actually compensates the consumer when there is a loss, and insurance law is only good if it helps to make that happen. It is time to make sure that the law does that.

So let us hear what is happening in the long-term disability insurance industry. Let us hear what we might do to fix it, and let

us do what we can to make sure that insurance is good for the consumer when there is a loss.

[The prepared statement of Chairman Baucus appears in the appendix.

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. The reason that Congress created the Social Security Disability Insurance and the SSI programs is because the loss of wages due to illness or injury can be devastating, both emotionally and financially.

In addition to these public programs, Congress has encouraged employers to provide additional protection to workers and their families through the ERISA legislation.

Much of today's testimony focuses around the alleged failure of ERISA to protect workers from unscrupulous practices of private insurance companies. But I would caution my colleagues that legislative jurisdiction over ERISA resides in the HELP Committee, not the Finance Committee.

Now, I agreed to this hearing because it is based on the fact that private disability affects Social Security. Those with private insurance are often required to apply for Social Security, which potentially adds to the backlog of pending applications.

Moreover, changes in private disability could be viewed by some as a green light for similar changes in Social Security. Any changes to ERISA must be carefully reviewed in terms of their impact on Social Security. There are both differences and similarities between Social Security and private disability, ranging from the definition of disability to the standard of judicial review.

Whether or not all of these parallels and distinctions are entirely justified remains to be seen. Our goal should be to make the disability application process faster, fairer, and easier to understand.

But given the looming insolvency of the Social Security Disability Trust Fund just a few years down the road, we must also be mindful of the needs to protect this vital program for future generations.

Thank you, Mr. Chairman.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. Thank you, Senator.

Now, I would like to introduce our witnesses. Ron Leebove is a certified rehabilitation counselor who has been working in vocational rehabilitation for about 30 years.

Second, Mark DeBofsky. Mr. DeBofsky is a partner at the firm Daley, DeBofsky, and Bryant, a Chicago disability law and employee rights law firm.

Next, Judge William Acker, Senior United States District Court Judge for the Northern District of Alabama. Appointed by President Reagan in 1982, Judge Acker has written more opinions on ERISA than any other district judge. Judge, thank you for being here. It is a real honor to have a sitting U.S. district court judge as one of our witnesses. Thank you very much for taking the time.

The next witness is David Rust, Deputy Commissioner for Retirement and Disability Policy at Social Security. Thank you, Mr. Rust.

And, finally, Paul Graham, who is senior vice president and chief actuary at the American Council of Life Insurers.

Gentlemen, it is our policy here to automatically include your statements in the record and ask each of you to summarize your statements for about 5 or 6 minutes, something along those lines.

Mr. Leebove, you are first.

STATEMENT OF RONALD LEEBOVE, CERTIFIED REHABILITATION COUNSELOR, DIPLOMATE, AMERICAN BOARD OF FORENSIC COUNSELORS, SCOTTSDALE, AZ

Mr. LEEBOVE. Mr. Chairman, Senator Grassley, and members of the committee, I would like to thank you for the opportunity to be here today and to be able to speak before this committee.

My name is Ron Leebove, and I am a certified rehabilitation specialist. I have been working in the field of vocational rehabilitation for approximately 30 years. I have maintained a private practice since 1989. I perform comprehensive vocational rehabilitation assessments and evaluations of patients who have disabilities with limitations and restrictions.

Patients who are disabled have restrictions in their life activities, and that would include employment. I would like you to know that I have my own disabilities. I am visually impaired, and I have a hearing loss, with limitations and restrictions. I want to thank the State of Michigan and the United States of America for providing me education and vocational rehabilitation services. That included training and, ultimately, employment.

The services that I have received have enabled me to fulfill my own vocational goals and, also, to be able to be successful in what I do.

There are many tricks and techniques or tactics used by insurance companies to deny claims. These tactics include video surveillance of minor activities of claimants that are then blown out of proportion to intimidate claimants, biased medical reviews conducted by doctors paid by insurance companies, harassment of claimants by omitting medical records, requiring unreasonable turnaround times on requests for information, and threatening to accuse the claimant of noncompliance over unimportant matters.

There are many other examples, which I really do not have time to go over.

My written testimony discusses two specific cases. In one case, a nurse who has a severe psychiatric disability was denied benefits, even though her human resource manager advised me that Mary F. was unable to work with patients and that to allow her to continue working at that job would put patients at risk, as well as the company.

In the other case, Jamie F. is legally blind and suffers from multiple sclerosis. She has been deemed totally disabled and unable to work by the Social Security Administration, which has the strictest conditions in the industry for identifying disability. However, the private long-term disability carrier continues to harass Jamie and has told her she is being investigated to determine whether she can work.

These two cases document the ruthless and inhumane treatment of people with disabilities by the insurance companies. That should not be allowed to continue.

Private long-term group disability insurance policies are covered under ERISA. Unfortunately, ERISA denies due process and limits legal remedies. As a result, persons with disabilities do not have a level playing field when dealing with the insurance industry.

Persons with disabilities should be entitled to an independent administrative review, where complete evidence may be submitted, as in Social Security disability adjudication. Moreover, standards of total disability should be uniform, not the ad hoc determinations private insurers make.

Furthermore, under ERISA, the private insurers are entitled to operate as judge and jury, which violates our common notions of due process. Equally as troublesome is the issue of insurers requiring claimants to apply for Social Security disability benefits even if the claimant and the company know that the application will not be approved. Insurance contributes nothing to the cost of the Social Security application process. These applications cost the taxpayers millions and millions of dollars.

It is clear that claimants are being treated unfairly by the private long-term disability companies. This situation should be remedied as soon as possible.

I will be happy to answer any questions that the committee may have for me, and I thank you for your time.

[The prepared statement of Mr. Leebove appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Leebove, very much.

Mr. DeBofsky?

STATEMENT OF MARK DEBOFSKY, ATTORNEY, DALEY, DEBOFSKY, AND BRYANT, CHICAGO, IL

Mr. DEBOFSKY. Senator Baucus, Ranking Member Grassley, and members of the Senate Finance Committee, thank you for giving me the opportunity to testify at today's hearing.

When the Employee Retirement Income Security Act was passed in 1974, one of the law's major sponsors, Senator Jacob Javits, hailed it as the greatest development in the life of the American worker since Social Security. That optimism was secured by a promise contained in the preamble to the statute proclaiming ERISA's purpose: to provide appropriate remedies, sanctions, and ready access to the Federal courts.

Yet, the story told over the past 35 years has been one revealing an utter betrayal of those lofty goals and an egregious absence of remedies, sanctions, and access to normal Federal court procedures.

Contrary to the clearly expressed legislative intent, the courts have transformed ERISA into a shield that protects insurance companies from having to face the consequences of unprincipled benefit denials and other breaches of fiduciary duty.

Claimants are denied a right to trial by jury, a basic constitutional right routinely available in every other type of insurance case and virtually all other civil litigation. In most cases, there is

not even a trial. Instead, courts conduct reviews of claim records assembled and shaped by self-serving insurance companies.

Claimants are given no opportunity to cross-examine adverse medical or vocational experts. Routine discovery procedures, such as compelling answers to written interrogatories and depositions, are denied, and no trial is held.

No provision of ERISA sanctions such a practice, and Supreme Court precedent establishes the impropriety of courts holding review proceedings rather than trials in cases such as this.

This insidious practice has also led to courts' willingness to overlook wholesale flouting of ERISA claim standards developed by the Department of Labor. Courts allow insurers to unduly delay claim decisions and deny benefit claimants any opportunity to rebut adverse evidence, without any adverse consequences.

Conversely, unsophisticated claimants who fail to meet complex and detailed rules governing the submission of claims and appeals are given no leeway whatsoever and are often barred from presenting crucial evidence in court, if they are even able to gain access to judicial review.

And even when claimants win, instead of simply ordering the payment of benefits when the benefit denial has been overturned, the routine practice is for courts to send the case back to the insurance company. Since insurance companies understand they will be given further opportunities to develop new reasons for denying the claim, there is no incentive to make an accurate decision in the first instance. Consequently, the practice of remands clogs the Federal court system with multiple rounds of litigation.

Following the 1989 Supreme Court Ruling in *Firestone Tire and Rubber Co. v. Bruch*, a vast transformation of ERISA litigation arose. So long as particular language is written into the insurance policy, courts are compelled to defer to the insurance company's determination, unless the claimant can prove the benefit denial was arbitrary and capricious, and not merely wrong, a concept that has been elevated above the goal of ensuring an accurate claim decision. As one court has remarked, the broader that discretion, the less solid an entitlement the employee has.

My written testimony contains numerous examples of how this has played out. The reason most frequently offered for preserving the ERISA regime is that the current state of the law holds down costs and, thus, encourages the formation of employee benefit plans. But that rationale is hardly a justification for a system in which courts give more deference to insurance companies than is given to Federal administrative law judges adjudicating Social Security claims.

Since employee benefits are a valuable tool utilized by employers to recruit and retain prized employees, it is extremely unlikely that employers would cease sponsoring benefit plans, nor is there a legitimate fear of markedly increased costs.

The only available actuarial study on this issue reveals that potential cost increases resulting from the elimination of insurer discretion would lead to, at most, a modest 4-percent rise in insurance premiums. To analogize, both history and common sense suggest that most consumers would willingly pay a ticket charge of $104

to fly on an airline that has a near-perfect safety record rather than paying $100 to fly on an airline perceived as being less safe.

That price is a small one to pay for the assurance of more solid rights to receive benefits when they are needed in times of sickness or injury and to have confidence that those who deserve benefits receive them expeditiously, while those who are not deserving are denied for valid, defensible reasons.

The ways in which ERISA can be amended to bring about these changes are not unduly complex. One possibility would be to amend the definition of welfare benefits in ERISA to clarify that the purchase of insurance as a means of funding employer-sponsored disability health or life insurance excludes the resulting plan from ERISA all together, leaving claimants with the existing protections of already well-established State laws, rights, and remedies.

Another proposal would be to amend section 502 of ERISA to provide that claims brought under insured plans will always be adjudicated in accordance with the same plenary standards and proceedings afforded any other civil action brought in Federal court.

These proposed changes would restore the intent and purpose of the comprehensive benefit reform enacted by Congress more than 35 years ago. More importantly, such changes can help rebuild public confidence in insurance companies that have for too long been able to hide behind legislative shields and judicial protections that no other industry receives.

Thank you.

[The prepared statement of Mr. DeBofsky appears in the appendix.]

The CHAIRMAN. Thank you very much, Mr. DeBofsky. That was straightforward and very clear. Thank you.

Judge Acker?

STATEMENT OF HON. WILLIAM M. ACKER, JR., SENIOR U.S. DISTRICT COURT JUDGE, NORTHERN DISTRICT OF ALABAMA, BIRMINGHAM, AL

Judge ACKER. It is a privilege to be able to share with you this morning some of the thoughts of a trial judge who has been grappling with ERISA for 28 years.

Appointed in 1982, I sweated over ERISA and watched other courts sweat over it for years, until, in 1998, I wrote a law review articled entitled "Can the Courts Rescue ERISA?" That is probably what prompted your committee to invite me, and I appreciate it.

A copy of the article is attached to my testimony as Exhibit A.

Although my arguments in 1998 are now dated, my 1998 answer to the question, can the courts rescue ERISA, was "no," and, since that time, I have not changed my mind. The courts have not rescued ERISA. If anything, they have dug the hole deeper.

I am not saying that the courts, including the Supreme Court, have not tried to make sense of ERISA, tried to make it workable. But the situation is worse now than it was in 1998 and getting worse every day.

I hope that the committee is not as interested in citations of authority to support my views as it is in the views themselves, developed from experience as a trial judge constantly confronted with ERISA under ever-changing judge-made rules.

I am assuming that—except for Chairman Baucus, whose State has done away with the so-called discretionary clause and thus far gotten by with it; Senator Stabenow, whose State has done the same thing; and Senator Cornyn, whose State is in the process of doing it, if it has not already done it, and who, as Texas attorney general, was sued in a case that became central to the 5–4 decision by the Supreme Court in *Rush Prudential v. Moran*—I am assuming that the other members of this group have no specialized knowledge of ERISA or of the effect that the so-called discretionary clause, first given prominence by the Supreme Court in *Firestone v. Bruch*, has had.

The committee has already heard or will hear testimony from others who are my intellectual equals or my superiors, who support the continuation of the discretionary clause as the basis for ERISA benefits decision-making.

I will spend the rest of my time telling you why the discretionary clause is a disaster. I call it the law of unintended consequences.

Bruch put the fox in the henhouse when it authorized plan administrators to operate under the now universally employed discretionary clause, the clause that, except for Michigan and Montana, allows the plan administrator both to interpret the plan and to decide how to apply it to a particular disability claim.

This concept is not only foreign to logic and common sense, but it is unworkable and expensive. I am attaching as Exhibit B a copy of the initial order I routinely use in ERISA benefits cases.

A look at it from top to bottom, something I will not undertake now, will illustrate the complexity of court decision-making, something that only takes place after the already lengthy process of administrative review and after the claim has been denied by the final, final, final administrative decision-maker.

A driving force behind the idea of granting the insurer almost unbridled discretion is the belief that the procedure will lessen costs and lessen court time spent on ERISA cases. This is the main argument made by the amici curiae, who supported Standard Insurance Company's unsuccessful certiorari petition seeking to overturn the decision that confirmed Montana's right to eliminate the discretionary clause.

It is, of course, true that, in drafting legislation, Congress has the obligation to consider the economic impact, as well as the needs of society. This judge is willing to assume that Congress engaged in this debate before it enacted ERISA in 1974.

The language it chose, if it had not, over time, been altered or obliterated by the courts, would provide for de novo consideration by a court of all denials of ERISA benefits. ERISA's section 502(a)(1)(B) straightforwardly provides that any beneficiary can bring a "civil action to recover benefits due him under the terms of his plan."

Rule 2 of the Federal Rules of Procedure provides, "There is only one form of action—the civil action."

The clear language of ERISA recognizes nothing less than a trial on the merits. This procedure contrived by the courts, now called judicial review, based on an examination of the administrative record, while giving deference to the conflicted decision-maker, simply does not fit the scheme that Congress contemplated.

I have found no empirical evidence to justify the argument that the cost of trial de novo would be greater than the cost of so-called judicial review. I only wish that I could have brought enough steamer trunks to hold all of the trial and appellate court opinions written under the *Bruch* regime and under the more recent case of *MetLife v. Glenn*, which only exacerbates the problem by requiring us to consider the inherent conflict of interest as a "factor" in our determination as to whether there has been an "abuse of discretion."

It makes one's head swim to read the long and convoluted opinions rendered by trial and appellate courts. I am guilty. The trial judge, if he or she takes *Bruch* and *Glenn* seriously, starts with being intimidated.

The long and the short of it is that the "independent" consideration of an ERISA claim contemplated by Congress, but denied by the courts, would save judicial resources and clients' money. I suggest that, if Congress doubts me, it should conduct an experiment and say again what it said in 1974, with no possibility of its being misconstrued this time, that de novo trials are the appropriate procedure in these cases.

It will find that the volume of cases and judicial opinions that follow will be substantially reduced. If I am proven wrong, I will gladly eat my words. At my age, that would be a safe bet.

Meanwhile, unless Congress gives me help, I will continue to scrupulously follow my judicial superiors.

I have not covered all my pet peeves, but I will conclude by telling the committee that ERISA jurisprudence will stay as messed up as it is unless Congress reworks it.

The courts have not rescued ERISA and cannot be expected to do so. The most important legislative change that I implore you to make is to make it absolutely clear that, when Congress says civil action, as it said in 1974, it meant what it said—civil action, and not judicial review.

Thank you for the opportunity to share these thoughts.

[The prepared statement of Judge Acker appears in the appendix.]

The CHAIRMAN. Thank you, Judge, very, very, very much. I appreciate that.

Mr. Rust?

STATEMENT OF DAVID RUST, DEPUTY COMMISSIONER FOR RETIREMENT AND DISABILITY POLICY, SOCIAL SECURITY ADMINISTRATION, BALTIMORE, MD

Mr. RUST. Chairman Baucus, Ranking Member Grassley, Senator Snowe, and members of the committee, thank you for inviting me today to testify. I am here to discuss the scope of review of our disability claims process.

We pay tax benefits to persons with disabling physical and mental disorders under the Social Security Disability Insurance and Supplemental Security Income programs. Under the Social Security Act, adult claimants can be found disabled only if their medical condition, one, prevents them from performing their previous work, and, two, prevents them from performing other work that exists in

the national economy, considering their age, education, and past work experience.

In addition, their disability must have lasted or be expected to last for at least 1 year or result in death. In 2009, we paid $115 billion in SSDI benefits to over 9 million Americans and over $40 billion in Federal SSI benefits based on disability to over 6 million Americans.

Our disability process consists of several stages. When we receive a disability claim, we generally send the claim to the State Disability Determination Service, which is responsible for developing medical evidence and making the initial determination of whether the claimant meets our definition of disability.

If the claimant is dissatisfied with the initial decision, our regulations provide for three levels of administrative review—reconsideration by the DDS, a hearing before an administrative law judge, and a request for a review by our appeals counsel.

Our administrative review process has been described by the Supreme Court as "unusually protective" of the claimant, as it strives to ensure that a person who truly needs disability benefits receives them.

A claimant dissatisfied with the agency's final decision may appeal to a Federal district court. The Federal district court considers two broad inquiries when reviewing our decisions: one, whether we have followed the correct legal standards; and, two, whether our decision is supported by substantial evidence of record.

On the first inquiry, whether we have correctly applied the law, the court will consider issues such as whether the ALJ applied the correct legal standard for evaluating the claimant's credibility or a treating physician's opinion on whether our interpretation of the relevant statutory provision is correct. Since these are issues of law, the court will consider them de novo.

The Act also provides that the agency findings of fact are conclusive as long as they are supported by substantial evidence developed during the administrative proceeding. The court does not review our findings of fact de novo but, rather, considers whether these findings are supported by substantial evidence.

The Supreme Court has defined substantial evidence as, "Such relevant evidence as a reasonable mind might accept as adequate to support a conclusion," and characterized it as more than a mere scintilla, but less than preponderance.

The reviewing court should consider evidence that both supports and detracts from the ALJ's decision. However, if the court finds conflicting evidence, that could allow a reasonable mind to differ; and, if the ALJ's findings are one of those possible interpretations, then the court must affirm the ALJ's finding of fact.

If the court concludes there is substantial evidence supporting the ALJ's finding of fact and the ALJ applied the correct legal standard, the court will affirm the agency's decision. Otherwise, the court will remand the case for further administrative proceedings.

In rare instances, the courts will reverse our final decision and find a claimant disabled.

Mr. Chairman, before I close, I would like to note that, despite the surge in disability claims, we are currently on track to elimi-

nate the hearings backlog in 2013 and reduce pending initial disability claims to pre-recession levels by 2014.

We are able to do this and continue our progress thanks to Congress's continuing support, our strategy, and especially the hard work of our employees. Full funding of our appropriation under the President's fiscal year 2011 budget request will allow us to take the next steps to reducing our backlog over the next several years.

Thank you, and I am willing to answer any questions you may have.

[The prepared statement of Mr. Rust appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Rust, very much.

Mr. Graham?

STATEMENT OF PAUL GRAHAM, SENIOR VICE PRESIDENT, INSURANCE REGULATION, AND CHIEF ACTUARY, AMERICAN COUNCIL OF LIFE INSURERS, WASHINGTON, DC

Mr. GRAHAM. Mr. Chairman, Ranking Member Grassley, members of the committee, my name is Paul Graham. I am senior vice president of insurance regulation and chief actuary at the American Council of Life Insurers, or the ACLI.

The ACLI represents more than 300 member companies that account for over 90 percent of assets and premiums in the U.S. life insurance and annuity industry. ACLI members also provide the majority of disability income insurance coverage in the United States.

I appreciate the opportunity to appear before you today to discuss the important role disability income insurance plays in helping families to protect against lost income due to a prolonged illness or injury. Essentially, if an individual becomes disabled and is unable to work, disability income insurance provides money to help a family pay its ongoing bills and avoid dipping into household savings accumulated for college or retirement. Families can protect themselves by purchasing short- or long-term disability coverage or any combination of the two.

More than 40 million Americans are covered by private long-term disability insurance policies, and insurers paid almost $9 billion in long-term disability claims payments in 2009 alone. Individuals covered by this insurance are overwhelmingly satisfied with their policies and the claims process. A 2008 industry survey found that four out of five claimants said that they are very satisfied or somewhat satisfied with their policy.

The vast majority of the time, disability coverage is provided to individuals at the workplace by their employers. Employers work with insurers to design policies that are most appropriate for their workforce. Approximately 39 percent of U.S. workers in private industry are covered by short-term disability insurance, and approximately 30 percent are covered by long-term disability insurance. We would, obviously, like to see that number higher and believe that it is good public policy to encourage employers to provide this coverage to their employees.

Although disability income insurance is a popular benefit in the voluntary workplace benefit system, limiting costs to employers is essential to having them provide such coverage to their workers. As

with any business decision, business owners would be disinclined to provide voluntary benefits if it becomes overly expensive or it exposes the business to the threat of costly litigation.

Workers covered by disability income insurance policies in the workplace are protected under Federal law by ERISA. In the context of disability income insurance plans, ERISA regulations specify that a plan fiduciary, generally the insurance carrier, is required to act in the best interest of the plan participants and beneficiaries.

For the protection of consumers, ERISA, additionally, sets out detailed and specific requirements for the fair, transparent, and timely handling of disability claims. These requirements address time frames for claim decisions, requirements for keeping claimants informed and apprised of claim actions and reasons for them, and the appeal rights afforded claimants whose claims are denied.

Under these various rules, ERISA sets forth an efficient process for review of claims and appeals. In addition to the strong protections afforded in ERISA, States have also established requirements to ensure that claims are handled promptly and fairly.

In 1990, the National Association of Insurance Commissioners adopted their model Unfair Claims Settlement Practices Act, which has since been adopted in various forms by 48 jurisdictions. Among other things, this act sets requirements regarding the appropriate disclosure of material facts about a claim, timing for a claims investigation and settlement, notice regarding why a claim may have been denied, as well as notice that an individual may have their claim reviewed by the State insurance department.

Further, this act sets out enforcement procedures that commissioners can use to sanction companies failing to follow the law. I would point out that, contrary to what some might believe, the U.S. Supreme Court has ruled that State laws that regulate the substance of insurance coverage or are aimed at the insurance claims administration process are not preempted by ERISA. This provides a dual level of regulation of the disability claims process for those policies issued under ERISA.

It is unfortunate that in some limited cases, there have been abuses in the marketplace. However, the current system of Federal and State regulations has worked well to identify problems, address insurer misconduct, and provide claimants with avenues to redress grievances.

Disability income insurance provides financial protection for millions of American families that complements the safety net provided by the Social Security Disability Income program. Employers appreciate that, by offering this voluntary benefit, they can attract the best talent and provide protection for their employees at an acceptable cost.

This system has worked very well for American families, and they are overwhelmingly pleased with their policies and satisfied with the claim process. This is, in large part, because ERISA and State insurance laws provide consumer protections and regulations that ensure that the claim process is fair and timely.

Furthermore, the current framework of Federal and State consumer protections ensures the all-important balance in providing a reasonable cost of coverage and the appropriate adjudication of claims.

Thank you.

[The prepared statement of Mr. Graham appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Graham.

First, am I correct in assuming—and anybody can answer this question—there are really three different standards, or procedures and rights, where a claimant can bring a disability case? One is under ERISA, another is Social Security disability, and the third is uniform State insurer administrative practices.

Are those all three different standards that might apply to a claimant? What am I missing, or am I right in my assumption?

Mr. DEBOFSKY. Can I answer the question?

The CHAIRMAN. Yes, certainly. You might turn your microphone on.

Mr. DEBOFSKY. The Social Security system is a stand-alone system that is applicable only to claims arising under the Social Security Act.

The CHAIRMAN. Right.

Mr. DEBOFSKY. And there are very specific procedures, such as the judicial review procedure under section 405 of title 42.

With respect to private disability insurance, individual disability insurance is a contract that an individual purchases directly. Those claims are adjudicated under normal State court proceedings.

The ERISA claims are the claims that are arising under employer-provided benefits. Those claims are generally governed by the ERISA law. If the discretionary language is written into the contract and has not been overruled by State laws, such as the law in Montana, Michigan, Illinois, I believe Maine, as well, the de novo standard applies.

The CHAIRMAN. To an otherwise ERISA claim.

Mr. DEBOFSKY. Correct. If the language is in the contract and there is no State law overriding it, it will be subject to the arbitrary and capricious standard. But with respect to the de novo standard, depending on the circuit that you are in, there are very different interpretations as to how that standard is applied.

In the majority of the 11 or 12 Federal circuits, the standard that is applied is still that a review proceeding is conducted by a court; that a judge will be reviewing the claim record and not permitting any testimony, no cross-examination, no trial procedures.

In the circuit that I am from, the seventh circuit, the seventh circuit has ruled explicitly that claimants are entitled to trials, but that is a minority viewpoint.

The CHAIRMAN. All right. What went wrong since 1974? When ERISA was written, as I hear the first three witnesses, including you, Judge, it sounds like ERISA was written to provide certain protection to consumers, and even, Judge, you quoted the phrase "civil action" in the ERISA law.

But as I hear you, it sounds like the courts—the judicial system has weakened those standards to the point where, basically, the plan administrator under ERISA is a judge and the jury and makes a lot of decisions, often to the detriment of the claimant.

Judge ACKER. I think that if you allow me to maybe get my two cents' worth in on that, which is maybe repetitive, I think that the courts and the judges, who came to grips with ERISA initially,

thought that they were going to save themselves some time and trouble by inventing judicial review and morphing what the Congress did into that system.

Then along came the discretion, which took it a step further, so that judicial review was a new thing entirely and nobody today tries a de novo review unless there is no discretionary clause.

Now, Mr. DeBofsky here has had experience, and I have had it as a judge, with using the *MetLife v. Glenn* case, where the Supreme Court has said you have to take the inherent or structural conflict of interest into account.

I have allowed discovery in cases, even discretionary cases, so that I can know, from evidence developed, it is not in the administrative record anywhere. What, if any, influence did the conflict of interest that is there—it is always there, maybe in varying degrees.

In my more lengthy remarks, I pointed out that, after *MetLife v. Glenn*, the plan administrators and the insurance companies have put in place procedures to blunt or disguise the depth of that conflict.

Now, I cannot help being influenced by something that is in my self-interest. That is what self-interest means. They are self-interested. Now, what do you do about that? You do about it—you give it to a court de novo, and that is the only way to do it.

The CHAIRMAN. Now, let me ask, Mr. Graham, what is wrong with that? I can anticipate your response. It is going to be, "Well, it is just too costly. The employers will not provide disability insurance if there is always a de novo trial."

Mr. GRAHAM. Well, actually——

The CHAIRMAN. Judge Acker said "no;" that paradoxically, costs would actually be lower. They would not increase.

Mr. GRAHAM. Well, certainly, that is his opinion, and there has been only one actuarial study of it, and it has shown that the costs are likely to go up.

But I think, before addressing your second question, I would like to go back to the first question, and that is that there is an assumption here that there is something broken right now. And, if you look at anecdotal evidence, you will be able to find individual cases where you might have had some egregious behavior, and that is, obviously, quite unfortunate.

But, if you take a step back and you look at sort of the raw statistics of what is happening at the insurance companies, you will find that, in a study that we did a couple years ago to look at—follow cohorts of lives through the claims adjudication process, that only 7 to 11 percent of claims ever are even appealed and, of those, less than 1 percent—I should not say of those, but by the end of the day, less than 1 percent ever go to court. In one of the cohorts, it was less than one-half of 1 percent.

So the idea that something is structurally wrong, I think, is not correct.

The CHAIRMAN. My time is expiring here. We can get back to this later, although I do note that, on April 15th of 2008—you are probably aware of this—the Massachusetts Division of Insurance announced that Unum, the country's leading provider of disability insurance, has completed a mandated claims reassessment process, which was mandated by a settlement of a lawsuit, and the result

of that is more than 40 percent of reviewed claims reversed, in whole or in part, resulting in a total of $676 million in additional benefits for consumers in every State and the District of Columbia.

That is 40 percent of the claims were reversed, in whole or in part. Now, that sounds like a pretty significant number. That sounds like something is not working very well.

Mr. GRAHAM. Certainly—and there is another example of another carrier that had a settlement similar to that. But those two cases, in and of themselves, were due to what I will call bad acting at two companies. They were breaking the law. The laws existed already that took care of them.

The CHAIRMAN. I understand. But this is the country's leading provider of disability insurance at the time. That is pretty significant.

Mr. GRAHAM. It certainly is significant and unfortunate. And we did reach out to the Maine Insurance Department prior to this hearing——

The CHAIRMAN. My time really has way expired. I am infringing upon the Senator from Maine, whom I would now like to recognize.

Senator SNOWE. Thank you, Mr. Chairman. And to follow up on that line of questioning, I think it is important, because the Regulatory Settlement Agreement was not raised with respect to Unum and 48 other State insurance commissions regarding that settlement in 2005.

I think it would be helpful to hear the views of those who testified, because it sounds like they are of the opinion that anything short of litigation will not work. Yet, we have not looked at the current system of remedies as to whether or not a number of these issues have been brought to the superintendents of insurance.

For example, in Maine, they have indicated that Unum has not only met, but in fact exceeded, the standards of the Regulatory Settlement Agreement.

So I think that we need to address the question of, where do the problems lie, and whether or not the States can address it. Our State, for example, in Maine, the superintendent has pulled discretionary clauses. So obviously, States have that ability to do it.

I would like to ask you, Mr. DeBofsky, the Regulatory Settlement Agreement, for beginners, had a series of best practices. Was there anything more that should have been included in this regulatory settlement that was not back in 2005?

Mr. DEBOFSKY. Senator, that is a hard question to answer, because my experience is anecdotal. I do see a lot of cases in my practice, and my experience has been that the number of cases that I have had against Unum has declined. But that does not mean that the situation has been completely cured.

So long as we still have the discretionary clause, Unum is still fighting, in policies that were issued before the regulatory settlement agreement, to maintain the discretionary clause, even though it has been banned in my State, Illinois, as well as in your State.

I think that there are still abuses with respect to doctors who review files for a living and are not actually examining the patient. I do not think it is my role or my desire to single out any particular company, but the system, as it exists, without a trial, is really the fly in the ointment.

The issue does go back to Senator Baucus's question. Where did we go wrong? It is that the judges jumped from the *Firestone* case saying, we can apply this arbitrary and capricious standard to analogizing what they are used to with respect to how they adjudicate Social Security claims.

Social Security claims are adjudicated in Federal court based on a file review, because there has been a hearing before an administrative law judge, where testimony has been taken under oath and cross-examination of witnesses has occurred.

There is nothing comparable in ERISA. So the claimants not only are not getting that hearing before they come to court, they are not even given the opportunity to cross-examine the opinions that are being used against them, which the courts are willing to give great deference to.

Senator SNOWE. Well, a couple of things come to mind, speaking of anecdotal. I do think, Mr. Chairman, it is important to have a GAO study to examine the practices in all 50 States, frankly, to see exactly what is the basis of the complaints in terms of those instances, how widespread, how pervasive. Secondly, how can it be addressed short of litigation, because it is a voluntary benefit on the part of the employers. I do think we should have employers as part of this review and understand that point, as well, in terms of raising the cost of the premiums and the cost of this benefit, and we need to address that. Third, about the superintendents of insurance, and, obviously, this is within the State purview—but what can they do differently?

I was looking at this multistate examination concluded back in 2007; it was done for Maine Bureau of Insurance, Massachusetts, New York State, Tennessee, and all other participating jurisdictions, most of the States, in fact, and it does not indicate that there is a problem in terms of claims processing.

So I think there is an avenue in which to address those particular instances so there is redress. The question is whether or not we should go as far as providing private rights as an action in litigation that could add to the cost. Is there another way of addressing that problem?

I know you cited the Milliman study, and that it found only a modest 4-percent rise in premiums if lawsuits were permitted for ERISA claims, but yet that study was of benefit changes in the State of California, not a sampling pervasive nationwide. So the proposed changes could add to the cost. So we would have to know a whole lot more.

Mr. Chairman, I would like to include the Milliman study in the record, because it does show that there would be a significant increase in cost in disability insurance and products.

The CHAIRMAN. Without objection.

Senator SNOWE. Thank you.

[The study appears in the appendix on p. 149.]

Senator SNOWE. But with this regulatory settlement agreement, talking to the superintendents of insurance, they are saying that, in this instance, this company is meeting or exceeding the standard.

So what is it that has to change? If the error threshold is up to 7 percent, which is under the National Association of Insurance

Commissioners' standard, and it is only ranging there—it ranged from 1 to 4 percent, well below the 7 percent. What is it that we can do to further address that error rate within the current system?

Mr. DEBOFSKY. Well, the error standard, 7 percent, that is over 100,000 claims a year, over 100,000 people who are denied the economic protection that they thought that they purchased.

Senator SNOWE. But that is the State that could change that standard. Is that a better way? I am just asking, because I think we need to know all of that.

Mr. DEBOFSKY. Well, while the States can be on discretionary clauses, given the Federal procedure that has taken its grip over ERISA litigation, only legislation or the courts can fix that, and the only court that can fix that at this point is the Supreme Court, and they seem uninterested in addressing this particular issue.

Senator SNOWE. Why is it, do you think, that States, for example, are not banning the discretionary clause? They must recognize these examples. Yes?

Judge ACKER. Speaking from my perspective as an Alabama citizen, I know that there has been an effort in Alabama to try to get the discretionary clause banned, as it apparently has been in Maine, which I was not familiar with, and the insurance industry has opposed it.

If the insurance industry does not like the idea of banning the discretionary clause, there must be a reason, and it has fought it everywhere; fought it in Montana all the way to the Supreme Court.

There must be a reason for the insurance industry to want to keep the discretionary clause, which was invented by the Supreme Court, not by you. And, if we could get all 50 States to adopt a nondiscretionary clause, a prohibition, that would come closer to a solution.

But, if you have a trial de novo, and both sides, the claimant (the beneficiary) and the plan administrator, know it, they know it from the start, if you are talking about the volume of settlements, the percentage of settlements, the percentage of settlements would go down. Both sides would know they were getting ready to face the judge, and it would not be that long, and there would be settlements, and the costs would be less.

Now, as I said in my remarks, I could be wrong. We will never know unless we try. And I thought in 1974 you did try, that is what I was reading, and then I was told I was wrong, and I have been fighting it ever since. I guess you could sense it in the tone of my voice, and probably in the tone of my sometimes provocative opinions, which the appellate courts do not always agree with.

The CHAIRMAN. I am a little unclear. Maybe, Judge, you can help me out here. To what degree does ERISA preempt State courts?

Judge ACKER. Well, in Alabama, the Supreme Court of my State has held that the State courts have concurrent jurisdiction over ERISA cases. I have forgotten the date of that case. It has been there for a while, and they never retreated from it. And the reason they have not, I think, is that all the cases filed, and the few filed in the State courts, are removed promptly so they never get to the

Supreme Court of Alabama, and it has not had occasion to revisit that question.

Personally, I think the State court justices are just as qualified, if they are given some ERISA cases, and I would be glad to share them with them, I mean, sure. I hold myself out as knowing more about ERISA than a few others, but the States are entirely capable of doing that.

So I do not call it anymore a preemption. I call it super-duper preemption. That is my descriptive term for it, because the Federal courts have reached out and told the State courts, "You cannot touch this in any shape, form, or fashion. It is ours."

Well, it just should not be ours. There is nothing in the statute, as it is now, that says the State courts do not have concurrent jurisdiction. They have concurrent jurisdiction over title 7. They have concurrent jurisdiction over the Fair Labor Standards Act. Why not ERISA? Because the courts have not rescued ERISA. They have made it worse.

The CHAIRMAN. Why are cases in Alabama in State court removed to Federal court? What is the basis?

Judge ACKER. Well, they are afraid. In the first place, ERISA is a Federal statute, and they can remove. So they knee-jerk remove. They are not going to stay there because, under the present regime, it is like super-duper preemption. The State court may act on it, and what the Alabama trial courts are doing now, in light of what the Federal courts—they read the Federal courts' reports just like they read the Alabama Supreme Court, but they believe the Federal courts in this area.

So, if the defendant does not remove it to the Federal court, the State judge dismisses it sua sponte, without prejudice. They have told me I do not have jurisdiction, and I am going to believe them, even though the Supreme Court of Alabama said the contrary. I am going to send it to the Federal court or send you there, and, of course, they know that, so they remove it.

The CHAIRMAN. But going back to my question. Apart from Alabama, generally, to what degree does ERISA preempt State courts?

Judge ACKER. It preempts all State law claims in State court, where there is a complaint filed. It may have some language in there which can be interpreted to invoke, maybe collaterally, maybe slightly, maybe arguably, something having to do with a plan, a disability plan.

Of course, there are exceptions, but not many. And so, when somebody looks at that, they say, "Well, that has some ERISA in it." If it has ERISA in it, it is removable.

So there is no way today, I do not think in any State, to draft a disability claim that would include the possibility of a jury trial and the possibility of mental anguish recovery without it being promptly removed and converted automatically into an ERISA claim, which would eliminate those remedies.

The CHAIRMAN. Let me ask a different question. Do you think that the procedures under the Social Security Disability Act are fair?

Judge ACKER. I think they are, but I think you designed them that way. They are just entirely different.

The CHAIRMAN. We designed ERISA, too.

Judge ACKER. They are different animals. Like Mr. DeBofsky said, they have no similarity. That was addressed and thought through, and I think you addressed and thought through this, but we did not believe you. We ignored you.

As Mr. DeBofsky said, an administrative—there has been a judge sitting on it. There has been evidence sworn. Now, in our instance, where I get these ERISA benefits claims on a cold record, I have never seen a witness. Nobody has seen a witness. Nobody has cross-examined a witness.

There is a vocational expert who says one thing and a vocational expert who says something else. There is a doctor who says one thing, there is a doctor who says something else. It is all written down. Some of them are treating physicians, some of them are paid by the insurance company. I cannot tell who is lying, but somebody is.

But under the present regime, it is on my desk to decide if there has been an abuse of discretion—or, if there is no discretionary clause as there would not be in Michigan, they are on a de novo review—if the decision was correct in denial. Of course, if there was no denial, it would not be with me. I would never have to see it.

The CHAIRMAN. Mr. Graham, what about the judge's observation or belief that, if there was de novo review or if there was no discretionary clause, that there would be a lot of settlements and that would reduce a lot of costs?

Mr. GRAHAM. Well, all I can say is, as far as I know, there has only really been one study into it. It is the Milliman study that you have put into the record here.

I think that if you think about it just from a common-sense standpoint, the—take a step back. Insurers do not want to go to court. There is no doubt, they do not want to go to court. They would like to settle all the claims in a legal manner, provide people with the benefits that they are due.

If there were de novo review, there is no doubt that the cost of discovery and any lengthy trial that may come out of it is going to take more time and effort than the singular review by a judge to go through the claims documents that already exist.

It is sort of hard to come to any other conclusion, and I think that is why Milliman came to the conclusion that they did.

So I guess that is—I do not believe that the costs would actually go down. And, in addressing something that the honorable Judge said earlier, the reason that the insurance companies have, in fact, fought the removal of discretionary clauses from the policies is because we believe that very thing. We believe the costs will go up and that we have only 30-percent penetration into the private employer marketplace at this point, and we think it is good to get that insurance to as many people as possible.

We think it is good public policy, and we believe that, when Congress put the law together originally, that balance was taken into account in determining how the review should be established by the courts.

The CHAIRMAN. Does ERISA prevent States from prohibiting discretionary clauses?

Mr. GRAHAM. Well, I guess there are court cases recently that would indicate that ERISA would not. The Montana case, where they have banned discretionary clauses, went all the way to the Supreme Court, and the Supreme Court agreed that the State had the right to do that.

The CHAIRMAN. And is that partly because discretionary clauses are not in ERISA, but as judicial-made doctrines, so that is why? I am just wondering why the Supreme Court reached that conclusion.

Mr. DEBOFSKY. Can I answer that, Senator?

The CHAIRMAN. Yes, Mr. DeBofsky.

Mr. DEBOFSKY. You asked earlier about what ERISA preempts and what ERISA does not preempt.

The CHAIRMAN. Yes, right.

Mr. DEBOFSKY. As Mr. Graham indicated during his testimony, State laws that regulate insurance are not preempted. So a discretionary clause ban has been held not to be preempted.

If States pass laws that say policies must include specific provisions, as most States do with respect to health insurance, that is not preempted. But the claims that you can bring are preempted. The remedies that you can obtain are preempted.

If an individual seeking disability benefits, who has been denied, loses their home on account of that denial, there is no claim that they can bring that is not preempted by ERISA.

If an insurance company or an employer has made a misrepresentation about the nature of coverage and an individual is denied benefits on account of that—and I give the example of the *Amschwand* case in my written testimony—there is no claim that can be brought that is not preempted by ERISA.

ERISA has huge preemptive force in this area and prevents the same kinds of rights, remedies, and court access that claimants who have private insurance would be able to access if they had a claim under their policy.

The CHAIRMAN. Changing subjects here a little bit. When we wrote health care law, there was sort of a loose assumption that ERISA works okay with large group plans, that the health insurance reform was more important in the individual market and in the small group market.

So I am asking you. These problems you think are very serious with respect to disability claims, to what degree do some of these problems also exist in health insurance that is also covered by ERISA?

Mr. DEBOFSKY. They are even far more serious, Senator, because people die on account of erroneous decision-making. If a treatment is withheld, if somebody is told that they can only have one treatment instead of another one that might prove life-saving, if the wrong medication is prescribed because that is the one that is on the formulary, there is no remedy that those individuals have, and the consequence can often be death.

Judge ACKER. I said in my written remarks, but I did not get to say to you, the beneficiary either exhausts himself administratively or exhausts himself to the point of view that he dies before he sees anything, and that happens all too often.

Now, Mr. Graham and the insurance industry support the discretionary clause and say that it will increase the costs to take it away. Now, it has not been gone very long in Michigan or Maine or Illinois, so we do not know what the cost effect will be.

We can know, we could know, maybe, if all 50 States enacted it, but I do not think all 50 States are going to, and I think there needs to be some uniformity, and the only way to get it is not to seek it one at a time, 50 States, because, if you try it in Alabama, you are not going to get it. I can tell you that right now. We are not going to get it. But you can give it to us.

The CHAIRMAN. I am just reminded that, in the health care legislation, the Congress did provide for external third-party review of health claims, and there may have been some other changes, too, under ERISA.

I do not know—maybe, Mr. DeBofsky, you have some opinion with respect to that change.

Mr. DEBOFSKY. I think that there is some good and there is some bad to that. I think that the notion of independent external review is always a good idea. The problem that I have seen with the ERISA cases that you alluded to in your opening remarks is that this so-called independent review is often not independent; that there are now organizations that have sprung up that do nothing but review claims for insurance companies by doctors who do not practice, they just make their living reviewing claims.

The CHAIRMAN. Even under health insurance claims, in addition to disability claims.

Mr. DEBOFSKY. Absolutely. There are companies that are set up that seem to have no purpose other than to deny a life-saving cancer treatment, and it is very unfortunate that those companies seem to be biased.

If there is a means of guaranteeing true independence—as there is in some States that already have independent external review, where a State agency is the one that assigns the case for the review rather than the insurance company picking the external reviewer—it is more likely to be successful.

Mr. GRAHAM. Mr. Chairman, could I address that for a second, too?

The CHAIRMAN. Sure.

Mr. GRAHAM. Because there is a very important difference between independent medical review and what would need to occur in the disability market, and that is, the medical review is really a medical necessity determination. It can be made by probably a single doctor or possibly even a nurse, depending on the particular claim.

However, for the determination of disability, there are a lot of things that have to be involved. First, somebody has to understand what the vocation is, what the person's job has been, what the physical demands of that job are. You need, obviously, medical evidence so you could determine medically that somebody is disabled, but that does not mean that they cannot do their job.

Insurance companies have large teams of people who are looking at all the different aspects to determine disability, and it would be very difficult to put together an independent reviewer that had all

of those expertises, especially if they were not a specialty organization that only did that.

So it would be very difficult to have that kind of reviewing requirement in disability as compared to medical insurance.

The CHAIRMAN. I understand. But do you not think that Judge Acker, for example, could, by asking certain questions, by cross-examining both sides or letting attorneys cross-examine each side, have a pretty good sense of kind of where the truth is?

Sure, there are a lot of decisions that are pretty complex, but district court judges have often very complex trials. Members of Congress have complex issues before them, I understand. But sometimes it is important to get an independent person who is not biased, is not influenced by one side or the other.

Mr. GRAHAM. Well, unfortunately, it is really quite difficult to remove all bias from this entire process. A person's own personal physician has some bias towards the relationship with that person.

As has been pointed out, there is some level of conflict of interest of the insurer, that is, reviewing the claims. Anybody that it hires, obviously, there is money coming from the insurer to that person. We can call it independent, but there may be some level of bias.

No matter how it is structured, it is impossible to remove all of the bias from the system. A claimant can, at any time, choose to pay a second doctor or a third doctor or a fourth doctor and bring more evidence to the insurance company that would be considered in the process of a claim review.

There is still some bias there, but it is more information that an insurance company would take into account.

So, while most of these independent reviewers are, in fact, hired by insurance companies and could be seen as being biased, we do not think it is right to have the claimant pay for that; but, if they choose to pay for another independent examination, they certainly can, and that would be taken into account in the claims adjudication.

The CHAIRMAN. Well, I appreciate this. Mr. Rust, I wanted to compliment you on your efforts to reduce the backlog of Social Security disability cases. I stumbled across this study a couple, 3 years ago when it was done, on the length of the backlog, and we had talked about denying justice—the whole thing about justice delayed is justice denied.

It was just unconscionable the backlog that existed. You say now that you will not be able to get it down to acceptable levels until 2013 or maybe 2014.

I know part of this is resources that you need, but I just urge you to burn the midnight oil. So many people need to know what the decision is, and I just encourage you to work even harder at reducing that backlog.

Mr. RUST. Well, I think during his confirmation hearing before you, Mr. Chairman, you impressed that point upon our commissioner, Mike Astrue, and he has certainly focused our attention on bringing those backlogs down. And we have been very successful, too, and we very much appreciate the support we have gotten from Congress in terms of the last three appropriations bills. You have given us the resources to do it.

The CHAIRMAN. Well, this has been kind of a disturbing hearing, frankly. There is clearly a huge problem here.

I am somewhat saddened saying I tend to, on the surface, anyway, agree with your observation, Judge, that courts are going to move in this direction probably to lighten their load a little bit. Whether that is true or not, I do not know, but it could be part of the reason why the 1974 law has not lived up, as it sounds, to its intent.

We have a lot of work ahead of us. We also have to work with another committee, the HELP Committee, and I very much hope that I will be talking to Chairman Harkin to see if there is some way that we can move ahead on this area.

But this is not good, and I just very much hope that we could find a better solution than we now have.

I have also received a series of materials relating to long-term insurance policies under ERISA that I would like to include in the printed record of this hearing.

Without objection, they will be included.

[The information appears in the appendix on p. 76.]

The CHAIRMAN. I am a bit disappointed at the attendance here on such a big issue, but I am sure most Senators are wrapping up this week, because we are going to be adjourning near the end of this week.

But I just thank all of you very much for taking the time to come here. You have worked hard to prepare your testimony. It is very thoughtful testimony. The answers, your comments were all very thoughtful, and I just deeply appreciate the time that you have taken to help us move maybe a step toward a solution here.

Thank you. The hearing is adjourned.

[Whereupon, at 11:29 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

TESTIMONY OF WILLIAM M. ACKER, JR.
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF ALABAMA
BEFORE THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
SEPTEMBER 28, 2010

It is a privilege to be able to share with you this morning some of the thoughts of a trial judge who has been grappling with ERISA for twenty-eight years. Appointed in 1982, I sweated over ERISA, and watched other courts sweat over it, until in 1998 I wrote the law review article that probably prompted this Committee to invite me. The article was entitled "Can the Courts Rescue ERISA?" A copy of that article is attached to my testimony as Exhibit "A". Although my old arguments are now somewhat dated, my answer to the question then was "NO", and since that time I have not changed my mind. The courts have not rescued ERISA. **If anything, they have dug the ERISA hole deeper.** I am not saying that the courts, including the Supreme Court, have not **tried** to make sense of ERISA, and to make it workable, but in truth, the situation is worse in 2010 than it was in 1998, and getting worse every day.

I hope that the Committee is not as interested in citations of authority to support my views as it is in the views themselves, acquired from experience as a trial judge confronted for twenty-eight years with a constantly changing ERISA.

I am assuming that except for Chairman Baucus, whose State has done away with the so-called "discretionary clause", for Senator Stabenow, whose State has done the same thing, and for Senator

Cornyn, whose State is in the process of doing it, if it has not already done so, and, who, as Texas Attorney General, was sued by Corporate Health Insurance in the case that became central to the "five-to-four" decision by the Supreme Court in *Rush Prudential v. Moran*, the other members of this Committee have no specialized knowledge about ERISA, or of the effect that the so-called "discretionary clause" (first given prominence by the Supreme Court in *Firestone v. Bruch*) has had on the ERISA courts and litigants as they plod along.

The Committee has already heard or will hear testimony from others who are my intellectual equals or my superiors, who support the continuation of the "discretionary clause", as central to ERISA benefits decision-making. I will try to explain why the "discretionary clause" is a disaster, both as a matter of economics and as a denial of "due process".

The Economic Effect of *Bruch*
"The Law of Unintended Consequences"

Bruch put the fox in the henhouse when it authorized ERISA plan administrators to operate under the now universally used provision (except for Michigan and Montana) that allows the plan administrator both to interpret the plan and to decide how to apply it to a particular disability claim. This concept not only is foreign to logic and common sense, but is unworkable and expensive. I am attaching as Exhibit "B" a copy of the initial order I routinely use in ERISA disability benefits cases. A look at it

from top to bottom will illustrate the complexity of court decision-making, something that only takes place after the already lengthy processing of the administrative claim, and after the claim has been denied upon final review by the plan administrator.

A driving force behind the idea of granting the insurer/plan administrator/plan sponsor almost unbridled discretion is the belief that the procedure will lessen costs and lessen the time spent on ERISA cases. This contention is the main argument in the *amici curiae* briefs filed in support of Standard Insurance Company's unsuccessful *certiorari* petition that sought to overturn the decision that confirmed Montana's right to eliminate the "discretionary clause".

It is, of course, true that in drafting legislation, Congress has an obligation to consider the economic impact, as well as the needs of society. This judge is willing to assume that Congress engaged in that debate before it enacted ERISA. The language it chose in 1974, if it had not, over time, been altered or obliterated by the courts, would provide for *de novo* consideration by a court of all denials of ERISA benefits. ERISA's Section 502(a)(1)(B) straightforwardly provides that any beneficiary of a plan governed by ERISA can bring a "**civil action...to recover benefits due him under the terms of his plan**". Rule 2 of the Federal Rules of Procedure provides: "There is one form of action—the **civil action**". This language recognizes nothing less

than an independent consideration by a court, a "trial on the merits". The procedure concocted by the courts in the years since 1974, now called "judicial review", based on an examination of the administrative record, while giving deference to the conflicted decision-maker who has already denied the claim, simply does not fit the scheme that Congress contemplated. Under *Bruch*, "judicial review", a phrase never used in ERISA, the burden of proof is on the plan beneficiary to prove to the court on a cold record that the denial decision was "arbitrary and capricious" or was "an abuse of discretion" (interchangeable terms used by federal courts). This burden is too great, and too time consuming.

I have found no empirical evidence to justify the argument that the costs of a trial *de novo* would be greater than the costs of so-called "judicial review". If the courts thought that they were reducing their load, they were dead wrong. I only wish that I could have brought enough steamer trunks to hold all of the trial and appellate court opinions written under the *Bruch* rule. It makes one's head swim to read the long, convoluted opinions rendered by trial and appellate courts, during the preparation of which the judges and their law clerks have labored and sometimes tossed a coin.

Before a plan beneficiary can even bring his claim to court, he will spend much energy, and probably attorneys' fees. Lawyers do not like to undertake these cases on a contingent fee basis,

because even if they win, the award of a fee is within the court's discretion. A claimant faces a structurally-conflicted decision-maker, whose self-interest not only bears on the way it looks at the claim, but provides every reason to prolong the review process. Once the case gets to court, using the *Bruch* "abuse of discretion" standard, a voluminous court opinion will eventually emerge. It will necessarily compare in detail the hearsay of opposing medical experts and vocational experts who opine on the income that can be realized from an alternative job that the plaintiff can perform, and then try to justify either an "abuse of discretion", or no "abuse of discretion". The trial judge, if he or she takes *Bruch* seriously, starts by being intimidated.

This problem was exacerbated by the Supreme Court in *Metropolitan Life v. Glenn*. In that case, the high court, which quickly acknowledged the existence of a structural conflict-of-interest, held that judges must consider the conflict-of-interest as a "**factor**" in determining whether or not there has been an "abuse of discretion". This new rule encourages plan administrators to create procedures that look like a blunting of their conflict-of-interest. It also increases the work of the trial court.

After the complaint has been filed, the court must first decide whether to limit its consideration to a review of the so-called administrative record, which may be a thousand pages, or to

allow limited discovery during which the plaintiff can seek evidence that may place more weight on the inherent conflict-of-interest. This judge does not criticize his fellow jurists, but sympathizes with them, for the head scratching they do as they decide a controversy under the instructions given in *Bruch* and *Glenn*.

Not only does *Bruch* tilt the scales against the beneficiary on questions of fact, but on the interpretation of the plan. Ordinarily, the interpretation of a contract is for a court or a jury. In one of my cases, *Oliver v. Coca Cola*, the Eleventh Circuit held that my opinion interpreting the plan to resolve an obvious ambiguity against the draftsman, was correct, but another panel of the Eleventh Circuit, in a separate case, held that the same plan was reasonably construed the other way by the Coco-Cola claims committee, meaning that Coca-Cola's claims committee did not abuse its discretion when it arrived at its favorable construction of the contract Coca-Cola had drafted. *Oliver* was remanded to me with instructions to remand it, in turn, to the Coca-Cola claims committee for its reconsideration. If the case had not been settled at that point, the courts would still be laboring over it.

What Shell is the Pea Under?

Another chore for the trial courts that needs to be removed arises from the fact that defendants don't often confess their liability, and plaintiffs don't know which entity to sue. The

funding source for the payment of monetary benefits is often obscure. I will give you an example from my personal experience. In *Florence Nightingale Nursing Service v. Blue Cross*, the only defendant named in the complaint was Blue Cross, but the truth was that the plan sponsor, who was the only obligor, was Integraph Corporation, the employer of the beneficiary. Integraph only hired Blue Cross to be its **claims administrator**. Blue Cross did not file a third-party complaint against Integraph. I accidentally flushed out the problem during a pretrial conference, and obtained the agreement of the plan sponsor and the claims administrator, who were represented by the same counsel, that if liability was found, one or the other would pay. If I had not ironed out this problem beforehand, and a judgment had not been entered against Blue Cross which was not a proper party, I do not know what would have happened.

The long and the short of it is that the "independent" consideration of an ERISA claim a contemplated by Congress would save judicial resources and clients' money. When Standard Insurance Company asserted in its petition for *certiorari* in the Montana case, that doing away with "discretionary clauses will lead to far more complex and costly litigation", it was not only wrong as a matter of fact, but was using a scare tactic.

If Congress doubts me, I recommend an experiment in which Congress will now reiterate what it said in 1974 (with no possible

misunderstanding this time) that *de novo* trials are the only appropriate procedure in ERISA cases, and wait to see the cases and judicial opinions that are produced. If I am proven wrong, I will gladly eat my words. At my age that may be a safe bet.

Justice Delayed Is Justice Denied

You have heard the cliche "justice delayed is justice denied". It has real application to ERISA. My friend and fellow district judge, Brock Hornby of the District of Maine, as recently as July 8, 2010, in *Kane v. SI Metro Services*, held that a plan beneficiary had plausibly demonstrated the futility of the final appeal to the plan administrator insisted upon by the administrator, and therefore could go directly to court to contest the lower level claim denial. As a judge, I have never been asked to go as far as Judge Hornby, although in the only case I ever argued before the Supreme Court of the United States, I did convince that Court to excuse my client's failure to exhaust remedies that were futile. If you have time, take a look at *Glover v. St. Louis & San Francisco Railroad* decided in 1969. I have had many ERISA benefits cases that, before they got to me, had bounced around the administrative process for years. By the time the matter gets to me, the beneficiary is not only administratively exhausted, but, unless he has died trying, his health has deteriorated to the point that a remand to the plan administrator for reconsideration is tempting. If the parties, to start with, understood that a denial

would shortly result in a trial on the merits, serious settlement negotiations would take place before access to the court is sought.

Plan administrators have often asked me to remand cases to them, asserting that they have uncovered something that now casts doubt on their administrative decision. Many courts remand under such circumstances. This procedure, of course, prolongs the agony. I do not remand such cases to the plan administrator unless ordered to do so by a higher court.

Until Congress grants relief, I will continue scrupulously to follow the directions given by the Supreme Court in *Bruch* and *Glenn*, that is, if there is a "discretionary clause".

Applicability of Rule 56

Attached as Exhibit "C", is an opinion I wrote on September 16, 2010, attempting to explain the impossibility of using Rule 56 as a vehicle for what Congress in 1974 described as a "civil action", but which has evolved into a "judicial review", sort of like a Social Security administrative review. If there is no real dispute of material fact, Rule 56 disposition is, of course, appropriate, but there is almost always a dispute of material fact. Competing doctors strangely see things differently, even in unsworn hearsay, and are subject to questions of credibility. If the employer/insurer/plan administrator is privileged to decide the truth of the "facts",and where those "facts" lead, as well as what the plan means, the decision is rarely for the beneficiary, that

is, unless it is a slam dunk, and not always then. It is difficult enough to read a thousand page administrative record, extensive briefs, and write an opinion that finds the decision-maker to have abused its discretion, or not to have abused its discretion, but Rule 56 does not fit this scenario. In footnote 4 of the Eighth Circuit's recent opinion in *Khoury v. Group Health Plan*, it worried over this problem, saying:

> Courts have struggled with the use of summary judgment to dispose of ERISA cases...We decline to decide the propriety of the use of summary judgment procedures in this case because the issue was not raised by the parties...If a district court rejects the ruling of the administrator, the district court would then have to independently weigh the evidence in the administrative record and render *de novo* factual determinations, contrary to the summary judgment standard of review.

The Eighth Circuit obviously had reservations about courts resolving factual disputes.

Super-Duper Preemption

In 1995, the Supreme Court of Alabama in *Weems v. Jefferson-Pilot Life*, held that Alabama courts have jurisdiction over ERISA cases, and that extra-contractual and punitive damages are recoverable because the Seventh Amendment gives the right to trial by jury. That decision still stands in Alabama, although the Alabama trial courts, unless a defendant first removes the case to federal court, dismiss an ERISA case without prejudice *sua sponte*. They are influenced by the federal courts that have suggested the complete "exclusivity" of federal courts over ERISA cases. I call

this "super-duper preemption". There is no language in ERISA, any more than in the Fair Labor Standards Act or in Title VII, that denies concurrent jurisdiction to the state courts. I do not blame the Alabama trial courts for doing what they do, although I have no reason to doubt that they can handle ERISA cases as well as I can, if not better. There is ambiguity as to whether ERISA creates this "super-duper preemption". The federal and state courts need to be on the same page on this question, and Congress should write that page in a clear hand.

Conclusion

I have covered some, if not all, of my pet peeves. ERISA jurisprudence will stay as messed up as it is, unless Congress reworks it. **The courts have not rescued ERISA**, and cannot be expected to do so. The most important legislative change that I implore you to make is to make it clear that when Congress says "civil action", as it did in 1974, it means what it said, "civil action" and not "judicial review".

Thank you for the opportunity to share these thoughts with you.

EXHIBIT A

CAN THE COURTS RESCUE ERISA?

HON. WILLIAM M. ACKER, JR.*

> [G]iven the acknowledged, underlying purpose of ERISA to protect employees and beneficiaries in employee benefit plans, this case represents the point at which the preemption tide should be stayed. A finding of preemption in this case not only fails to further any such protective policy, it conceivably offers an unscrupulous employer a method of avoiding employee benefit "burdens." An employer in this circuit can now hoodwink a long time employee and leave him stranded without any recourse whatsoever. This result stands the entire statutory scheme on its proverbial head.
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> . . . .
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> [T]he combination of the majority's holdings—that Sanson's state cause of action is preempted by ERISA even while ERISA denies him any alternative remedy—is disappointingly pernicious to the very goals and desires that motivated Congress to enact pension laws in the first place.[1]

Occasionally, a statute comes along that is so poorly contemplated by the draftspersons that it cannot be saved by judicial interpretation, innovation, or manipulation. It becomes a litigant's plaything and a judge's nightmare. ERISA falls into this category. In *Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield*[2] I started my opinion with these three sentences:

> A hyperbolic wag is reputed to have said that E.R.I.S.A. stands for "Everything Ridiculous Imagined Since Adam." This court does not take so dim a view of the Employee Retirement Income Security Act of 1974. Instead, this court is willing to believe that ERISA has lurking somewhere in it a redeeming feature.[3]

Since writing *Florence Nightingale*, I have changed my mind. ERISA is beyond redemption. No matter how hard the courts have tried, and they have not tried hard enough, they have not been able to elucidate ERISA in ways that will accomplish the

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* Senior United States District Judge for the United States District Court for the Northern District of Alabama. Graduated from Yale Law School in 1952 and from Birmingham-Southern College in 1949. Appointed to the federal bench in 1982 after 30 years as a trial and appellate practitioner and has written several opinions on ERISA.

[1] 966 F.2d 618, 623, 625 (11th Cir. 1992) (dissent of Judge Birch).

[2] 832 F. Supp. 1456 (N.D. Ala. 1993), *aff'd*, 41 F.2d 1476 (11th Cir. 1995).

[3] *Id.* at 1457.

purposes Congress claimed to have in mind. For more than ten years, I have consistently and constantly criticized ERISA, and I feel no compunction in lifting passages from my prior opinions as I write this article. I cannot plagiarize myself.

Although ERISA contains many provisions worthy of critical comment, in my few allotted pages I will concentrate on the jurisprudence that deals with the relief, if any, obtainable by the employee-participant-beneficiary of an alleged ERISA plan when she or he claims to have been mistreated.

Since its passage, the Employee Retirement Income Security Act of 1974[4] has been the subject of multitudes of legal opinions and scholarly comments. The numbers of problems dealt with by courts, both in published and unpublished opinions, are impossible to count, but they run into the multiple thousands. Because ERISA invites dispute and frustration, judges are deluged with ERISA cases. A quick reading of my own many opinions (if a quick reading were possible) reveals why I have now arrived at the conclusion that ERISA cannot be rescued and made workable by the courts.

Congress enacted a badly flawed statute. ERISA's shortcomings are so myriad that the only possible judicial fix would be by the Supreme Court of the United States itself taking a much more active role than it has taken thus far in reconciling conflicts between the circuits and in filling in the congressionally created interstices by some consistent, fair and logical jurisprudence. Because I am not willing to be counted among those who advocate judicial activism as a substitute for legislative action, I would like to see the courts abdicate in favor of Congress. It will take courageous judges or justices to say: "This statute doesn't make sense, so we'll just remand the matter to Congress while the litigants wait until the legislative branch gets its act together."

Congress must take a completely new look at the public policy issues it thought it was solving when it abdicated to the courts a perceived societal problem. Congress claimed to be adopting a scheme designed to protect the interests of participants in and beneficiaries of employee benefit plans. Thousands of opinions have mouthed platitudes about the broad remedial purpose behind ERISA, but the implementation of that purpose, if that purpose was ever really intended by Congress (a matter of legitimate debate), is in shambles.

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[4] 29 U.S.C. §§ 1001-1461 (1985 & Supp. I 1998).

THE DOCTRINE OF PREEMPTION

The subject that has spawned the largest number of judicial opinions is "preemption."[5] Some courts call it "super preemption." I call it "super-duper preemption." The Supreme Court itself has noted the tremendous amount of judicial effort expended as courts attempt to get a handle on this concept. In *De Buono v. NYSA-ILA Medical and Clinical Services Fund*[6] the Supreme Court expressed its chagrin as follows:

> The boundaries of ERISA's pre-emptive reach have been the focus of considerable attention from this Court. ... [I]n the 16 years since we first took up the question, we have decided no fewer than 13 cases. The issue has also generated an avalanche of litigation in the lower courts.... [A] LEXIS search uncovered more than 2,800 opinions on ERISA pre-emption.[7]

Any discussion of the preemption doctrine starts with the fact that ERISA supersedes state laws "insofar as they may . . . *relate to* any [ERISA covered] employee benefit plan."[8] It is difficult to reconcile this broad preemptive language with ERISA's legislative history. This history suggests that the recipients of retirement and medical benefits were the objects of great concern.[9] Yet, as the statute is applied, the real beneficiaries of ERISA, if any, turn out to be the fiduciaries, the administrators, the employers and the insurers. Preemption has come to mean that once state remedies are eliminated, ERISA provides the only remedy, which is either a pallid remedy or no remedy. This is why I call it "super-duper."

Super-duper preemption has fostered several lines of inquiry in most ERISA benefits cases. The defendant-fiduciary-administrator-employer-insurer invariably wants ERISA to govern because of ERISA's severely limited or absent remedies for the plaintiff-employee-participant-beneficiary. The plaintiff, on the other hand, invariably wants to proceed under some state law theory that provides what ERISA was supposed to provide,

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[5] For an overview of ERISA preemption, see generally Jack F. Fuchs, *Federalizing State Law Tort and Contract Claims: The Scope of ERISA Preemption*, 39 FED. B. NEWS & J. 582 (1992); David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427 (1987); Leon E. Irish and Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REFORM 109 (1985); Jolee Ann Hancock, Comment, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 CUMB. L. REV. 385 (1995).

[6] 520 U.S. 806 (1997).

[7] *Id.* at 1749 n.1 (citations omitted).

[8] 29 U.S.C. § 1144(a) (1985 & Supp. I 1998) (emphasis added).

[9] *See* S. REP. NO. 93-127, at 18 (1973) ("It is intended that coverage . . . be construed liberally to provide the maximum of protection to working men and women covered by private retirement programs.").

namely a greater "degree of protection to working men and women covered by private retirement programs."[10] In this context, several questions inevitably arise for a putative plaintiff:

1. How direct must the connection to an ERISA plan be for my particular claim to "relate to" the plan and thus be preempted?

2. Is there really an ERISA-governed plan to which my claim can "relate?" If so, who are the plan's fiduciaries or my other possible targets under ERISA?

3. Does my complaint invoke a state law scheme designed to regulate insurance, thus exempting it from ERISA preemption by ERISA's so-called "savings clause?"[11]

4. If my claim "relates to" an ERISA plan that is not subject to the "savings clause," what remedies, if any, does ERISA itself provide for me? If ERISA's precise language does not expressly provide an adequate remedy, can the "federal common law" of ERISA fill the void? As a plan beneficiary, am I entitled to a jury trial?

DOES THE CLAIM "RELATE TO" A PLAN?

In choosing the phrase "relate to," Congress may have intended to make ERISA preemption as broad as possible. Alternatively, Congress may have intended to give the courts unlimited discretion to decide when ERISA should provide the only remedy for a person aggrieved and when it should not. Legislative history, cited as usual in both directions, provides little help. As for the courts, a majority has found that relates to is as broad as the ocean, preempting everything. A sizeable minority, however, has required an ERISA plan to be *directly* affected in order for an ordinary state law claim to evaporate under super-duper preemption. Of course, some claims are so obviously related to an ERISA plan as to admit of no argument, regardless of how the term is defined. A great number of claims remain for which the ruling court's attitude toward ERISA determines the outcome on the preemption question.

The whimsical nature of this outcome can be illustrated not only by the marked difference in results among federal courts, but also by the varied results between federal and state courts.[12] The clash between state and federal courts should come as no surprise inasmuch as state courts are bound only by the Su-

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[10] *Id.*

[11] *See* 29 U.S.C. § 1144(b)(2)(A) (1985 & Supp. I 1998) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities . . . . ").

[12] States have concurrent jurisdiction over claims for ERISA benefits. *See* 29 U.S.C. § 1132(e)(1) (1985 & Supp. I 1998).

preme Court's interpretation of federal law.[13] The ability to disagree with the ERISA decisions of lower federal courts has allowed state courts (predictably) to be more reluctant than their federal counterparts in eliminating traditional state remedies and jury trial.[14] Unfortunately, the Supreme Court has given neither federal courts nor state courts sufficient guidance to make ERISA law uniform in either forum.[15] State courts have had little opportunity to speak on the subject because cases filed in state courts are promptly removed to a federal forum before the state courts can speak.

A survey of cases indicates that the words "relate to" stretch and contract like a rubber band. Within the expanding phase of the rubber band stand hundreds of cases in which courts (mainly federal courts) have found that a claim relates to an ERISA plan and, therefore, is preempted by ERISA, despite the fact that ERISA either affords no remedy whatsoever or a woefully inadequate one.[16] Within the contracting phase of the

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[13] *See* United States v. Woods, 432 F.2d 1072, 1075 (7th Cir. 1970). As the United States Court of Appeals for the Seventh Circuit explained: "Finality of determination in respect to the laws of the United States rests in the Supreme Court of the United States. Until the Supreme Court of the United States has spoken, state courts are not precluded from exercising their own judgment upon questions of federal law." *Id.*

[14] *See generally* Weems v. Jefferson-Pilot Life Ins. Co., Inc., 663 So. 2d 905, 911-13 (Ala. 1995).

[15] In *The Prudential Insurance Co. of America v. National Park Medical Center*, 154 F.3d 812 (8th Cir. 1998), the Court of Appeals for the Eighth Circuit spoke for all lower courts by saying: "The precise scope of ERISA preemption of state law has left courts, including the Supreme Court, deeply troubled." *Id.* at 815.

[16] *See, e.g.*, Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1010 (9th Cir. 1998) ("ERISA preempts state law claims, even if the result is that a claimant, relegated to asserting a claim only under ERISA, is left without a remedy. The focus is on ERISA. If it does not provide a remedy, none exists."); Franklin v. QHG, Inc., 127 F.3d 1024, 1029 (9th Cir. 1997) (holding ERISA preempts state law tort claims of fraud in the inducement where determination of fraud claim would have required construction of ERISA plan benefits); McCleod v. Oregon Lithoprint, Inc., 102 F.3d 376, 378 (9th Cir. 1996), *cert. denied*, 520 U.S. 1230 (1997) (holding that ERISA's civil enforcement scheme was exclusive, that ERISA preempted the state law claims, and that damages were unavailable despite fact that plaintiff was left with no adequate remedy); Tolton v. American Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) ("That ERISA does not provide the full range of remedies available under state law in no way undermines ERISA preemption."); Custer v. Pan Am Life Ins. Co., 12 F.3d 410, 418-19 (4th Cir. 1993) ("Custer's contention that the defendants may be nonfiduciaries or that ERISA provides no remedy against nonfiduciaries, leaving a gap, is, in our view, immaterial to the resolution of this issue. The Act's preemption clause does not place the analysis on whether remedies are provided by the Act, but rather on whether the action *relates* to any employee benefit plan."); Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992) ("While we are not unmindful of the fact that our interpretation of the pre-emption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, the lack of an ERISA remedy does not affect a pre-emption analysis."); Cromwell v. Equicor-Equitable HCA Corp.,

rubber band stands a growing minority of courts that has been unable to stomach the absence of any real remedy for a defrauded or otherwise abused beneficiary under ERISA.[17] Faced with this situation, these courts have found an insufficient relationship between the claim and an ERISA plan to trigger preemption, thus leaving state law remedies in place.[18] Alternatively, such courts have manufactured an ERISA common law remedy that virtually duplicates the preempted state law remedy.[19] I call

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944 F.2d 1272, 1276 (6th Cir. 1991) ("Nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without remedy.").

[17] *See, e.g.*, Michigan Affiliated Healthcare Sys., Inc. v. CC Sys. Corp., 139 F.3d 546, 550 (6th Cir. 1998); Whitt v. Sherman Int'l Corp., 147 F.3d 1325, 1331-32 (11th Cir. 1998); O'Connor v. Unum Life Ins. Co. of Am., 146 F.3d 959, 962-64 (D.C. Cir. 1998); Wolf v. Reliance Standard Life Ins. Co., 71 F.3d 444 (1st Cir. 1995) (holding ERISA preemption waived as a defense); Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53 (4th Cir. 1995); Warner v. Ford Motor Co., 46 F.3d 531, 534 (6th Cir. 1995).

[18] *See, e.g.*, Toumajian v. Frailey, 135 F.3d 648, 654 (9th Cir. 1998); Washington Physicians Serv. Ass'n v. Gregoire, 147 F.3d 1039, 1043 (9th Cir. 1998) ("A law does not 'relate to' an ERISA plan merely because it produces indirect economic effects that happen to influence the shopping choices that the benefit plan must make."); Morstein v. National Ins. Serv., Inc., 93 F.3d 715, 724 (11th Cir. 1996) (en banc) (holding that state law claims against an independent insurance agent and his agency for fraudulent inducement to purchase and negligence in processing an application for an ERISA-governed insurance plan are not preempted by ERISA because these claims "do not have a sufficient connection with the plan to 'relate to' the plan"); Forbus v. Sears Roebuck & Co., 30 F.3d 1402, 1407 (11th Cir. 1994) (holding that an Alabama fraud statute was not preempted by ERISA, when the statute at issue "does not require the establishment or maintenance of an ongoing plan, makes no reference to an ERISA plan, and functions irrespective of any such plan"); National Rehabilitation Hosp. v. Manpower Int'l, Inc., 3 F. Supp. 2d 1457, 1460 (D.D.C. 1998); McNatt v. Franklin Life Ins. Co., 998 F. Supp. 1253, 1254 (N.D. Ala. 1997); Levett v. American Heritage Life Ins. Co., 971 F. Supp. 1399, 1402 (M.D. Ala. 1997); Alacare Home Health Serv., Inc. v. Prudential Ins. Co., 957 F. Supp. 208, 209 (M.D. Ala. 1997); Gray v. New York Life Ins. Co., 879 F. Supp. 99 (N.D. Ala. 1995); Hensley v. Philadelphia Life Ins. Co., 878 F. Supp. 1465, 1466 (N.D. Ala. 1995) ("ERISA's super-preemption as a basis for federal question jurisdiction pursuant to 28 U.S.C. §§ 1441(b) and 1331 cannot be triggered simply by calling a particular insurance policy an ERISA plan and alleging that the plaintiff's claim relates to it."); Cook Wholesale of Medina, Inc. v. Connecticut Gen. Life Ins. Co., 898 F. Supp. 151, 153 (W.D.N.Y. 1995); Haley v. Trees of Brookwood, 838 F. Supp. 1553 (N.D. Ala. 1993) ("ERISA's superpreemption of state law claims does not render removable a state court complaint alleging that employer represented that insurance coverage would be continued under the Consolidated Omnibus Budget Reconciliation Act of 1988 (COBRA), knowing that there would be no such coverage and that the former employee would have no right to complain under COBRA."); Bryant v. Blue Cross & Blue Shield of Al., 751 F. Supp. 968 (N.D. Ala. 1990); McDonald v. Houston Brokerage, Inc., 928 S.W.2d 633, 638 (Tex. Ct. App. 1996).

[19] *See* Cisneros v. Unum Life Ins. Co., 115 F.3d 669 (9th Cir. 1997), *withdrawn and superseded by* 134 F.3d 939, *cert denied*, 119 S. Ct. 1495 (1999). In the seminal preemption case of *Ingersoll-Rand v. McLendon*, the Supreme Court may have temporarily encouraged a belief among the federal courts that remedies similar (if not identical) to preempted state remedies could easily be fashioned with a principle of federal ERISA "common law." Ingersoll Rand Co. v. McLendon, 498 U.S. 133,

these not examples of judicial activism, but of justice. This judge has joined this new reluctance to make ERISA a black hole.[20]

The Supreme Court has recently indicated that the reach of the relates to language is not unlimited.[21] In *De Buono v. NYSA-ILA Medical and Clinical Services* the Supreme Court used the stated objectives of ERISA to limit the scope of "relates to."[22] At issue in *De Buono* was a New York state law that imposed a tax on gross receipts for certain health care services.[23] The court considered the actual operation of the state statute and concluded that the law at issue was one of a "myriad [of] state laws of general applicability that impose some burdens on the administration of ERISA plans, but nevertheless do not 'relate to' them."[24] The court acknowledged that the state law had a direct impact on the ERISA fund's decisions regarding coverage of health care services provided to its beneficiaries, but found this impact insufficient to bring the plan within ERISA preemption.[25] Specifically, the court stated that "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."[26] This statement represents a significant narrowing of the court's interpretation of ERISA preemption.

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145 (1990). This still-lingering idea derives from the Supreme Court's statement, made after unanimously finding the state claim at issue preempted, that "*the relief requested here is well within the power of federal courts to provide.*" *Id.* at 145 (emphasis added). Apparently, the Supreme Court did not mean what it said, because it has never repeated or encouraged other courts to follow the above-quoted expression. Some of the lower courts have also retreated from decisions that attempt to fashion an ERISA common law. *See Cisneros*, 134 F.3d at 947 (retreating from an earlier opinion issued in the same case in which the court incorporated the state law rule at issue into the federal common law of ERISA).

[20] *See, e.g.*, *McNatt*, 998 F. Supp. at 1253; *Gray*, 879 F. Supp. at 99; *Hensley*, 878 F. Supp. at 1465; *Haley*, 838 F. Supp. at 1553; *Bryant*, 751 F. Supp. at 968.

[21] *See* De Buono v. NYSA-ILA Med. and Clinical Serv. Fund, 520 U.S. 806 (1997). *See generally* California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316 (1997); New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

[22] De Buono v. NYSA-ILA Med. and Clinical Serv. Fund, 520 U.S. at 813-14 ("[W]e must go beyond the unhelpful text and the frustrating difficulty of defining [ERISA's] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." (citations omitted)).

[23] *Id.* at 1749.

[24] *Id.* at 1752 (citations omitted).

[25] *See id.* at 1752-53.

[26] *Id.* at 1753 (footnote omitted).

Wilson v. Zoellner[27] provides another recent example of a federal court flatly rejecting preemption under circumstances that most federal courts would have construed as sufficiently related to an ERISA plan to accomplish preemption. In *Wilson* the United States Court of Appeals for the Eighth Circuit found that because the state common law dealing with negligent misrepresentation was a law of general application, made no reference to, and functioned independently of ERISA, it did not relate to ERISA.[28] As the Eighth Circuit explained: "The law is clear that fraud claims against an insurance agent who solicits participation in an ERISA plan are not preempted under ERISA."[29]

Wilson's action against Zoellner would not have had any direct economic impact on the ERISA plan. A majority of courts would have found that Wilson's claim related to an ERISA plan and would have preempted his fraud claim against his insurance agent. Was the Eighth Circuit foolhardy or prophetic? In *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*[30] the Eighth Circuit demonstrated its internal schizophrenia by finding Arkansas's so-called "Patient Protection Act" preempted "by virtue of [its] making reference to and having a connection with ERISA plans . . . ."[31] At the same time the Eighth Circuit was retreating in *National Park Medical Center*, the Court of Appeals for the Ninth Circuit was advancing. In *Emard v. Hughes Aircraft Co.*[32] the Ninth Circuit decided that California's community property law, which clearly interfered with an ERISA plan's contractual obligation to pay benefits in a specific way, was not sufficiently related to the plan to be preempted. The most interesting thing about this obvious conflict between the Eighth and the Ninth Circuits is that they both rely on *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*[33] They simply read the Supreme Court differently.

The lower courts' resentment of ERISA's ambiguity and impracticality is palpable.

IS THE PLAN AN ERISA PLAN?

Many courts simply *assume* that ERISA provides the only

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[27] 114 F.3d 713 (8th Cir. 1997).
[28] *Id.* at 717 (citations omitted).
[29] *Id.* at 719.
[30] 154 F.3d 812 (8th Cir. 1998).
[31] *Id.* at 817.
[32] 153 F.3d 949 (9th Cir. 1998).
[33] 514 U.S. 645 (1995).

remedy for an employee complaining that he or she has been defrauded, or complaining that a benefits obligor has not met its obligation. This second assumption is based on the first assumption that there is an ERISA plan. Some judges, however—including this one—do not indulge the assumption that every scheme designed to provide employee medical, disability, or pension benefits is an ERISA plan. This judge requires litigants to prove that an ERISA plan *actually exists*, something that is not always easy to do.[34]

An extended question confronted by the would-be ERISA plaintiff is: "Who can I sue?" On this question, the courts again go in different directions. Some have difficulty finding a fiduciary or fiduciaries, even if a plan exists.[35] Others find that even a non-fiduciary can be sued under ERISA.[36] This creates chaos. For its part, the United States Court of Appeals for the Eleventh Circuit has held that the employer, not the insurer, is the only proper party defendant if the employer is the plan administrator.[37] A beneficiary's finding a target under ERISA has become a shell game.

WHEN DOES THE "SAVINGS CLAUSE" PROVIDE ESCAPE FROM ERISA?

Even if a claim admittedly relates to a proven ERISA-governed plan, the claim is "saved" from preemption if it is brought pursuant to a state law regulating insurance.[38] Courts of various jurisdictions have diversely interpreted ERISA's "savings clause." The confusion surrounding what is and is not saved from ERISA preemption can be illustrated by *Cisneros v. Unum Life Insurance Co.*[39]

In *Cisneros* the United States Court of Appeals for the Ninth Circuit found that a state law prohibiting an insurer from avoiding liability due to a beneficiary's late filing (unless the insurer

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[34] *See* Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118, 1120 n.2 (9th Cir. 1998) ("The burden of establishing the existence of an ERISA plan is on Paul Revere."); Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822 (N.D. Ala. 1988). *See generally* Kemp v. International Bus. Machines Corp., 109 F.3d 708 (11th Cir. 1997).

[35] *See* Santana v. Deluxe Corp., 920 F. Supp. 249 (D. Mass. 1996); Useden v. Acker, 721 F. Supp. 1233 (S.D. Fla. 1989), *aff'd*, 947 F.2d 1563 (11th Cir. 1991).

[36] *See, e.g.*, Herman v. South Carolina Nat'l Bank, 140 F.3d 1413, 1420 (11th Cir. 1998); LeBlanc v. Cahill, 153 F.3d 134 (4th Cir. 1998).

[37] *See* Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186 (11th Cir. 1997).

[38] *See* 29 U.S.C. § 1144(b)(2)(A) (1985 & Supp. I 1998). A self-insured plan does not constitute "insurance" for the purposes of the "savings clause." *See* 29 U.S.C. § 1144(b)(2)(B) (1985). No court appears to have considered the effect of a state insurance regulation on an employer's self-funded plan that is reinsured by an insurance company subject to regulation.

[39] *See generally* 115 F.3d 669 (9th Cir. 1997), *withdrawn and superseded by* 134 F.3d 939 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1495 (1999).

proved substantial prejudice from the delay) was saved from preemption because the state law constituted an insurance regulation.[40] The Ninth Circuit's first opinion went even further and found that this notice-prejudice concept was incorporated into the federal common law of ERISA.[41] On rehearing, the court retreated from this alternative justification for non-preemption.[42] In *Unum Life Ins. Co.* v. *Ward*[43] the Supreme Court reviewed the Ninth Circuit's *Cisneros* opinion and unanimously agreed that California's notice-prejudice rule was saved because it "regulate[d] insurance" and thus was not preempted. Inconsistently, I think, the Supreme Court simultaneously found that California's court-created rule, which made an employer the "agent of the insurer in performing the duties of administering group insurance policies," was nothing more than part of the general law of agency, did not "regulate insurance," and was therefore preempted. Why one of these two California rules regulated insurance and the other did not defies explanation.

The ultimate impact of the savings clause is yet to be determined. Any state legislature jealous of the traditional rights of action available to victims of fraudulent or abusive acts by insurers or their allies could enact a statutory scheme that expressly names regulation of the insurance industry as its purpose. Such a statutory scheme could justifiably incorporate traditional remedies for misrepresentation and other fiduciary abuses, such as claims for mental anguish and punitive damages, under carefully defined circumstances. Thus far, with the exception of Arkansas, no state legislature has been this gutsy. The Arkansas state legislature, however, has made the mistakes recognized by the Eighth Circuit in *Prudential Insurance Company v. National Park Medical Center*[44] by targeting only "health care providers" and having the audacity to mention ERISA while proscribing certain conduct.[45] When a state legislature awakens to the possibilities of the savings clause and enacts a statutory scheme that can survive judicial scrutiny, super-duper preemption, as a practical matter, will become less than super-duper.

WHAT REMEDIES DOES ERISA ITSELF PROVIDE?

Defendants' routine removal to a federal forum of every

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[40] *Id.* at 675.
[41] *See id.*
[42] *See* Cisneros v. Unum Life Ins. Co., 134 F.3d 939, 947 (9th Cir. 1997), *cert. denied*, 119 S. Ct. 1495 (1999).
[43] 119 S. Ct. 1380 (1999).
[44] 154 F.3d 812 (8th Cir. 1998).
[45] *Id.* at 819.

case in which there is even the slightest possibility of successfully contending that the claim relates to an ERISA plan proves (if proof were needed) that ERISA's few express remedies are pitifully inadequate. Either Congress was hypocritical in stating ERISA's predominant purpose to be the protection of the rights of the beneficiaries of medical and retirement plans while simultaneously eliminating traditional remedies, or Congress was asleep at the switch.

In ERISA, Congress did not mention whether disputes were to be resolved by jury or by judge, leaving the courts to decide whether jury trials are available in ERISA cases. Most courts that have addressed the matter, including the Eleventh Circuit, have held that jury trials are not available under ERISA.[46] Congress apparently deliberately failed to address the availability of extra-contractual damages in ERISA controversies. A majority of courts that has addressed the issue, again including the Eleventh Circuit,[47] has limited an ERISA plaintiff to contractual damages, misdescribed as "restitution," which is a traditional equitable remedy.[48] This limitation prevents a prevailing ERISA plaintiff from recovering damages for mental anguish or for punishment of the malefactor, regardless of how much suffering a deliberately malicious fiduciary has caused by an intentional misrepresentation or by an inexcusable refusal to pay a valid claim.[49]

Although federal courts generally find extra-contractual damages and jury trials unavailable in ERISA actions, some state courts have reached different conclusions. The Supreme Court of Alabama, for example, allows recovery of extra-contractual and punitive damages, plus a jury trial, in ERISA cases.[50] Ala-

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[46] *See, e.g.*, Adams v. Cyprus Amax Minerals Co., 149 F.3d 1156, 1162 (10th Cir. 1998); Blake v. Unionmutual Stock Life Ins. Co. of Am., 906 F.2d 1525, 1526 (11th Cir. 1990); Bair v. General Motors Corp., 895 F.2d 1094, 1096 (6th Cir. 1990).

[47] *See, e.g.*, *Blake*, 906 F.2d at 1525.

[48] *See generally* Drinkwater v. Metropolitan Life Ins. Co., 846 F.2d 821 (1st Cir. 1988); Hemelt v. United States, 951 F. Supp. 562 (D. Md. 1996), *aff'd*, 122 F.3d 204 (4th Cir. 1996); Rutledge v. American Gen. Life and Accident Ins. Co., 871 F. Supp. 272 (N.D. Miss. 1994).

[49] *See, e.g.*, Godfrey v. BellSouth Telecommunications, Inc., 89 F.3d 755, 761 (11th Cir. 1996); Sanson v. General Motors Corp., 966 F.2d 618 (11th Cir. 1992) (Birch, J., dissenting); McRae v. Seafarers' Welfare Plan, 920 F.2d 819, 821 (11th Cir. 1991).

[50] *See, e.g.*, *Ex parte* Metropolitan Life Ins. Co., 679 So. 2d 686 (Ala. 1996) (Justice Houston, who had dissented from *Weems*'s holding that the Seventh Amendment guarantees an ERISA claim the right to a jury trial, joins majority in *Metropolitan Life* only because U.S. Supreme Court denied certiorari in *Weems*.); Weems v. Jefferson-Pilot Life Ins. Co., 663 So. 2d 905 (Ala. 1995); Haywood v. Russell Corp., 584 So. 2d 1291 (Ala. 1991).

bama is not the only state that deviates from the Eleventh Circuit's denial of extra-contractual damages, punitive damages and trial by jury.[51] In *Shaw v. Atlantic Coast Life Insurance Co.* the Court of Appeals of South Carolina, swimming upstream with Alabama, held that an ERISA claimant is entitled to a jury trial.[52]

Whether these state courts are correct or the Eleventh Circuit is correct regarding these ERISA issues depends on a definitive expression by the Supreme Court of the United States, or by Congress. One hopes that the Supreme Court will not ignore the Seventh Amendment jury trial issue in ERISA cases as it did in Title VII cases between 1964, the date of the enactment of the Civil Rights Act of 1964, and 1991, the date of when that Act was amended to provide for jury trial.[53] After twenty-six years Congress finally recognized the Seventh Amendment when the Supreme Court would not.

The federal courts have not obtained and will not obtain unanimity on the jury trial issue and the extra-contractual damages issue without Supreme Court direction. Before the Eleventh Circuit made clear its position that ERISA does not permit jury trials, the writer of this article held to the contrary.[54] Other federal judges have also occasionally held that the Seventh Amendment guarantees trial by jury in an ERISA case.[55] In *Adams v. Cyprus Amax Mineral Co.*, for example, a perspicacious district judge found an ERISA beneficiary entitled to a jury trial.[56] He was promptly reversed by the United States Court of Appeals for the Tenth Circuit.[57]

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[51] *See* Shaw v. Atlantic Coast Life Ins. Co., 470 S.E.2d 382 (S.C. Ct. App. 1996).

[52] *Id.* at 387.

[53] *See generally* 42 U.S.C.A. § 1981 (West 1984).

[54] *See* Whitt v. Goodyear Tire & Rubber Co., 676 F. Supp. 1119 (N.D. Ala. 1987), *reconsideration denied sub nom.* Amos v. Blue Cross and Blue Shield of Al., 681 F. Supp. 1515 (N.D. Ala. 1988), *rev'd*, 868 F.2d 430 (11th Cir. 1989), *reh'g denied*, 875 F.2d 878 (11th Cir. 1989), *cert. denied*, 493 U.S. 855 (1989). The Supreme Court of Alabama followed the author of this article instead of the Eleventh Circuit. *See also* Blue Cross and Blue Shield of Ala. v. Lewis, 753 F. Supp. 345 (N.D. Ala. 1991); Rhodes v. Piggly Wiggly Ala. Distrib. Co., 741 F. Supp. 1542 (N.D. Ala. 1990).

[55] *See generally* U.S. CONST. amend. VII (The Seventh Amendment states: "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.").

[56] 954 F. Supp. 1470 (D. Colo. 1997).

[57] *See* 149 F.3d 1156 (10th Cir. 1998). The Tenth Circuit had earlier "decline[d] to reach this thorny issue [of ERISA jury trial]" after acknowledging that "ERISA does not specify whether cases arising under section 502 or section 510 are to be tried by a jury." Zimmerman v. Sloss Equip., Inc., 72 F.3d 822, 829-30 (10th Cir. 1995).

Even the Eleventh Circuit may be undergoing an opinion shift on the jury trial issue. In *Stewart v. KHD Deutz of America Corp.*[58] the Eleventh Circuit joined the Seventh Circuit in holding that "plaintiffs are entitled to a jury trial in hybrid LMRA/ERISA actions."[59] *Stewart* involved a claim for relief under both the Labor Management Relations Act (LMRA) and ERISA for defendant's failure to provide health benefit coverage in violation of collective bargaining agreements.[60] Though Eleventh Circuit precedent made clear that a jury trial is unavailable to plaintiffs in a pure ERISA claim,[61] the *Stewart* plaintiffs claimed a right to a jury trial under the LMRA, an issue of first impression for the Eleventh Circuit.[62] In granting plaintiffs a right to a jury trial, the court looked into the same question that it had considered when earlier it looked at ERISA, that is, whether the relief sought was "legal" or "equitable" in nature.[63] The court noted: "Monetary relief . . . is only presumed to be a legal remedy. A monetary award may be characterized as an equitable remedy if it is found to be 'incidental to or intertwined with injunctive relief.'"[64]

Arguing that the monetary relief sought in *Stewart* was equitable in nature, defendant understandably relied on the Eleventh Circuit's decision in *Blake v. Unionmutual Stock Life Insurance Co.*[65] In *Blake* the Eleventh Circuit characterized monetary relief in ERISA claims as equitable relief, thus precluding Seventh Amendment jury trial.[66] The *Stewart* Court rejected defendant's argument, finding that *Blake's* classification of monetary damages in ERISA claims was "not determinative" of what constitutes monetary damages in LMRA-ERISA cases.[67] In my view, *Blake* suffered serious erosion in *Stewart*. The Eleventh Circuit could have easily applied *Blake* to prevent the *Stewart* plaintiffs from obtaining a jury trial.

Further erosion of the basis for denials of jury trials in ERISA cases has occurred at the Supreme Court level. Last year

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[58] 75 F.3d 1522 (11th Cir. 1996).
[59] *Id.* at 1528.
[60] *Id.* at 1524.
[61] *See* Blake v. Unionmutual Stock Life Ins. Co., 906 F.2d 1525, 1526 (11th Cir. 1990).
[62] *Stewart*, 75 F.3d at 1525.
[63] *Id.* at 1525-26.
[64] *Id.* at 1526 (citing Chauffeurs, Teamsters & Helpers Local No. 391 v. Terry, 494 U.S. 558, 571 (1990)).
[65] *Id.* at 1526-27; *see also Blake*, 906 F.2d at 1526.
[66] *Blake*, 906 F.2d at 1526.
[67] *Stewart*, 75 F.3d at 1527.

the Supreme Court in *Feltner v. Columbia Pictures Television, Inc.*[68] reiterated its recognition that the "'general rule' [is] that monetary relief is legal" and, therefore, a statutory cause of action for monetary relief carries with it the Seventh Amendment right to trial by jury.[69] The Court relied on this principle in holding that the Fair Labor Standards Act provides a right to trial by jury, despite the absence of any express authorization by Congress.[70] Other courts have reached similar decisions when construing statutes that, like ERISA, contain no express provision authorizing a jury trial.[71]

The combination of the bleeding wound *Blake* suffered in *Stewart* and the Supreme Court's statement in *Feltner* provides a more than sufficient reason for trial courts within the Eleventh Circuit to reopen the question of whether ERISA claims are triable by a jury. A recent statement by the Eleventh Circuit provides even further encouragement for reexamining the availabity of jury trials in ERISA cases.[72] In *Chambers v. Thompson* the Eleventh Circuit acknowledged an obligation to repudiate its prior holdings under circumstances such as here exist. The court stated: "We are bound to follow a prior panel or en banc holding, except where that holding has been overruled or undermined to the point of abrogation by a subsequent en banc or Supreme Court decision."[73]

Ironically, state and federal courts, sharing jurisdiction over most ERISA matters, split on issues that have not been addressed with sufficient particularity by the Supreme Court of the United States and that have not been clarified by Congress. As noted above, the Supreme Court sidestepped the jury trial issue in Title VII employment discrimination cases for twenty-six years and has likewise avoided the issue in ERISA cases since 1974. With the scholarly commentators divided[74] and the courts in

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[68] 523 U.S. 340 (1998).

[69] 118 S. Ct. at 1287.

[70] *See id.* at 1283-84.

[71] *See, e.g.*, Lorillard v. Pons, 434 U.S. 575, 580-81 (1978) (finding right to jury trial in Age Discrimination in Employment Act despite no express provision); Frizzell v. Southwest Motor Freight, 154 F.3d 641 (6th Cir. 1998) (finding right to jury trial in Family Medical Leave Act despite no express provision).

[72] *See* Chambers v. Thompson, 150 F.3d 1324, 1326 (11th Cir. 1998).

[73] *Thompson*, 150 F.3d at 1326.

[74] *See generally* Denise Drake Clemow and Lisa Hund Lattan, *ERISA Section 510 Claims: No Right to a Jury Trial Can Be Found*, 73 NEB. L. REV. 756 (1994); Michael McCabe, Jr., Comment, *The Right to a Jury Trial in Benefit Recovery Actions Brought Under ERISA Section 502(a)(1)(B)*, 20 U. BALT. L. REV. 479 (1991); Nancy L. Pirkey, Note, *The Availability of Jury Trials in ERISA Section 510 Actions: Expanding the Scope of the Seventh Amendment*, 27 VAL. U. L. REV. 199 (1992); Note, *The Right to Jury Trial in Enforcement Actions Under Section 502(a)(1)(B) of ERISA*, 96 HARV. L. REV.

disarray, the Supreme Court should now take a case in order to decide, at the very least, the jury trial issue. The court has already expressed its displeasure with ERISA, but more action is needed.

A new flexibility may also be developing in the once strict rule that denied plaintiffs traditional damage awards such as compensation for mental anguish and punitive damages for particularly egregious conduct on the part of an ERISA obligor. Although Eleventh Circuit decisions clearly prohibit an award of extra-contractual damages, *contract* damages have not yet been precluded. Alabama allows recovery for mental anguish for breach of contract under circumstances where such damages are foreseeable or within the contemplation of the parties.[75] In *McWilliams v. American Medical International, Inc.*[76] a judge of my court employed this concept and in an ERISA case awarded substantial contract damages for mental anguish.[77] That case is on appeal to the Eleventh Circuit. I do not predict the appellate outcome, but do point out that a contract requiring the payment of medical benefits, when breached by the obligor, virtually always causes some degree of mental anguish to a person who may desperately need medical attention, but cannot receive it. If damages for mental anguish can be recovered under a contract theory, the ERISA prohibition against extra-contractual damages (except punitive) may become passé.

THE SOLUTION, IF THERE IS ONE

On September 9, 1998, the Pension and Welfare Benefits Administration of the Department of Labor, which has certain ERISA rule-making power, issued proposed regulations that would require ERISA health benefit plan administrators to decide a claim for urgent care within 72 hours of receiving the claim and a non-urgent care claim within 15 days after the claim is filed.[78] The proposals would also require the prompt furnishing of pertinent information to the claimant. In my view, this will be applying a "band-aid" to the problem, even though it may reduce the defendant-employer-administrator-fiduciary's footdragging, previously done with impunity. After the comment period ends on November 9, 1998, these proposals, unless deep-sixed, will become final. Still, they fall far short of provid-

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737 (1983).

[75] *See* Sexton v. St. Clair Fed. Sav. Bank, 653 So. 2d 959, 960 (Ala. 1995).

[76] 960 F. Supp. 1547 (N.D. Ala. 1997).

[77] *McWilliams*, 960 F. Supp. at 1547.

[78] 63 Fed. Reg. 48, 391 (1998).

ing a solution to the problems inherent in the Congressional language, and unresolved by the Supreme Court.

The "Long Range Plan for the Federal Courts," adopted in December 1995, by the Committee on Long Range Planning of the Judicial Conference of the United States, contains the following recommendations:

> The jurisdiction of the federal courts to adjudicate routine claims for benefits under ERISA employee welfare benefits plans should be abolished, except when application or interpretation of federal statutory or regulatory requirements are at issue.
>
> Any new cooperative federal-state program to establish national standards for employee benefits (e.g., health care) should designate state courts as the primary forum for the review of benefit denial claims. However, any such program should include establishment of an administrative remedial process that must be exhausted before a state court action may be filed.[79]

In 1995, a publication entitled "Federal Practice Advisory"[80] proposed the following:

> Certain kinds of federal rights ought to be adjudicated only in the state courts, which have always had concurrent jurisdiction over suits involving workplace injuries under the Federal Employers' Liability Act and the Jones Act, as well as suits for employee benefits under the Employee Retirement Income Security Act (ERISA). Any new program establishing national guidelines for health care should make the state courts the primary forum for review of the denial of benefits.

I agree with these recommendations. They simply translate into a recommendation that ERISA be repealed. Congress is presently contemplating several possible corrective measures. If Congress is unwilling to recognize ERISA's abject failure, we will have a long wait for either ERISA's judicial or regulatory redemption. I will not be around to see it if it comes.

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[79] *Long Range Plan for the Federal Courts*, Dec. 1995 at 29 (published by Committee on Long Range Planning of the Judicial Conference of the United States).

[80] Issue No. 63, Jan. 16, 1995, p. 3.

EXHIBIT B

INITIAL ORDER IN ERISA BENEFITS CASES

The above-styled case appears to claim benefits and/or other relief under the Employee Retirement Income Security Act ("ERISA"). It therefore requires specialized treatment. Pursuant to Rule 26(f) and Rule 16, Federal Rules of Civil Procedure, the court will conduct a scheduling and status conference in chambers at ____ on _____, 201_. No less than seven (7) calendar days before said conference, each party shall file with chambers (not the Clerk) paper answers to the following questions involving subjects that will be more fully explored at the conference:

(1) If plaintiff has named more than one defendant, is a particular named defendant, or a third-party who is not a defendant, the entity liable for the ERISA violation or violations alleged if any such violation is found by the court? If so, name that entity.

(2) Does any defendant, if it has done so, plan to file a cross-claim or third-party action?

(3) Furnish a paper copy of the administrative record as it presently exists, including the plan document and the summary plan description. Are the parties in agreement about the accuracy and completeness of the administrative record as it presently exists? If the parties disagree about the accuracy or completeness of the current administrative record, what is the basis for disagreement?

(4) If the court should find any defendant liable under ERISA, do the parties agree as to the amount due, taking into consideration any offsets? If so, state that amount. If not, each party shall explain the amount it proposes in the event of a finding of liability.

(5) If the parties agree on the interest rate on benefits from the date of accrual, state the rate. If disputed, state the rate proposed by each party with its explanation.

(6) Does plaintiff seek benefits only pursuant to 29 U.S.C. § 1332(a)(1)(B), or does plaintiff seek relief pursuant to 29 U.S.C. § 1332(a)(3)?

(7) Should the case be decided on the administrative record alone? If not, what additional presently available evidence should be considered, and why?

(8) Will discovery beyond the administrative record be needed? If so, describe the nature of such evidence, and how the requesting party proposes to obtain it.

(9) What is the standard-of-review, and why?

(10) Does any defendant rely upon a discretionary clause in the plan? If so, does the clause meet the *Bruch* standard? If not, why not, including any contention by plaintiff that the summary plan description is deficient or inconsistent with the plan?

(11) Did any decision-maker whose decision is being contested, operate under a structural conflict-of-interest? If so, explain.

(12) Does any defendant claim insulation from liability by virtue of the existence of a trust or a totally disinterested decision-maker? If so, describe, including all documents by which decision-making authority is delegated. Furnish paper copies of all contracts or agreements by or between the plan sponsor, the claims administrator, the ultimate decision-maker, and the funding source.

(13) What entity or entities fund, whether directly or indirectly, any obligation to pay benefits?

(14) What, if any, control does the plan sponsor have over the benefits decision-making process, including any right to appoint any who participate in the decision-making process?

(15) Upon any appeal by the alleged beneficiary from an original denial of benefits, are the decision-makers the same as those who originally denied benefits? If different, explain the difference.

(16) If there is any alleged conflict-of-interest by any decision-maker, what steps have been taken, if any, to eliminate or

ameliorate that conflict?

(17) If any defendant interposes a defense of plaintiff's alleged failure to exhaust administrative remedies, what does that failure consist of?

(18) Is any defendant unwilling to waive all right to seek a remand of the dispute to the plan administrator or other decision-making entity? If not willing, why not?

(19) Does plaintiff claim that there is any procedural shortcoming by defendant or defendants that may affect liability, such as untimeliness of the denial decision (without limiting the scope of the question)? If so, describe.

(20) Has the Social Security Administration been involved in any way in the subject-matter of the case. If so, describe and give the result.

(21) Does plaintiff complain about any decision-maker's interpretation of plan language? If so, what is the difference in interpretation between the parties?

(22) Does plaintiff complain about any of the plan administrator's findings of fact (in contrast to conclusions reached upon such findings)? If so, in what respects?

(23) Does any party believe that the liability question cannot be finally disposed of on cross-motions upon a written record, whether or not supplemented beyond the present administrative record? If not, why not?

(24) Does any party dispute the right of the court, upon unsworn and uncross-examined written testimony, to make credibility determinations when material facts are in dispute? If so, explain.

(25) When will the case be ready for final disposition, whether upon cross-motions or upon bench trial?

(26) Does any party desire mediation?

DONE and ORDERED this ____ day of ____, 201_.

_____
UNITED STATES DISTRICT JUDGE

EXHIBIT C

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

TOMMY EDGAR,	}	
	}	
Plaintiff,	}	
	}	CIVIL ACTION NO.
v.	}	09-AR-1562-S
	}	
DISABILITY REINSURANCE MANAGEMENT SERVICES, INC., et al.,	}	
	}	
Defendants.	}	

MEMORANDUM OPINION AND ORDER

This court has previously held, and still believes, that Rule 56, F.R.Civ.P., was not designed for, and is only awkwardly used for, the resolution of disputes over entitlement to disability benefits under the Employee Retirement Security Act of 1974, 29 U.S.C. § § 1001, *et seq.* ("ERISA"). Nevertheless, the case law as it has evolved since 1974, despite the variants and contradictions introduced to the hodge-podge by the courts forced to deal with it, overlooks the plain language Congress used in ERISA. ERISA, properly understood, simply provides a trial *de novo* in all cases in which an application for benefits under an ERISA plan is finally turned down by the plan functionary. Section 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B)) straightforwardly says that any participant in a plan governed by ERISA can bring a **"civil action" "to recover benefits due him under the terms of his plan".** (emphasis added). What is a "civil action", if not a lawsuit? The courts have substituted for the trial *de novo* unequivocally

mandated by Congress a procedure akin to, and borrowed from, the review of an administrative law judge's decision on a Social Security disability benefits claim. The words "judicial review" nowhere appear in ERISA. "Judicial review" is expressly provided for in a section of the Social Security Act, 42 U.S.C. § 405(g), which is itself entitled "**Judicial Review**". ERISA complaints and Social Security appeals are different animals.

The above-entitled case perfectly illustrates the problem inherent in an attempt to use Rule 56 as the device for resolving an ERISA controversy, especially when only one of the parties files a motion for summary judgment, and the parties do not agree to submit on the record. In the instant case, defendants, Disability Reinsurance Management Services, Inc. and Boston Mutual Life Insurance Co. ("defendants"), have jointly moved for summary judgment. Defendants are represented by the same counsel, and agree that they are to be treated as one. Siamese twins do not ask to be separated if they are happy together.

In the joint report of parties' planning meeting, the parties on October 8, 2009, expressed a stark difference of opinion as to the procedure under which their dispute must be resolved. The court, at the present instant, cannot resolve their **ultimate** dispute, but the court **must** resolve the difference of opinion as to **how to proceed** at this juncture. Defendants' position on October 8, 2009, was that "the Court's review of the claim decision is

limited to the administrative record and no discovery is appropriate beyond production of the administrative record with the possible exception of information relating to Plaintiff's income and other financial information that would be pertinent to Plaintiff's ongoing claim for benefits". On the other hand, plaintiff, Tommy Edgar ("plaintiff"), on October 8, 2009, took the position that limited discovery should be allowed and that the *de novo* standard of review applies. On October 9, 2009, the court entered its scheduling order, adopting the parties' joint suggestion of dates for early disclosure of expert witnesses. Plaintiff was to disclose experts by February 12, 2010, and defendants by March 12, 2010. Those dates have passed. What the purpose of disclosing experts was if a **trial** was not contemplated is not explained by defendants. Plaintiff has only implicitly and enigmatically attempted to explain it. The court ordered a discovery deadline of July 16, 2010, and a dispositive motion deadline of August 20, 2010. The lengthy time period between entry of the scheduling order and the deadline for completing discovery suggests that some discovery outside the administrative record was contemplated. Exactly what discovery has actually been undertaken is not known by the court, because there have been no objections to any discovery requests and no motions to compel.

Although the parties did not request a planning meeting with the court before the court entered its scheduling order, the court

eventually sensed what it should have sensed much earlier, namely, that the parties have diametrically opposing views about the so-called "standard of review". When the light dawned, the court ordered a conference on May 24, 2010, for the purpose of exploring and deciding upon the proper "standard of review". On June 8, 2010, defendants formally conceded that the "standard of review" is *de novo*. The reason for this concession may be that defendants' "discretionary clause", a provision now found in virtually every ERISA disability plan, and given overriding significance by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 (1989), is defective. Perhaps defendants' draftsman did not understand *Bruch*.

If defendants had admitted *ab initio* that the "standard-of-review" is *de novo*, and had convinced the court that the case must be decided on the administrative record alone, this case would have been decided much sooner, and with less expense. An early motion for partial summary judgment on the "standard of review", would have helped.

The joint report of parties filed on October 8, 2009, requested, *inter alia*, a "final pretrial conference with the Court 30 days before **trial**"; that "final lists of **trial** witnesses and experts under Rule 26(a)(3) must be filed by the parties 30 days before **trial**"; that "objections be filed within 10 days after a service of final list of trial evidence"; and that "the case should

be ready for **trial** by October 4, 2010" (emphasis added). The scheduling order entered on October 9, 2009, provided, *inter alia*: "All *in limine* motions based on *Daubert* must be filed prior to the final pre-trial conference." The court's reference to *Daubert* was without meaning unless a challenge by one party of the credentials and opinions of the opponent's experts was a future possibility. There can be no gate-keeping role for the court if an administrative record provides the only basis for decision.

The parties' planning report concluded with these revealing counter-expressions: "Defendants request a trial on briefs because this is an ERISA case and the Court's review is limited to the administrative record", whereas, "Plaintiff requests a bench trial and states that the trial is expected to last two days". Why would defendants even speak of a "**trial**"? The word "**trial**" does not fit an appellate review. Who ever heard of a "**trial**" in the Supreme Court, unless in a conflict between States? The "summary judgment" concept is not employed in appellate review any more than is a "trial". Defendants must have meant to be requesting oral argument on anticipated motions for summary judgment.

Defendants timely filed their Rule 56 motion, now under submission. Perfectly consistent with plaintiff's unwaivering position, he did not file a motion for summary judgment. Instead, he argues that there are disputes of material fact that preclude summary judgment, either for him or for defendants.

No citation is needed to support the long established acknowledgment by the federal courts, including the Supreme Court and the Eleventh Circuit, that on its face Rule 56 places upon the movant the burden of demonstrating that there are no disputes of material fact and that movant, on those facts, is entitled to judgment as a matter of law. The presentation of evidence by the non-movant, together with all reasonable inferences to be drawn therefrom, is to be treated as true for the purposes of deciding whether there is a genuine issue of material fact. It is not surprising that defendants' rendition of the evidence (lifted from the administrative record) is only supportive of, and consistent with, the conclusion, adverse to plaintiff, that was reached by the defendants' ERISA plan decision-makers. Defendants necessarily argue that upon a *de novo* consideration of the administrative record, they were **right** to deny plaintiff's claim for disability benefits. The evidence employed by the claim evaluators to reach their decision is elaborately described by defendants. There is no recognition by defendants of *contra proferentem*, a rule that applies to contract interpretation upon any *de novo* consideration of a contract. Defendants have no trouble in construing in their favor the contract they drafted. Defendants' evidence, of course, may prove ultimately successful at trial. It need not be repeated or analyzed here. Plaintiff's evidence proffered in opposition to defendants' Rule 56 motion is also detailed, but plaintiff

concentrates upon his argument that there **are** disputes of material fact, rendering Rule 56 inappropriate. This court agrees with plaintiff on this score.

The parties have not cited a single Eleventh Circuit or Supreme Court case, and this court has found none, making a persuasive argument that ERISA alters the routine way Rule 56 motions are to be treated and decided. It is somewhat strange that there is such a dearth of jurisprudence attempting to solve this procedural anomaly. There is some academic comment on the subject, but this court finds nothing to compare with the following thoughtful treatment of the problem by the Seventh Circuit in *Krolnik v. Prudential Ins. Co.*, 570 U.S. 841, 843 (7th Cir. 2009), a case that fits this case like a glove:

> *Firestone* holds that "*de novo* review" is the norm in litigation under ERISA. Cases such as this show that "*de novo* review" is a misleading phrase. The law Latin could be replaced by an English word, such as "independent." And the word "review" simply has to go. For what *Firestone* requires is not "review" of any kind; it is an independent *decision* rather than "review" that *Firestone* contemplates. The Court repeatedly wrote that litigation under ERISA by plan participants seeking benefits should be conducted just like contract litigation, for the plan and any insurance policy are contracts. 489 U.S. at 112-13, 109 S.Ct. 948. In a contract suit the judge does not "review" either party's decision. Instead, the court takes evidence (if there is a dispute about a material fact) and makes an independent decision about how the language of the contract applies to those facts.
>
> That's well understood in insurance litigation under the diversity jurisdiction. If the plaintiff says that a fire at his home destroyed a valuable painting, and the insurer declines indemnity after finding that (a) there was no such painting, and (b) the fire was caused by

> arson, the federal judge won't ask what evidence the insurer considered. The court will decide for itself where the truth lies. A judge would not dream of forbidding the parties to take discovery, let alone of rejecting affidavits that did not depend on discovery. Evidence is essential if the court is to fulfill its fact-finding function. Just so in ERISA litigation. When review is deferential—when the plan's decision must be sustained unless arbitrary and capricious—*then* review is limited to the administrative record. See *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir.1999). Otherwise, however, the court decides on the record made in the litigation. And, if material evidence conflicts, then there must be a trial.

(emphasis in original). The Seventh Circuit denied rehearing and rehearing *en banc*.

What can a trial court do when there is a legitimate dispute of material fact in an ERISA benefits case in which the parties have not agreed to submit on the administrative record? The Seventh Circuit was entirely correct in *Krolnik* when it held that an ERISA benefits claim is nothing more or less than a claim for breach of contract. Rule 56 does not lend itself to making credibility determinations or decisions about ambiguous language when witnesses disagree about crucial facts, such as the conflicting medical findings in this case. At **trial**, the burden of proof will, of course, be on the plaintiff, as in any contract case, to prove by a preponderance of the evidence the terms of the contract, and that the contract was materially breached. The court assumes that plaintiff understands his obligation.

This court does not pretend to have the right, much less the ability, to decide a controversy based upon unsworn opinions and

unseen, uncross-examined witnesses. From experience as a trial lawyer and as a judge, this court knows that a trier-of-fact may find that the "light was green" on the basis of **one** sharp-eyed, disinterested witness, even though he is contradicted by **three** other witnesses, all of whom say the "light was red", when one of the three was drunk, one is the best friend of the injured party, and one is vision-impaired. **Believability** is something that cannot be fairly determined on a cold record that is made up of disputed renditions of the evidence upon which differing conclusions can reasonably be reached.

Defendants' final brief in response to plaintiff's brief spends little time trying to refute plaintiff's contention that Rule 56 is not the appropriate vehicle for a decision in this case. Instead, defendants reiterate the evidence and arguments that accompanied their Rule 56 motion, and upon which they may very well prevail at trial. Oral argument would be fruitless at this time. Material facts are in dispute, and defendants' denial of benefits is not to be accorded deference. The inevitable, structural conflict-of-interest recognized in *Metropolitan Life v. Glenn*, 552 U.S. 1161, 128 S.Ct. 1117 (2008), may be at play at trial, but it is not relevant now. Defendants' argument that Rule 56 disposition is mandatory under the present circumstances makes no sense. If the "standard of review" had been "abuse of discretion" or "arbitrary and capricious" (synonyms in the Eleventh Circuit), the

court would be bound by precedent (with which it respectfully disagrees), and would have had to decide this dispute without a trial on the merits, whether under Rule 56 or under the "made-up" procedure employed by some courts. A *de novo* standard requires an entirely different approach. This standard has been **statutorily** mandated by Michigan and Montana where "discretionary clauses" are forbidden. *See Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009), and *Standard Insurance Company v. Lindeen*, 584 F.3d 837 (9th Cir. 2009), *cert.den.* ____ U.S. ____, 130 S.Ct. 3275 (2010). Why Alabama has not followed Michigan and Montana is an academic question because the way to look at this dispute is anew.

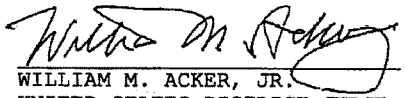
For the foregoing reasons, defendants' motion for summary judgment is DENIED. This opinion would have required a fist full of pages if the court had been forced under the deferential standard to struggle to explain why the evidence does provide or does not provide a rational basis for defendants' denial decision. The fact that the standard here is *de novo*, or, as the Seventh Circuit says, "**independent**", locks in the requirement that the case be tried on the merits.

ERISA badly needs revision, but this court is not Congress and is neither authorized to rewrite ERISA nor to amend the Federal Rules of Civil Procedure.

The case is hereby SET for pretrial conference in Courtroom 4B, **at 9:30 a.m., September 30, 2010,** in accordance with the

attached pretrial instructions.

DONE this 17th day of September, 2010.



WILLIAM M. ACKER, JR.
UNITED STATES DISTRICT JUDGE

**ANSWERS BY WILLIAM M. ACKER, JR.
TO FOLLOW-UP QUESTIONS FROM
SENATOR BAUCUS ON BEHALF OF
THE SENATE FINANCE COMMITTEE
AFTER THE HEARING OF SEPTEMBER 28, 2010**

Question No. 1: Judge Acker, what needs to be done to correct the problems that have been brought up in your testimony and the testimony of other witnesses?

Answer: The simplest and best way to solve the problems discussed with the Committee on September 28, 2010, is to amend Section 502(a) of the Employees **Retirement** Income Security Act of 1974 (**misnamed**, as far as the hearing on September 28, 2010, is concerned, because the participants were not invited to give their views on "retirement" or "pension" benefits) is for Congress to eliminate all doubt about the claimant's right to trial *de novo*. While Congress is at it, it should separate the apples from the oranges. "Disability benefits" and "pension benefits" require different treatment. Those treatments are now awkwardly squeezed into one statute. The new and separate statute should be named the "Employees **Disability** Income Security Act of 2011". Also, ERISA should be amended to provide that short-term disability claims are deemed denied if not granted within ninety (90) days of initial filing with the claims administrator, and that long-term disability claims are deemed denied if not granted within six months. Such limitations may be waived only by written consent of the claimant.

I believe that the trial should be by jury, except when

equitable remedies were sought. This is consistent with the Seventh Amendment. But, at the very least, there must be an **actual trial**, rather than just another layer of administrative review. The competing evidence must be evaluated, and the ultimate truth decided, by a judge or jury. Of course, if a party truly believes that he/she or it is entitled to judgment as a matter of law on undisputed facts, the party can file a Rule 56 motion, just as in any other civil case.

My alternative suggestion for a "fix" is legislation that would eliminate the so-called "discretionary clause" nationwide, both for insurers and self-insured ERISA plans. As it is now, with the universal use of "discretionary clauses", the Plan's decision-making team cannot resist providing well-written, reasonable sounding expert reports, and writes a carefully crafted denial decision that eloquently argues its own reasonableness. Applicants for disability don't have an experienced and competent ERISA lawyer at the "get go", as the funding party does.

Question No. 2: Judge Acker, under the current claims review process, the insurance companies have an inherent conflict of interest, but Mr. Graham from ACLI indicated that the treating physician may be biased towards the claimant. Mr. Graham also said that removing bias from the system may be impossible. What do you think is the best way to address the issue of bias?

Answer: Witnesses are often biased, as Mr. Graham suggests.

This, of course, is true in all trials *de novo*, whatever the subject matter of the controversy. The problem of bias in a disability benefits dispute is automatically ameliorated by *de novo* trial. It is my experience that the possibility of bias by the plan administrator's evaluators under the current "abuse of discretion" standard is greater than that of the beneficiary's treating physicians. All physicians and vocational experts **should be subject to cross-examination**, the long-recognized way to protect against witnesses with a stake in the outcome.

Incidentally, I strongly dispute the accuracy of actuarial reports suggesting that the cost to beneficiaries will increase if trial *de novo* is put in place. Actuaries may be professional and good at their trade, but their prediction is pure speculation. It is contrary to human nature. The current regime cannot empirically be proven to be less expensive than a *de novo* trial regime. If the funding parties in ERISA plans attempt to increase premiums when and if *de novo* trials are mandated, they will only be making good on threats. Congress should wait to see what **actually** happens when *de novo* trials are mandated and then make any necessary adjustments, and it should not blindly follow the direful predictions of the insurance industry's actuaries. My prediction on the cost question is just as good as that of the actuaries, who could not possibly have factored in all of the judicial time now spent under the "abuse of discretion" standard.

Furthermore, if premiums do slightly rise after *de novo* trials are in place, the assured increase in "fairness" will be worth the rise.

Question No. 3: Judge Acker, could you explain the difference between concurrent jurisdiction, preemption, and super-duper preemption?

Answer: "**Concurrent jurisdiction**" by the federal and the state courts over ERISA disputes is nowhere mentioned or impliedly precluded by any language in ERISA. The Alabama Supreme Court, as of now, holds that its state courts have concurrent jurisdiction over such cases. Intimidated by expressions from federal courts, and happy to get rid of any case, Alabama trial judges routinely dismiss ERISA cases "without prejudice" in the erroneous belief that federal jurisdiction under ERISA is "exclusive". When a complaint is filed in state court and the complaint expressly invokes ERISA, the defendant will, if the case has not already been dismissed without prejudice, remove to federal court under 28 U.S.C. § 1331, obviating the state court's need to worry about jurisdiction. The jurisdictional issue becomes moot. I do not advocate the enaction of "concurrent jurisdiction". I think ERISA cases should begin and end in federal court. If a state court plaintiff does not invoke ERISA, and invokes only state law, the defendant removes anyway, claiming that the complaint **relates** to ERISA. This is called "**preemption**". All state law liability

theories, including simple breach of contract, are deemed somehow transmogrified into federal claims and are removable under § 1331. When such a "preempted" case arrives in federal court, the defendant inevitably moves to dismiss all claims that cannot be restated by plaintiff so as to limit his remedies to those narrowly provided by ERISA. This is what I call "dragging the ship into the federal harbor for scuttling", or "**super-duper preemption**". At one time long ago, the federal courts, including the Eleventh Circuit, recognized something called ERISA "common law" to fill in the gaps, but those days are gone forever.

COMMITTEE ON FINANCE
NEWS RELEASE

Max Baucus (D-Mont.)
http://finance.senate.gov

Hearing Statement of Senator Max Baucus (D-Mont.)
Regarding Long-Term Disability Insurance

Black's Law Dictionary defines "insurance" as:

"A contract whereby . . . one party undertakes to compensate the other for loss . . . ."

Thus, an insurance policy is only good if the insurance company actually compensates the consumer, when there's a loss.

Today, we'll look at long-term disability insurance. We'll consider cases where insurance companies are failing to live up to their side of the bargain. And we'll hear ideas about how to fix that.

We'll learn about plans offered to employees through their employers. This occurs under ERISA, the Employee Retirement Income and Security Act.

And we'll compare what happens under ERISA with what happens under Social Security.

Abusive insurance company tactics start with having doctors with conflicts of interest review claims. Many of these doctors are employed either by the insurance company or by companies that do a lot of business with the insurance company.

These arrangements make it far too easy for the doctors to deny claims, terminate claims, or reject appeals.

Consider the case of Charles Tucker.

Charles's neurologist diagnosed him with multiple sclerosis. Charles's doctor said that the disease "basically disabled him from performing his occupation." Ten other doctors agreed.

Charles filed a claim with his long-term disability insurance company, Standard Insurance Company.

Meanwhile, a doctor who worked for Standard put a medical report in Charles's file. The company doctor never met Charles. The company doctor never examined him.

Even so, the company doctor concluded that "the diagnosis of multiple sclerosis is not supported . . . and the patient could return to a sedentary work activity."

When Charles found out about this report, he was, understandably, quite upset. He contacted the news media, who contacted the insurer. Only then did Standard approve Charles's claim.

Or consider the case of Rocky Whitten.

Rocky suffered a broken neck. As a result, Rocky had severe headaches, memory loss, pain, and significantly-reduced vision from all the medicines that he had to take.

Rocky's doctor said that he was permanently disabled.

But Rocky's insurance company, The Hartford, hired a private investigator. The private investigator put Rocky under video surveillance.

The private investigator took videos of Rocky getting in and out of a van, reading a magazine, and dipping corn chips into salsa at a restaurant.

So The Hartford sent Rocky a letter telling him that he was "physically capable of performing full-time sedentary occupations." And The Hartford terminated his benefits.

Rocky appealed the decision through The Hartford's internal appeals program. But the company's internal appeals program turned him down. Soon his finances became desperate.

Rocky and his attorney prepared to sue The Hartford. And Rocky reached out to the news media. The media called the company. And miraculously, The Hartford paid Rocky's back benefits and reinstated his monthly benefits.

Abuses like these are not uncommon. Thousands of cases clog the district courts.

Many claimants end up in desperate straits. Some lose their homes, their savings, and even their spouses or custody of their children.

How do insurance companies get away with these abuses? Unfortunately, loopholes in the law permit them.

First, ERISA preempts state insurance measures to address these abuses.

That means that claimants cannot get jury trials, pre-trial discovery, or the right to submit evidence to the court. And claimants cannot receive punitive or consequential damages.

Second, companies can include what's called a "discretionary clause" in their insurance plan document.

In most states, these clauses mean that it's not enough for a claimant to prove that the company's reasoning is weak when it decides to deny benefits. To win the case, the claimant has to prove that the company's reasoning is arbitrary or capricious. That's a significantly higher standard.

It's time to close these loopholes. It's time to end these abuses.

An insurance policy is only good if the insurance company actually compensates the consumer, when there's a loss. And insurance law is only good if it helps to make that happen. It's time to make sure that the law does that.

And so, let's hear what's happening in the long-term disability insurance industry. Let's hear what we might do to fix it. And let's do what we can to make sure that insurance is good for the consumer, when there's a loss.

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September 11, 2010

The Honorable Max Baucus
Chairman

The Honorable Chuck Grassley
Ranking Member

Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: September 28 Senate Finance Committee Hearing on changes to ERISA

Dear Senators Baucus and Grassley,

I am writing to beg you to amend current ERISA laws to put the protection of consumers of long term disability insurance policies on an equal footing with big insurance companies. Current ERISA laws may have once been based on an assumption of fairness and ethics by the industry but as countless examples, both in the past and in the last 10 years have shown, without checks and balances, finding ways to use laws to a company's advantage at the expense of the people who are at their mercy is all too common.

If you can do nothing else, then please allow a claimant to file for for both punitive damages and attorney fees after successfully filing an appeal or overturning a denial or termination in court. Current ERISA laws mean that any LTD insurer can arbitrarily and capriciously terminate any claim with zero risk of penalty. The only thing they have to pay is what they owed to begin with. And it's the claimant left to pay fees for attorneys and consultants because insurance companies surprisingly don't act fairly, ethically or honestly with their claimants and ERISA is so complex that most of us are too sick and/or injured to manage the huge volume of paperwork and legal knowledge required in filing an appeal. Then the money we are owed is significantly reduced by attorney fees at a time when we are struggling to pay for basic living expenses because we can't work.

Follow the Supreme Court's lead by repealing the "discretionary authority" of the Insurers. There is no possible way there is not a conflict of interest when the Insurer can decide who does or does not meet their medical definition of disabled, even with overwhelming independent medical opinions to supporting the claimants disability.

Restrict the appeal process to 1 appeal before allowing an ERISA claimaint to file suit in court. LTD insurers play the odds by dragging out and delaying the appeal process as long as possible to wear the claimant down both mentally and financially. Since there are no punitive damages, they have absolutely nothing to lose by continuing to deny legitimate claims as long as possible and everything to gain by manipulating their balance sheet at the expense of the claimant.

If, as I am sure the lobbyists for the insurance industry will tell you, these companies are acting in good faith, then they have nothing to worry about. If they are denying claims legitimately, then their financial risk is minimal. Perhaps with checks and balances in place, they will actually act with the fiduciary responsibilities they are charged with.

Reopen an investigation into UNUM. Everything they were called out for in the Multi State Settlement agreement of 2004 is everything they have done with my claim and many others:

- Deliberately targeting my claim for termination not based on any medical evidence but because it is an "own occupation" ERISA policy.
- Ignoring their own internal physician's assessment and continuing to "doctor shop" trying to get any of my MD's to recant the work limitations they have all imposed on me.
- Not ordering an Independent Medical Exam or Functional Capacity Evaluation. Since I could not perform the material and substantial responsibilities of my own occupation in 4 hours a day, I am sure Unum knew that an IME or FCE would not support their decision to terminate my claim.
- Cherry picking words or phrases from my physician's notes to support a termination even though my physician never agreed with their assessment or changed his restrictions and deliberately overlooking coexisting conditions that ended up with me having my 3rd surgery.

I am not an attorney but even I could see that UNUM's termination of my claim was arbitrary and capricious, made up of any ridiculous excuse they could think of and not based on any of the substantial medical evidence. I have spent 5 years being treated for work related injuries that have resulted in surgeries on both arms and permanent nerve damage in my right and dominant arm. None of my physicians will permit me to go back to the type of work I did before and all agree that my injuries were caused by that same type of work. My whole life and ability to take care of myself have been affected by this.

In 2008, Mila Kofman, Superintendant of the Maine Insurance Bureau, was quoted as saying that "UNUM is a model for other LTD insurers". If that is the case, then people buying LTD coverage are in deep, deep trouble. The Leopard has not changed their spots. Don't take my word for it. Talk to any ERISA attorney, talk to the American Association of Justice or anyone involved in filing appeals with UNUM. Investigate claims where they have done everything they vowed not to do. For every claim investigated in violation of the Multi State Settlement Agreement, fine UNUM. I'd be happy to share my own claim with you.

I live in Maine. I know the influence UNUM has on my elected and appointed officials but I am begging you to put special interests aside. This is truly a bi-partisan issue. UNUM and other LTD insurers don't care if you are republican or democrat when wrongfully denying claims and it affects everyone in this country who paid years for disability coverage only to find themselves injured, sick, unable to work and pay bills and in many cases going bankrupt due to companies like UNUM.

Like many in this country, I am sick to finally realize that most of the issues that affect my life and well being have everything to do with the influence of a select group of entities like Wall Street, oil companies, drug companies and yes, the insurance industry. It has to stop. The theory that as long as these top companies and CEO's are making huge amounts of money by any means possible, the benefits will eventually trickle down into an improved quality of life for the working middle class of this country is misguided and a lie.

Current ERISA laws are nothing short of a license to steal.

Thank you.

Natalie A. Messier

Natalie A. Messier

Cc:
John F. Kerry, MA
Olympia J. Snowe
Claire Green
Alan Cohen

Holder & Grover, P.A.

Attorneys at Law
77 Mt. Desert Street
P. O. Box 920
Bar Harbor, Maine 04609
general@holderandgrover.com

Jon Holder, Esq.
Kathleen Grover, Esq.
Heather Sinclair, Paralegal

Phone: (207)288-1220
1-800-864-1780
Fax: (207)288-0220
Portland Office:(207)774-2899

September 14, 2010

Claire V. Green
Congressional Fellow
Senate Committee of Finance
219 Dirksen Building
Washington, DC 205610-6200
Via Email: Claire_Green@finance-dem.senate.gov

Re: ERISA Changes

Dear Ms. Green,

A business acquaintance of mine, Linda Nee, contacted me last summer indicating that you were interested in problems with ERISA and potential changes. As an ERISA attorney representing people with claims for such welfare benefits as disability and health insurance against insurers who routinely deny claims it is my opinion that ERISA through its preemption provisions has exacted a great human cost from those to whom it was supposed to afford increased protection.

I do agree that ERISA has provided greater protection for pension plans than existed prior to its effective date on January 1, 1975. However, it appears that the welfare benefit plan provisions which have no vesting requirements were thrown into ERISA's coverage as an afterthought. That afterthought has had horrible negative consequences for the hundreds of thousands of people who have been denied ERISA governed benefits over the years since ERISA's passage. I have attached a memo from one notorious insurance company, Provident Life, now UnumGroup, which discusses how much money can be saved by having disability insurance claims governed by ERISA as opposed to state common law which has always been the law that regulated and policed the insurance industry. Removal of the latter through preemption has created a vacuum in terms of insurance regulation which ERISA has not even attempted to fill.

You can see from the attached McCall memo how much money Provident believed it could save measured by only a few cases. Imagine that translated to millions of cases.

What ERISA has really given to the insurance industry is a guarantee that there are no disincentives whatsoever to denying health or disability insurance claims because there are no compensatory damages under ERISA and there are no punitive damages under ERISA no matter how outrageously an insurance company behaves in denying benefits. Because there is no disincentive to act badly every claim that can be rationalized as a denial is denied. The insurance companies will come up with certain statistics but those are wholly inaccurate. They will for instance that they pay 90% of their claims more or less depending on the company. However, that does not include the number of claims they merely pay for a little while and then subsequently deny.

I have seen countless examples of denials which were unjust and which were only reversed because of the intervention of an attorney or the rare and lucky persistence of a denied beneficiary. One of my former clients had his benefits denied but truly could not work as a result lost his house, and because of the follow-on financial stress lost his marriage. Not surprisingly that sent him into a downward spiral to the pit of major depression.

However, the lack of any disincentive to wrongfully deny claims is but one pitiful result of ERISA's preemption. Another stems from the fact that § 503(2) of ERISA (29 U.S.C. § 1133(2)) creates a mechanism for appealing ERISA denials. Such appeals as the courts have interpreted them have become adjudicative procedures which are analogized in judicial decisions to the process by which denied Social Security Disability claimants can appeal their cases to an administrative law judge. But there is nothing in ERISA that prohibits an insurer, the very entity creating the denial giving rise to the appealed dispute from also acting as the judge of its own case. Virtually every insurer does that now. And unfortunately in every circuit court of appeals in the country claimants are required to exhaust their so called ERISA remedies before they can proceed to court. Needless to say it would be interesting to know what percentage of those appeals ever succeed in comparison with the percentage of appeals before the Social Security Administration which succeed.

Much of the difference is at the margins. A person who has terminal cancer is generally going to get benefits. That's less of a problem because they are likely to live for a much shorter period of time than someone who has a chronic illness such as rheumatoid arthritis or MS or lupus or any number of other chronic illnesses which can disable but not kill, at least not immediately.

By way of concrete example UnumGroup, which I follow closely, faced a market conduct examination in which it entered into agreements to avoid further litigation with insurance commissioners, in Maine, Massachusetts and Tennessee and ultimately nationwide with the exception of California and perhaps one or two other states. (California imposed harsher standards.) Right after the agreement was reached with Unum (then UnumProvident), Unum in its public announcements to the investment

industry conceded its benefit ratio-the ratio of premiums paid in to claims paid out expressed in a percentage so that the lower percentage is the more profitable percentage-was at 92%. It indicated at the time that it had a goal of reducing the benefit ratio to 87%. In its most recent announcement to the investment community its benefit ratio was down to approximately 84%. Each percentage drop in benefit ratio means millions of dollars to the insurer across its product line. That's not an evil, per se. This is a capitalist society and necessarily the driving and informing corporate imperative is to increase profits. Any corporation with a desire to survive is going to do precisely what it is allowed to do within the bounds of the law to increase profits. So to will its employees as long as they have some expectation of lasting at the company. As it is with children. Boundaries are required to be set.

Thus the negative double whammy of ERISA's preemption of welfare benefits and of its provision of an administrative appeal proceeding under § 503(2) which allows insurers themselves to decided their own cases really harms people who receive insurance coverage both for healthcare and for ancillary insurance benefits like disability insurance coverage and think they have real protection instead of protection that is often illusory.

There are some things which could be done by statute, although I'm certainly aware of how very difficult it is to achieve change through legislation especially at the federal level.

Perhaps the most important change would be to eliminate ERISA's preemption of state law causes of action against insurance companies. That is, 29 U.S.C. § 1144(a) could be amended to state that the provisions of "this chapter and subchapter 3 of this chapter shall supersede any and all state law insofar as they may now or hereafter related to any employee benefit plan describe in § 1003(a) of this title" with the exception of insuraned welfare benefits as defined in this subchapter and subchapter 3 provided by any insurance company licensed to provide insurance coverage of the laws of any state.

The reality is that the courts have distorted the plain meaning of the statute. The statutory language itself clearly defines the term "state law" as including ***all laws, decisions***, rules, regulations or other state action having the effect of law of any state.

If you marry the above provision with the so-called insurance savings clause § 1144(b)(2)(A) which states: "Except as provided in subparagraph (B) nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities all insurance law should be exempt from preemption.

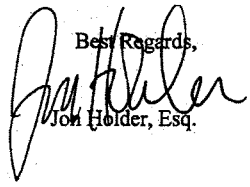
The language of the statute is actually quite clear. It undoubtedly reflects the original intent of the legislature in enacting ERISA. It is doubtful that the legislature intended to wipe out any preexisting protections under any form of state insurance law which in this statute includes common law inferentially intending that state laws of any kind which provide greater protection than ERISA (now almost any state law) should survive. Of course, a judicial shift of an ideological nature favoring corporate interests

which coincided with the whole privatization movement and the marketplace will regulate best movement basically nullified the insurance savings provisions so that no state law claim governing an insured welfare benefit could survive in parallel with ERISA, as was thought to be the case before the Supreme Court issued its tandem decisions in *Metropolitan Life v Dedeaux* and *Pilot Life Insurance Co. v Taylor.* These cases were really the brooms that swept state law entirely out of insurance regulations which now includes eliminating contrary state statutory law which might conflict with the specific remedies offered by ERISA. That is if you sue and win you get the basic benefits you were supposed to have gotten under the plan in any event. That's it. Thus just strengthening the language that obviously tried to save ERISA from preemption in the first place so that it really prohibited the courts from twisting it would go a long way toward giving ERISA welfare plan participants some sort of leverage over insurers.

Of course insurers will cry that any such change would make the provision of health and disability insurance so expensive it would become prohibitive. That is nonsense for two reasons. One argument you hear is by completely deregulating welfare benefits as ERISA has, the availability of employer supplied coverage has expanded and to impose more restrictive regulation on the insurance industry would cause employers' ability to cover employees to contract. The truth is that employer paid welfare benefits have contracted and more employees are having to pay for insurance coverage they buy through their place of work. That seems particularly unfair but as the courts have bent the law ERISA even applies to benefits paid for by employees who choose to purchase their own coverage under a group insurance plan if there is any way an insurer can say that the employer sponsored it. Unfortunately the sponsorship threshold is almost incapable of being perceived.

The other possible change, among many, is either to eliminate § 503(2) of ERISA (29 U.S.C. § 1133(2)) or modify it so that insurance companies couldn't appoint themselves the "appropriate named fiduciary" for providing "a full and fair review". That ability makes "full and fair" meaningless. As now interpreted by the Department of Labor and enjoyed the insurance industry that lets insurers become the first and most important judge of its own claim denials. And if a claimant goes to federal court what the insurer does at the so-called administrative level is what controls the outcome in court to a very large extent. Such a result suggests that, when it comes to ERISA, Congress has lost its way. It is worth bearing in mind the observation of James Madison at the time of the drafting the Constitution and the first ten amendments. Including the due process of law provision. Madison said in Federalist No. 10: "No man is allowed to be a judge in his own cause because his interest would bias his judgment and not improbably corrupt his integrity."

Best Regards,



Jon Holder, Esq.

JH/hs
Enc

PRIVILEGED

Provident Internal Memorandum

Jeff, Looks good. See comment on last page. Ken D. 10/4/95

To: *IDC Management Group*
Glenn Felton

From: *Jeff McCall*

Date: *October 2, 1995*

Re: *ERISA*

A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.

In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. Accordingly, I have attached a rough draft of questions that should be asked in our claim investigation process. I recommend that it be used for all claims. The key for determining the applicability of ERISA is whether or not the employer "sponsors" or "endorses" the plan. If the employer pays the premium, the policy would usually, but not always, be considered to be governed by ERISA. Salary allotment or payroll deduction arrangements, by themselves, do not necessarily mean that a policy is subject to ERISA. While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.

Another requirement needed in order to take advantage of the protection offered by ERISA, is to establish a formal appeal process for ERISA situations. When we deny a claim, we must include language in our letter that informs the claimant of the right to appeal our decision within 60 days. I have attached a copy of sample language. The appeal must be in writing and should be reviewed by a panel specifically established to review ERISA appeals. I recommend that the panel be composed of Chris Kinback, Bob Parks, Becky Absher, Tom Timpanaro and me.

We will be modifying the salary allotment agreements used at the point of sale to include endorsement language.

I am interested in any comments or feedback you may have on this issue.

JM:sjr

Paul Donders

PRV97/00014632

14 September 2010

Charles B. Jenkins

U.S. Senate Finance Committee
U.S. Capitol Building
Washington D.C.

Dear Chairman Baucus and members of the U.S. Senate Finance Committee,

I am writing to tell you about my experience with the long term disability (LTD) portion of the federal law known as ERISA. I will try, with brevity and honesty, to summarize who I am as a U.S. citizen, what my health is like, and how the ERISA law did not ensure me the continuity of promised benefits that I feel it should have.

My name is Charles Jenkins. I am a 48 year-old man, and a person with AIDS. I was born and raised in Southwest Illinois which is where I currently reside with my father who is a retired mechanical engineer. I earned a BA degree in Social Sciences from Southern Illinois University at Edwardsville in 1985 (g.p.a. of 4.4 on a 5 point scale). I spent six years in the Illinois Army National Guard and four years in the Army Reserves' Individual Ready Reserve. In 1982, at the age of 20, I earned an Army reserve commission as a Second Lieutenant. I honorably separated from service as a Captain in 1989. After college, I was hired by Electronic Data Systems (EDS) in Dallas, Texas; where, I learned to program mainframe computers for business applications. After several years with EDS, I left to work for the accounting firm PriceWaterhouse [as the firm was known then – currently, it bears the name PricewaterhouseCoopers (PwC)].

In December of 1993, I met with my managing partner at PwC to request the start of LTD, relating to him my diagnosis of AIDS. I immediately went on 'sick-leave,' and the process of requesting LTD status began. I am happy to say that, in 1994, I had no notable problems entering LTD status with either PwC's private insurance company (CIGNA) or public support (Social

Security). Per the PwC benefits package, I remained an employee of the firm while I was on LTD. So I was still covered by PwC for things like: dental insurance, life insurance, and most importantly, prescription drug expenses.

My health during the years that I have been on LTD has varied. First off, it should be understood that being 'HIV positive' and having 'full-blown AIDS' are very different things. The CDC says an HIV positive person with a T-cell count below 200 qualifies as having AIDS. Most healthy people have T-cell counts between 800 and 1200. The count of 200 is important because below this level many opportunistic diseases thrive in humans. My T-cell counts have varied over the years from as low as 0 (zero), to as high as the low 300's. My last count was 231. Viral load, for the last few years (the amount of virus in the bloodstream) is also an important indicator of health. My viral load, for the last few years, has been at or just above the 'undetectable' level (undetectable doesn't mean the virus is gone – just that it's so low that the test can't detect it). I have, in the past, had viral loads which were essentially off-the-chart (over 1 million). There are ramifications to having had T-cell counts so low, and for having had viral counts so high.

I suffer bouts of nausea (from the meds) and fatigue (from the disease) every day to one degree or another. I suffer from chronic sinusitis (both bacterial and fungal), chronic bronchitis, chronic joint and muscle pain, recurring warts, and an apparently untreatable rash that I have had on my face for some years now. Each of these symptoms/side-effects is unpredictable in occurrence and varies in severity from one day or bout to the next. If my T-cell count drops below 200, then I also have to contend with thrush and other opportunistic diseases. My health is bad enough that I'm not aware of any employer (whom I might reasonably work for based on my education and work experience) who would consider me 'reliable' in any sense of the word.

In January of 2006, CIGNA (the LTD plan administrator) discontinued my LTD benefit which I had been collecting since 1994. It was their contention that I should return to sedentary work, in spite of the evidence that my health

had not improved at all. I retained a lawyer (Mark DeBofsky) to assist me in filing an appeal. It took about three months for my lawyer to assemble and prepare all the data and documents needed for my appeal. It took CIGNA over three months to deny this appeal. At the end of July, 2006, PwC fired me because I had exhausted my six month grace period allotted for convincing CIGNA that I indeed still qualified for LTD status.

My lawyer then filed suit against CIGNA and PwC in federal district court. The problems with ERISA became evident to me as soon as I read the district judge's opinion which ruled against us. I am not a lawyer, but it is obvious to me that the law (read that as the 'system') is stacked against the common person. In spite of the fact, that the one doctor CIGNA hired to actually examine me in person expressed doubts about my being able to consistently work 40 hours per week, at even a sedentary job, the judge ruled against us. Of course, the insurance corporation also had three other 'paper-pushing,' not patient attending, not HIV/AIDS experienced, doctors saying that I would be just fine going back to work; even though, they had never laid eyes on me. The insurance corporation also had a physical therapist on the payroll who thought I was just right as rain.

Unfortunately for me, the district judge, and, later, the appeals judges, all bought the corporate line. They bought the opinions of non-qualified health professionals, and they allowed generalizations about people with HIV infection to sway their minds; instead of, restricting their evaluations of CIGNA's action to **my** health – **my** specific disabilities. Even though my primary doctor, who has been treating me since 1997, is a well-respected expert in the field of HIV/AIDS, these judges gave his opinion only equal weight to that of the previously mentioned physical therapist!

Further, the appeals judge, who wrote the opinion affirming the district judge, had the poor notion to compare my situation to that of basketball star Magic Johnson. I'm sure Mr. Johnson's a great guy; but, I'm not a former professional athlete with millions of dollars of pay in the bank, nor am I a celebrity with terrific connections, nor has, to my knowledge, Mr. Johnson ever been diagnosed with AIDS. Besides, even if he had been so diagnosed,

my case should have been evaluated on its own merits -- without regard to how others in similar circumstances fair. But it wasn't.

Whereas I was able to fend for myself sufficiently before, I now find myself in a difficult financial situation. As soon as I spend down what little savings I have, I will become completely dependant on government to pay my way. I will further draw down government resources, and the corporations that were actually originally responsible for these expenses are laughing all the way to the bank.

While it can be said that many find themselves in financial dire straits today, I have the added difficulty in pointing out that I thought I would be covered. I had planned ahead by buying the optional LTD insurance my employer offered, and I relied on my government to assure that the corporations would meet their obligations. I hope this letter will lead to alterations in ERISA which benefit the sick and injured – those in our country least able to fight for themselves.

Thank you for your attention to this matter.

Very best regards,

Charles B. Jenkins

Holder & Grover, P.A.

Attorneys at Law
77 Mt. Desert Street
P. O. Box 920
Bar Harbor, Maine 04609
general@holderandgrover.com

Jon Holder, Esq.
Kathleen Grover, Esq.
Heather Sinclair, Paralegal

Phone: (207)288-1220
1-800-864-1780
Fax: (207)288-0220
Portland Office:(207)774-2899

9/24/10

Claire Green
Senate Finance Committee
Via Email: Claire_Green@finance-dem.senate.gov

Hi Claire,

I enjoyed talking to you about the ERISA/Insurance problem last night because your sincerity really came through. Reforming ERISA preferably by killing its application to welfare benefit plans is so important because so many thousands of Americans are denied benefits under insurance coverage they thought they had. Either that or they are terminated early and unjustly.

You asked me to list the ways Unum has become worse since the first Market Conduct Exam forced Unum subsidiaries to agree to the Regulatory Settlement Agreement (RSA). First remember, a measure of the degree to which things have worsened for plan participants is visible in the drop in Unum's benefit ratio. (Lower is better.)

As I indicated earlier, the Unum Group benefit ratio for its group LTD product line across its subsidiaries dropped from more than 93.4% in the first quarter of 2007 to a present level of 84.6% for the second quarter of 2010. How did Unum do that? It's possible to decrease the benefit ratio by raising prices while maintaining the same level of benefits paid out (increase premium income). However, in the group insurance arena large companies choose the insurer. They either buy or make available insurance (even when the employees pay). Price competition is stiff. In fact, Unum's most recent report says, "Ongoing price competition...were contributing factors to the decline in current premium". The only other serious way you create a more favorable benefit ratio is by cutting the benefits you have to pay out. You can also reduce operating costs but those are relatively small compared to premium income and benefits paid out. Given that each percentage drop in the benefit ratio means millions of dollars retained by the company.

(Unum's premium income in group disability in the second quarter of 2010 was $520.7 million.)

ERISA has made disabled claimants the easy target for improving benefit ratios. Not surprisingly, that is the group upon which Unum has been increasing its pressure to improve its benefit ratio. It has become relentless.

The notion that the marketplace has any impact on preventing the abuses which I will itemize below is pure nonsense. A well functioning market place theory of regulation assumes perfect knowledge in all parties to a transaction. Unfortunately, the employees who ultimately get hurt have only very imperfect knowledge of the weakness of their insurance coverage and their rights, or lack of rights under ERISA. They are not the party to the insurance transaction deciding which company is to supply the insurance coverage. In short, they have no clout. Thus it's easy for a large employer to look for the lowest price without looking at the quality of the insurance product. The working men and women who do become disabled, however, have no clue until they attempt to collect. Then, when an insurer denies the claim the insured faces enormous hurdles. For one thing, few attorneys accept ERISA governed cases on behalf of plaintiffs, and fewer still are competent to handle the enormous complexities of ERISA in view of the fact that it has been defined almost drip by drip by the courts rather than by statutory provisions that are clear and accessible[1]. Additionally, the law of ERISA itself provides no disincentive, but every incentive for insurers to behave badly. The most they will lose in the end is the money they should have paid a claimant in the first place.

No one knows how many denied or terminated claimants simply give up. I suspect that it is a majority and that the group insurance industries count on that. Against that backdrop I have seen Unum increasingly employ the following tactics:

1. In cases where Unum insures employees for both short and long term disability it will frequently terminate a short term disability claim just before an employee becomes eligible for a period of long term disability benefits. That way it can claim the employee wasn't disabled long enough to qualify for long term disability. Generally there is a 6 month waiting period for LTD which is the length of time short term disability benefits usually run.

2. Insurers including Unum will frequently represent that they pay 90% of their claims. All that means, however, is that they may pay 90% of their claims initially and for a relatively short period of time. An interesting question would be: how do they account for early terminations for people who are still disabled? Unum at one time used the notation returned to work (RTW) to indicate a claim was terminated whether the claimant returned to work or not. I do not think they still do that. But they do cut people off arbitrarily and maintain that people have to reprove their entire case every time Unum wants them to do so.

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[1] Just read Judge Ackers written testimony. He is absolutely right that the courts have made a mess of ERISA.

3. Benefit terminations are sudden. The checks will stop with almost no or only a little advance warning. They will also remain stopped during the entire appeals period which is 6 months. Even if benefits are reinstated during the appeal (which is always to the insurance company itself) no interest is paid on late benefit payments.

[I think I mentioned that the Social Security Administration used to do this very thing until hearings at a Senate Subcommittee chaired by William Cohen (and I think at the time Carl Levin was the ranking minority member) instituted statutory changes that required the SSA to sustain the burden of proving a claimant's condition improved in a vocationally relevant way. A hearing was also required before a termination could actually become effective.]

4. The inclusion in disability policies/plans of a huge array of exclusions and limitations which are invariably broadly applied by the insurer to deny claims. Among these are:

- Preexisting condition exclusions (some of which apply to conditions that you may have had yet didn't see a doctor about but "should have").

- Limitations based on disabilities resulting from largely "self-reported" symptoms including generally chronic fatigue syndrome, fibromyalgia, severe migraine headaches to name but a few of the common ones.

- Limitations to disability benefits for people with mental or emotional disabilities to two years.

- Mischaracterizing disabilities: e.g. MS generally takes a substantial period of time to diagnose. During that time Unum will either characterize the symptoms as resulting from a mental or emotional problem, resulting from fibromyalgia, or resulting from some undiagnosible condition for which no benefits are payable.

5. In the regulatory settlement agreement Unum was required to accept the assessment of a qualified treating physician. Or if they disagreed with a treating physician to document in specifically detailed medical terminology why they disagreed. In my recent experience Unum always follows the recommendation of its own in house or external doctors who almost always do not examine the claimant but merely perform a paper review resulting in a grossly inadequate assessment, yet the one that will almost invariably control the outcome.

6. The RSA also required Unum to train its physicians to conduct fair and neutral medical assessments and not to attempt to bias their reading of medical records in favor of a claim denial. In almost every case I have seen since 2006 Unum physicians have blatantly looked for ways to deny claims.

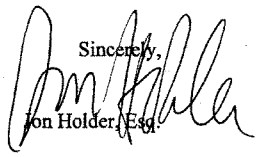
7. The RSA required Unum to cease using the phrase "no objective medical evidence" in denying claims. Unum does not use that phrase anymore. Unum now uses, "No medical evidence" in denying claims.

8. When one consulting physician favors a claimant's disability Unum will generally attempt to obtain a second consultation in hopes of finding a rationale for denial.

9. Unum will have its in house captive doctors call a claimant's treating physician to nudge concessions out of them. "Surely your patient can do some work?" "When will he return to work?" These are called "peer to peer" calls as if there was some professionalism evident.

The above represents just a partial list noting some of the more important abuses allowed because ERISA virtually provides no meaningful regulation of welfare benefit plans. Until it does so all insurers will to varying degrees visit abuses on the most vulnerable of the participants in an LTD (or health) benefit plan. Competition is intense and ERISA rewards the abusers by failing to protect plan participants.

Sincerely,



Jon Holder, Esq.

JH/hs

Patricia Fortlage

October 5, 2010

Committee Members
United States Senate
Committee on Finance
Washington, DC 20510-6200

Dear Committee Members,

I am writing to encourage amending the ERISA laws regarding long term disability insurance.

Up until 4 years ago, I worked as a very successful Corporate Human Resource Executive for a law firm in San Francisco. My annual income was over $200,000. Then I was diagnosed with Sjogrens Syndrome. This is an auto-immune neuro muscular disease that prevents me from working full-time for a number of reasons, most notably because I have lost much of the use of my hands and feet, and the remainder of my muscles fatigue with use (including swallowing, speaking, digesting, breathing, my heart, etc.).

Unfortunately it took over two years for the doctors to figure out why my muscles were fatiguing, why my blood pressure was hovering in the 80/40 range, why the blood supply was cut off to my left eye causing severe double vision, etc. I spent the bulk of this time in and out of emergency rooms only to be told 'it must be cancer, we just can't seem to find it.' Committee Members, you may be aware of how intricate the human body is and how little is truly understood about auto immune and neuro muscular diseases. The statistics show that it averages doctors about 6 years to diagnose an auto immune disease. This is not only due to limited research in these fields but more importantly due to the inherent variability of the human body. Even highly publicized conditions such as Lupus and Parkinson's Disease can take years to recognize because there is no one definitive test for them. Oftentimes it takes months if not years of simple observation before a diagnosis can be made. This does not mean that one is not disabled.

But therein lies the rub. Insurance companies do not want to pay without a diagnosis... never mind the doctors who have clinically deemed a patient disabled (do we really need to know *why* a person is disabled to consider them disabled?). And thus begins my difficulty with Unum Provident... my long term disability carrier. You see, doctors were quite clearly stating that I was unable to work. But without a diagnosis, Unum Provident decided not to pay my benefits. Instead, they are equating the state of being *disabled and not having a diagnosis* with the term *not disabled*. And because the courts will not allow

substantiated evidence beyond the date the insurance company denied benefits, even my eventual diagnosis was not considered.

And it gets worse. Why? Because the ERISA laws allow insurance companies the discretion of deciding who is disabled. They get to put doctors of their own choosing on their payrolls and then ask them their opinions of an employee's medical condition. Do we really expect this to be objective? Do you know they have a retired cardiologist stating I am not disabled? A retired cardiologist? Can I tell you how difficult it is to find a cardiologist in general who has even a hint of experience with auto-immune diseases, let alone as a specialization? I live in the SF Bay Area and have seen the best of the best... Stanford, UCSF, you name it. Most wanted to put in a pacemaker before they watched the disease progress. But there you have it. A cardiologist telling a renowned rheumatologist, neuro ophthalmologist and neurologist that they are wrong. Apparently even the folks at Social Security are wrong because they have approved my condition for disability income.

Again, because ERISA gives the insurance companies the discretion of determining who is disabled, they often don't. And why would they? After all, who without an income can afford an attorney to fight for what is rightly theirs? Not many. So the insurance companies walk away with free money - without having to uphold their end of the agreement. For me, I do indeed have an attorney fighting for my rights. As it stands right now, my attorney has logged over two years worth of hours on my case and every time it goes to a judge, that judge remands it to Unum Provident. And the cycle of discretion begins again. Should I really be forced to live on $2,030 per month when I held up my end of the bargain with timely premium payments? Given my monthly income should be $9,350, I am sure you can understand why Unum Provident has unilaterally decided I am not disabled.

Committee Members, my entire life savings is gone. Gone on medical expenses saving my life. And never did I hesitate for a moment in using my savings to keep up with my medical bills. Why would I? My insurance policy states that Unum Provident will pay 66% of my income should I become disabled. Well, here I am... disabled. Where are they? I won't take any more of your time here, but please know that I am willing to share any other details of my situation if it would be of help to anyone in this matter. I do hope you will correct the ERISA laws regarding long term disability insurance. Thank you for your time and careful consideration of this issue.

Respectfully,

Patricia Fortlage

TESTIMONY BEFORE THE COMMITTEE ON FINANCE
UNITED STATES SENATE

September 28, 2010

Mark D. DeBofsky
Attorney at Law
Adjunct Professor of Law – John Marshall Law School
55 W. Monroe St., Suite 2440
Chicago, Illinois 60603
(312) 372-5200
mdebofsky@ddbchicago.com

Introduction

Chairman Baucus; Ranking Member Grassley; Members of the Senate Finance Committee. Thank you for giving me the opportunity to testify at today's hearing.

When ERISA (Employee Retirement Income Security Act) was passed in 1974, one of the law's major sponsors, Senator Jacob Javits, hailed it as "the greatest development in the life of the American worker since Social Security."[1] That optimism was secured by a promise contained in the preamble to the statute proclaiming ERISA's purpose: to provide "appropriate remedies, sanctions, and ready access to the federal courts."[2] Yet the story told over the past 35 years has been one revealing an utter betrayal of those lofty goals and an egregious absence of remedies, sanctions, and access to normal federal court procedures. Contrary to the clearly expressed legislative intent, the courts have transformed ERISA into a shield that protects insurance companies from having to face the consequences of unprincipled benefit denials and other breaches of fiduciary duty. Claimants are denied the right to trial by jury, a basic Constitutional right routinely available in every other type of insurance case and virtually all other civil litigation. In most cases, there is not even a trial. Instead, courts conduct reviews of claim records assembled and shaped by self-serving insurance companies without hearing any testimony whatsoever, under a procedure that gives more deference to the insurance company than a court would give a Social Security administrative law judge in its review of a Social Security disability benefit claim denial.[3] Thus, the worst that can happen to an insurance company that improperly withholds benefit payments, often for years after they are due, is that a court *may* require the benefits to be paid without additional cost or penalty, although the courts have created rules that further delay the payment of benefits. Instead of simply ordering the payment of benefits when the benefit denial has been overturned, the routine practice is for courts to send the case back to the insurance company, which allows the insurer another opportunity to come up with yet another reason to deny the benefits. No damages whatsoever are available for the harm caused when benefits are

[1] 120 Cong. Rec. 29, 933 (1974) (statement of Senator Javits)
[2] 29 U.S.C. §1001(b)
[3] *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir. 1999)(Wood, J., dissenting)

wrongfully denied such as bankruptcy, home foreclosure, or even death if necessary medical treatment has been denied.[4]

Commenting on this paradox, a federal judge in California several years ago issued a special opinion in a disability insurance case recognizing "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."[5] Another judge wrote,

> *Caveat Emptor!* This case attests to a promise bought and a promise broken. The vendor of disability insurance now tells us, with some legal support furnished by the United States Supreme Court, that a woman determined disabled by the Social Security Administration because of multiple disabilities which prevent any kind of work cannot be paid on the disability insurance she purchased through her employment. The plan and insurance language did not say, but the world should take notice, that when you buy insurance like this you are purchasing an invitation to a legal ritual in which you will be perfunctorily examined by expert physicians whose objective it is to find you not disabled, you will be determined not disabled by the insurance company principally because of the opinions of the unfriendly experts, and you will be denied benefits.[6]

Judicial voices such as these are few and far between. Instead insurers gloat over how ERISA has worked to their benefit, with one industry executive bragging in an internal memo:

> The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review.[7]

The current regime cries out for Congressional reform aimed at correcting the means by which most abuses arise:

- Abolish the right given insurers to grant themselves a deferential review and allow claimants the ability to present witnesses and evidence in open court;
- Provide for jury trials;

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[4] *Sarkisyan v. Cigna Healthcare of Cal., Inc.*, 613 F. Supp. 2d 1199 (C.D.Cal. 2009)
[5] *Dishman v. Unum Life Ins. Co. of Am.*, No. 96-0015 JSL, 1997 WL 906146 (C.D. Cal. May 9, 1997)
[6] *Loucks* v. *Liberty Life Assurance Co. of Boston,* 337 F. Supp. 2d 990, 991 (W.D. Mich. 2004) (vacated following post-judgment settlement)
[7] Provident Internal Memorandum October 2, 1995

- Preclude courts from "remanding" benefit claim disputes to the insurers;
- Permit awards of statutory or other damages in appropriate cases.

The Deferential Standard of Review

In a watershed 1989 Supreme Court ruling, *Firestone Tire & Rubber Co. v. Bruch,*[8] the Supreme Court dramatically altered the litigation of ERISA claims. Although the Court recognized the typical manner of adjudicating benefit claim disputes is through a plenary proceeding, it nonetheless sanctioned deferential review of benefit denials. As a consequence of *Firestone,* so long as certain language is written into the insurance policy, courts are compelled to defer to the insurance company's determination unless the claimant can prove the benefit denial was arbitrary and capricious[9] and not merely wrong, a concept that has been elevated above the goal of assuring an accurate claim decision. That point is illustrated by a comment made in a recent federal appellate ERISA ruling involving disability benefits which pronounced: "Under no formulation, however, may a court, faced with discretionary language like that in the plan instrument in this case, forget its duty of deference and its secondary rather than primary role in determining a claimant's right to benefits."[10]

The consequences of the application of an arbitrary and capricious standard of court review are profound given the recognition by the courts that "[t]he very existence of 'rights' under [employee benefit] plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has..."[11] Examples abound:

- An employee of a major accounting firm who first received disability benefits in 1994 when his HIV infection worsened and developed into full-blown AIDS lost his benefits in 2006 despite no improvement whatsoever in his health status. Even a physician hired by the insurance company found a lack of stamina to handle a 40-hour workweek. Nonetheless, because other doctors consulted by the insurance company who had never examined the claimant thought otherwise, the benefit termination was sustained based on the insurance company's discretionary authority.[12]

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[8] 489 U.S. 101 (1989)

[9] *Pokratz v. Jones Dairy Farm,* 771 F.2d 206, 209 (7th Cir. 1985)("The 'arbitrary or capricious' standard calls for less searching inquiry than the 'substantial evidence' standard that applies to Social Security disability cases. Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action. Any questions of judgment are left to the agency, or here to the administrator of the Plan.")

[10] *Evans v. Eaton Corp. Long Term Disability Plan,* 514 F.3d 315, 323 (4th Cir. 2008)

[11] *Herzberger v. Standard Ins.Co.,* 205 F.3d 327, 331 (7th Cir. 2000)

[12] *Jenkins v. Price Waterhouse Long Term Disability Plan,* 564 F.3d 856 (7th Cir. 2009)

- A human resources specialist suffering from a spinal impairment had her benefits terminated even though a consultant hired by the insurance company to review her claim initially found her disabled. The consultant changed his opinion, though, when shown snippets of surveillance video that a dissenting judge characterized as "a highlight reel of [the insured's]most active moments during several days of surveillance." Yet the decision was sustained as being within the insurer's discretion.[13]

- Despite the findings of an expert neurologist based on imaging studies that a data processing specialist was disabled on account of a seizure disorder, a court deferred to an insurance company's finding that the condition was psychiatric, which enabled the insurer to limit the duration of benefit payments to 24 months rather than to age 65. Although the court commented it may have reached an entirely different conclusion if the standard of review was not deferential[14] that finding was of little comfort to the employee who lost his benefits nonetheless.

- A court of appeals rejected a challenge that a disability insurer failed to perform an independent assessment of the claimant's disability. The court concluded it was permissible for the insurance company to rely solely on its employee physician-consultants even though those doctors never examined the insured; and the court accepted the insurance company doctors' opinions as *ipso facto* reliable without a trial where such opinions could be subject to cross-examination.[15]

- Despite reports from doctors at the Cleveland Clinic and other prestigious medical institutions certifying the disability of the executive director of a major summer festival, along with disability findings made by the Social Security Administration and a second independent disability insurance company, an insurance company's denial of benefits was upheld as not arbitrary and capricious based on contrary medical reports submitted by physicians frequently retained by the insurer who conducted pure paper reviews.[16]

And there are many more.

The arbitrary and capricious standard also permits insurance companies to interpret ambiguous policy terms in a self-serving manner, ignoring over 200 years of insurance law principles that require ambiguities in an insurance policy to be construed in favor of the insured. Even as to the basic definition of what constitutes a "disability," courts have permitted insurance companies to interpret a clause that defines disability as the insured's inability to perform all of his or her material job duties to mean that so long

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[13] *Mote v. Aetna Life Ins.Co.*, 502 F.3d 601 (7th Cir. 2007)
[14] *Fischer v. Liberty Life Assur.Co.*, 576 F.3d 369 (7th Cir. 2009)
[15] *Davis v. Unum Life Insur.Co. of America*, 444 F.3d 569 (7th Cir. 2006)
[16] *Black v. Long Term Disability Ins.*, 582 F.3d 738 (7th Cir. 2009)

as the insured can perform a single job duty, they would not qualify.[17] That interpretation, if applied to someone like the late Christopher Reeve, a quadriplegic who required a respirator in order to breathe but who was able to speak during limited times when the respirator was not needed, could not have qualified for benefits since speaking is a material job duty of an actor.

The acceptance of the arbitrary and capricious standard has also transformed judicial oversight of ERISA benefit claim disputes into quasi-administrative proceedings where the court conducts a review of a so-called "administrative record,"[18] which, despite its lofty appellation, is nothing more than a claim file created by an insurance company. Claimants are given no opportunity to cross-examine adverse medical or vocational experts, routine discovery procedures such as written interrogatories and depositions are denied, and no trial is held. No provision of ERISA sanctions such a practice; and Supreme Court precedent establishes the impropriety of courts holding review proceedings rather than trials in civil actions not governed by the Administrative Procedure Act.[19] This insidious practice has also led to courts' willingness to overlook wholesale flouting of ERISA claim standards developed by the Department of Labor. Under the guise of permitting "substantial compliance" with the ERISA rules, courts allow insurers to unduly delay claim decisions and deny benefit claimants any opportunity to rebut adverse evidence without any adverse consequences. Conversely, unsophisticated claimants who fail to meet complex and detailed rules governing the submission of claims and appeals are given no leeway whatsoever. An example is what occurs when an applicant for disability insurance receives a favorable Social Security disability determination, which, through no fault of the insured, is not obtained until after the claim appeals are exhausted. The general rule in such circumstances is that a court will refuse to give any consideration at all to such crucial evidence.[20] It is therefore no wonder that a leading ERISA scholar has observed: "[A] self-interested plan decisionmaker will take advantage of its license under Bruch to line its own pockets by denying meritorious claims."[21]

Jury Trials

Nowhere in ERISA is there a prohibition against jury trials, yet the federal courts have almost uniformly precluded jury trials of ERISA benefit disputes even though the identical claims were routinely tried to juries prior to ERISA.[22] Since disputes involving disability benefits are essentially claims for breach of contract, several commentators have challenged the rationale behind court rulings that have precluded jury trials of

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[17] *Gallagher v. Reliance Standard Life Insur.Co.,* 305 F.3d 264 (4th Cir. 2002)
[18] *Perlman v. Swiss Bank Corp.,* 195 F.3d 975 (7th Cir. 1999)
[19] *Chandler v. Roudebush,* 425 U.S. 840 (1976)
[20] *Majeski v. Metropolitan Life Ins.Co.,* 590 F.3d 478 (7th Cir. 2009)
[21] Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA," 101 N.W. U. L. Rev. 1315, 1321 (2007)
[22] See, e.g., *Pearce v. General American Life Ins.Co.,* 637 F.2d 536 (8th Cir. 1980)

ERISA cases.[23] And no one has put it better than a federal judge who pointed to both the history and value of juries in resolving disputes over entitlement to benefits, and remarked:

> Without juries, the pursuit of justice becomes increasingly archaic, with elite professionals talking to others, equally elite, in jargon the eloquence of which is in direct proportion to its unreality. Juries are the great leveling and democratizing element in the law. They give it its authority and generalized acceptance in ways that imposing buildings and sonorous openings cannot hope to match. Every step away from juries is a step which ultimately weakens the judiciary as the third branch of government.[24]

Remands

The ERISA law lacks any provision that justifies the practice of courts allowing insurance companies the opportunity to articulate new reasons for denying claims rather than simply ordering the payment of benefits when the claim determination is overturned. Yet courts routinely "remand" ERISA claims to insurers for reconsideration even though at least one court has recognized "[i]t would be a terribly unfair and inefficient use of judicial resources to continue remanding a case to the Committee to dig up new evidence until it found just the right support for its decision to deny an employee her benefits."[25] Not only are remands extra-statutory; they also fail to fully adjudicate the parties' rights and remedies, arguably in violation of Article III of the United States Constitution which mandates that federal courts issue final decrees of conclusive character.[26] Moreover, remands offer an excuse for insurers to sloppily or inadequately evaluate a claim in the first instance. Since insurance companies are aware they will be given further opportunities to develop new reasons for denying the claim, there is no incentive to make an accurate decision in the first instance. Consequently, the practice of remands clogs the federal court system with multiple rounds of litigation.

Damages/Penalties

The addition of damages or penalties to ERISA is a necessity due to the Supreme Court's interpretation of ERISA's limited remedies which has led to tragic results. An illustration of the existing vacuum in ERISA remedies is the case of *Amschwand v. Spherion,*[27] where a widow was denied life insurance indemnity on account of misrepresentations concerning coverage made by her late husband's employer. The court

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[23] Bogan, ERISA: Rethinking Firestone in Light of Great-West - Implications for Standard of Review and the Right to a Jury Trial in Welfare Benefit Claims, 37 J. Marshall L. Rev. 629 (2004)

[24] *Radford Trust v. First Unum Life Ins.Co. of Amer.,* 321 F.Supp.2d 226, 241 (D.Mass. 2004)

[25] *Dabertin v. HCR Manor Care, Inc.,* 373 F.3d 822, 832 (7th Cir. 2004)

[26] *Aetna Life Ins. Co. v. Haworth,* 300 U.S. 227, 241 (1937)

[27] 505 F.3d 342 (5th Cir. 2007); *cert. denied* 128 S.Ct. 2995 (2008)

concluded that ERISA only permits equitable remedies; and that a claim for damages due to the misrepresentation was barred by ERISA. It is difficult to imagine that Congress intended to victimize an innocent widow by barring such a claim.

Conclusion

The reason most frequently offered for preserving the existing ERISA regime is that the current state of the law holds down costs and thus encourages the formation of employee benefit plans. But that rationale is hardly a justification for a system in which courts give more deference to insurance companies than is given to federal administrative law judges. Moreover, since employee benefits are a valuable tool utilized by employers to recruit and retain prized employees, it is extremely unlikely that employers would cease sponsoring benefit plans. Nor is there a legitimate fear of markedly increased costs. The only available actuarial study on this issue reveals that potential cost increases resulting from the elimination of insurer discretion would lead to at most a modest 4% rise in premiums.[28] To analogize, both history and common sense suggests that most consumers would willingly pay a ticket charge of $104 to fly on an airline that has a near-perfect safety record rather than paying $100 to fly on an airline perceived as being less safe. That price is a small one to pay for the assurance of more solid rights to receive benefits when they are needed in times of sickness or injury and to have confidence that those who deserve benefits receive them expeditiously while those who are not deserving are denied for valid, defensible reasons.

The ways in which ERISA can be amended to bring about these changes are not unduly complex. One possibility would be to amend the definition of "welfare benefits" in ERISA[29] to clarify that the purchase of insurance as a means of funding employer-sponsored disability, health, or life insurance benefits excludes the resulting plan from ERISA altogether, leaving claimants with the existing protections of already well-established state laws, rights, and remedies. Another proposal would be to amend § 502 of ERISA[30] to provide that claims brought under insured plans will always be adjudicated in accordance with the same plenary standards and proceedings afforded any other civil action brought in federal court.[31] Finally, the language in § 502(a)(3)(B) which currently permits plan participants to seek *appropriate* equitable relief has led to a judicial interpretation that too often results in there being no relief whatsoever available to claimants such as those aggrieved by misrepresentations or omissions by employers.[32] Simplifying the statutory language to enable recovery of relief at large would remedy a

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[28] Milliman Inc. November 14, 2005

[29] 29 U.S.C. § 1002(1)

[30] 29 U.S.C. § 1132

[31] It is important to distinguish insured welfare benefit plans from Taft-Hartley plans or other self-funded plans which have governance, funding, and other procedural mechanisms in place offering greater protection to plan participants than insured plans.

[32] *Mertens v. Hewitt Associates,* 508 U.S. 248, 256, 124 L. Ed. 2d 161, 113 S. Ct. 2063 (1993)(interpreting "appropriate equitable relief" as limited to relief typically available in equity in the 18th century)

great unfairness that currently exists. These proposed changes would restore the intent and purpose of the comprehensive benefits reform enacted by Congress more than thirty-five years ago. More importantly, such changes can help rebuild public confidence in insurance companies that have, for too long, been able to hide behind legislative shields and judicial protections that no other industry receives.

United States Senate Committee on Finance Hearing
Do Private Long-Term Disability Policies
Provide the Protection They Promise?
September 28, 2010

Responses to Questions Submitted for the Record From Mark DeBofsky

Questions from Senator Baucus

1. Mr. DeBofsky, what is your view of the 2005 Millman study, which estimated that the removal of the discretionary clause in insurance policies would increase group disability insurance premiums between 3% and 4%

   Do you believe that the conclusions of the Millman study which pertained only to the California market would also be accurate nationally?

   Although I am not an actuary myself, and cannot comment on the methodology used in the study, I am familiar with and respect the work of the actuaries who compiled the study and therefore have no reason to question the accuracy of the study. I also believe the California market is representative of the United States at large given the size and diversity of the State of California; and the statistics should therefore be accurate nationally.

   The authors of the report should also be available and would no doubt be willing to further answer these questions.

2. Mr. DeBofsky, do you believe that the abuses you described in your opening statement are systemic, or are the problems with one or two companies?

   From my extensive experience in litigating several hundred long-term disability claims, most of which were subject to ERISA, I have absolutely no doubt that the issue is systemic. Every insurer I deal with utilizes similar tactics and tends to make nearly-identical arguments in court. The point was also made by Professor John Langbein of the Yale Law School, who wrote:

   > **Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga lacks legal policy implications. On this view, a rogue insurance company behaved exceptionally badly, it got caught and was sanctioned, and its fate should deter others. The other reading of these events is less sanguine: For reasons discussed below in Part III, conflicted plan decisionmaking is a structural feature of ERISA plan administration. The danger pervades the ERISA-plan world that a self-interested plan decisionmaker will take advantage of its license under Bruch to**

> **line its own pockets by denying meritorious claims. Cases of abusive benefit denials involving other disability insurers abound. Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect.**
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> **Langbein, "Trust Law As Regulatory Law: The Unum/Provident Scandal And Judicial Review Of Benefit Denials Under Erisa," 101 Nw. U.L. Rev. 1315, 1321 (2007).**

Likewise, Edward Becker, the former chief judge of the United States Court of Appeals for the Third Circuit before his recent passing, wrote in a concurring opinion issued in *Difelice v. Aetna U.S. Healthcare,* 346 F.3d 442 (3rd Cir. 2003):

> **I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly tangled ERISA regime.**
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> *** * ***
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> **[ERISA and its remedial provisions have become] virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided."**
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> *** * ***
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> **This "regulatory vacuum" creates situations in which plan beneficiaries have little or no recourse for even the most egregious violations of their rights . . .**
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> *** * ***
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> **The unavailability of extracontractual damages has effects that are perverse. . . . it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see, Pilot Life,* 481 U.S. at 54-56, 107 S.Ct. 1549, so that if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such**

profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently.

3. Mr. DeBofsky, what needs to be done to correct the problems that have been brought up in your testimony and the testimony of other witnesses?

   First and foremost, the ERISA law needs to be amended so that courts stop giving deference to insurance companies – the arbitrary and capricious standard as applied to insurers has to be eliminated; and at the same time, courts need to treat these cases in the same manner that other litigation is adjudicated in federal court in accordance with the Federal Rules of Civil Procedure and the Federal Rules of Evidence.

   The complete elimination of ERISA preemption for all insurance claims, including those that are currently deemed ERISA welfare benefit claims (i.e., health, life and disability insurance) would fulfill a goal the Supreme Court announced in *Firestone Tire v. Bruch,* 489 U.S. 101, 114 (1989) that claimants for benefits not receive less protection than they enjoyed prior to ERISA's enactment. Alternatively, an amendment of § 502 of ERISA (29 U.S.C. § 1132) to provide that welfare benefit claims arising under unfunded benefit plans should be adjudicated in the same manner as any other claim for breach of contract would eliminate the majority of the abuses. As the Supreme Court noted in *Firestone,* while there may be a need to apply a deferential standard in claims arising under the Labor Management Relations Act, "[t]he *raison d'etre* for the LMRA standard...is not present in ERISA, which explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with plans." 489 U.S. at 102. The Supreme Court further noted in that ruling that "the threat of increased litigation is not sufficient to outweigh the reasons for a *de novo* standard." 489 U.S. at 115.

4. If ERISA rules were removed, and all private long-term disability claims were treated the same (i.e., subject to state law and remedy), do you believe that there would there be a significant increase in premiums?

   Based on the Milliman study, I do not believe the premium increases would be significant, and the gain would outweigh the detriment. As Judge Richard Posner wrote in *Herzberger v. Standard Insurance Company,* 205 F.3d 327, 331 (7th Cir. 2000), "The broader th[e] discretion [possessed by the insurer], the less solid an entitlement the employee has."

5. In your testimony, you discuss a number of cases of claims being unfairly denied by long-term disability insurance companies. You also suggest that these kinds of actions by

the insurance companies are prevalent in your professional practices and nationwide. Could you specifically tell us now if the cases you have presented in your testimony are replicated throughout your professional practices? What about nationwide?

The cases I cited in my testimony were brought by clients I represented who were themselves unable to testify before the committee. I could have also cited many other cases from my own professional practice where benefits were denied solely on account of the ERISA deferential standard of review; and from my review of similar cases brought in other jurisdictions, the cases I cited were representative of situations that have been replicated in other jurisdictions. As a further example, I cite *Brigham v. Sun Life of Canada,* 317 F.3d 72 (1st Cir. 2003), where disability benefits being paid to a paraplegic were terminated and the court upheld the insurer's actions, ruling:

> **The question we face in this appeal is "not which side we believe is right, but whether [the insurer] had substantial evidentiary grounds for a reasonable decision in its favor." ... Beyond this, it seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. Moreover, it seems clear that Sun Life has taken a minimalist view of the record. But it is equally true that the hurdle plaintiff had to surmount, establishing his inability to perform any occupation for which he could be trained, was a high one. As to that issue, we have to agree with the district court that the undisputed facts of record do not permit us to find that Sun Life acted in an arbitrary or capricious manner in terminating appellant Brigham's benefits."**

6. With regard to claims processing by the long-term disability insurance companies, Mr. Graham's testimony on behalf of ACLI states the following: "Any pattern of abuse discovered through either market conduct exams and other regulatory means can and have led to corrective actions."

   Do you think that corrective actions have been successful at eliminating unfair denial of claims?

   No. Corrective action has been limited and has primarily been brought against only one company without addressing the systemic issues that, as Judge Becker noted in *DeFelice* (cited above), create a perverse economic incentive for all companies to deny benefits. Moreover, market conduct exams are all performed after the fact; the abuses could and would have been rooted out sooner or would never have occurred had claimants been able to utilize normal discovery tools and trial procedures that all other civil litigants possess.

Questions from Senator Snowe

1. Mr. DeBofsky, thank you for raising your concerns about these employee benefit plans with the committee. The question of how claims are administered and whether insurance benefits are being properly paid are of great concern to beneficiaries, the employers who furnish these benefits, and for those of us who are policymakers both here in Washington and in the states. The ability of insurance commissioners, or the Superintendent of Insurance as we refer to the position in Maine, to oversee the insurance industry is well within the "safety clause" of ERISA.

   Insurance Commissioners are empowered to perform market conduct examinations and review the practices of insurance companies and take complaints from consumers into account when performing these examinations. Our Superintendent has worked to ensure that consumer complaints are thoroughly investigated, and the insurers in our state are quite aware that they have an active and aggressive regulator.

   Mr. DeBofsky, your testimony advocates for significantly changing insurance claim appeals that arise in ERISA plans. The questions of ERISA remedies and fiduciary standards are issues that Congress chose not to legislate upon during the massive health reform debate; and they should not be undertaken lightly by a Committee without jurisdiction. Before we consider overthrowing almost 40 years of employee benefit law, I would like to explore the remedies currently available through the regulators currently in place.

   So, Mr. DeBofsky, how often have you worked with insurance commissioners to bring to light alleged patterns of abuse by insurers? If you referred cases, could you list what actions resulted in those instances?

   The State of Maine should be very proud of Superintendent Mila Kofman. I have known Ms. Kofman for many years and admire her zealous concern for consumer protection. However, not every insurance commissioner or superintendent is as capable or focused on consumer protection as Maine's superintendent; and most commissioners are appointed from the industry itself. Many insurance commissioners are also wary of treading in an area in which there is broad federal preemption, even with the savings clause that permits state regulation of insurance. Further, even with the savings clause, state regulation is local, which creates significant disuniformities that result in a resident of Maine enjoying greater benefit protection than a resident of Montana or Iowa (or vice versa) under the identical policy of insurance. ERISA is a national law; and the only means of offering uniform protection is through federal law.

   Alternatively, Congress may choose to exempt insured welfare benefit plans from ERISA just as employers' liability and other insurance is not regulated by ERISA, consistent with the McCarron-Ferguson Act that leaves to the states the authority to regulate insurance. If an employer can sue its insurers for damages for wrongful

denial of insurance coverage or indemnity, its employees should enjoy the same rights and remedies.

In your statement you say "insurers gloat over how ERISA has worked to their benefit". In instances when you have found this to be the case, did you bring this to the attention of regulators? Do you find that market conduct examinations find patterns of abuse by insurers? Do some states do a better job of oversight than others and, if so, do you have any recommendations for addressing that?

I believe my answer to the prior question addresses much of this question as well. I have been fortunate in Illinois that our Insurance Commissioner has been responsive to these concerns; and like Maine's Superintendent of Insurance, has banned discretionary clauses in health and disability insurance policies. However, no state insurance department has the resources to conduct multiple market conduct studies in order to compare the practices of different insurers; and many lack the resources to perform any market conduct studies.

A study by the General Accounting Office may be helpful in further evaluating this issue, along with supplemental hearings to be held by the appropriate Senate and House Committees.

American Council of Life Insurers (ACLI) Statement for the Record
"Do Private Long-Term Disability Policies Provide the Protection They Promise?"
Senate Finance Committee
United States Congress
September 28, 2010

The American Council of Life Insurers (ACLI) appreciates the opportunity to appear before this Committee to discuss the important issue of disability income insurance. We thank Committee Chairman Baucus (D-MT) and Ranking Member Grassley (R-IA) for giving us the chance to discuss the critical role private disability insurance plays in helping families manage what is very often a difficult time in their lives.

The ACLI represents more than 300 legal reserve life insurer and fraternal benefit society member companies operating in the United States. These member companies represent over 90% of the assets and premiums of the U.S life insurance and annuity industry. ACLI member companies provide the majority of disability income insurance coverage in the United States.

In order to provide the Senate Finance Committee with a better understanding of private disability insurance, our testimony is intended to provide a brief overview of the product as well as highlight the value this coverage offers to policyholders and certificate holders. In addition, we summarize the current federal and state regulatory framework that governs the claims handling process.

Overview of Disability Income Insurance

If an individual becomes disabled, disability income insurance provides money to help pay ongoing bills and avoid prematurely depleting household savings they may have accumulated for a child's education or retirement. Private disability insurance is a valuable option that provides income protection that complements the safety net provided by the Social Security Disability Income program.

Private disability insurance is generally sold in two forms: short-term disability coverage and long-term disability coverage. Additionally, the market consists of disability income coverage that is sold to employers for the benefit of its employees and that is sold to an individual consumer. Approximately 39 percent of U.S workers in the private industry are covered by short-term disability insurance and about 30 percent of the U.S work force is covered by long-term disability insurance.[1]

Private long-term disability insurers provide income protection coverage to approximately 43,600,000 individuals,[2] the vast majority of which are covered through their employer. The employer is the policyholder and decision maker in choosing the

[1] National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2007
[2] American Council of Life Insurers calculation based on NAIC data as of 12/31/2009

overall benefit design. Because employers can provide these benefits in a cost-effective way, millions of workers are able to enjoy coverage.

Short-term disability coverage makes benefits available when an individual is unable to work for a short period of time due to a covered illness or injury. These policies typically provide benefits for a maximum of 13 to 26 weeks.

When an individual is unable to work for longer periods of time, there is private long-term disability coverage. This coverage usually begins when sick leave and short-term disability coverage has been exhausted. Long-term disability insurance allows policyholders to sustain themselves financially should an illness or injury keeps them out of the workplace for an extended period of time. The duration of benefits available under this type of contract varies greatly, but generally ranges anywhere from a minimum of 2 years all the way to a maximum of the insured's retirement age.

Value to Consumers

In 2009 alone, insurers paid over $8.95 billion in long-term disability benefits.

In 2008 Harris Interactive conducted a survey to assess disability insurance claimants' satisfaction with their policy, as well as their experience filing a claim and receiving benefits. Key findings from that survey were as follows:

- Overall, four out of five claimants (82 percent) said that they are very satisfied or somewhat satisfied with their policy.
- Most claimants were satisfied with the process for filing a claim (81 percent), promptness of payment (79 percent), responsiveness of the insurer (75 percent), and overall communication from the insurer (71 percent).
- Two-thirds of claimants (66 percent) did not encounter any problems with the claims process, and among those that did, the vast majority (84 percent) had their problem resolved satisfactorily.
- The vast majority of claimants (96 percent) say it is at least somewhat likely they would have suffered financial hardship if they did not have disability income protection. Furthermore, two-thirds (67 percent) say it would have been very or extremely likely that they would have suffered financial hardship if they had not received private disability insurance payments.

In addition to replacing lost income for claimants in a timely manner, private disability insurers can play a key role in restoring disabled workers to financial self-sufficiency and maintaining productivity for America's businesses. The industry has been proactive by designing policies that facilitate claimants return to work. Additionally, by investing in rehabilitation and return-to-work programs, private disability insurers are actively engaged in assisting workers with disabilities return to the workforce.

Innovative rehabilitation and return-to-work programs include a wide range of strategies in recognition of the fact that persons with disabilities are highly diverse and face varying circumstances. Services offered include medical case management, vocational and employment assessment, worksite modification, purchase of adaptive equipment, business and financial planning, retraining for a new occupation, child or dependent care benefits during rehabilitation and education expenses. These innovative benefits reflect the industry's strong commitment to promoting employment and self-sufficiency among persons with disabilities.

Disability insurers also help consumers exercise their rights under the Social Security Disability Income (SSDI) program. The integration of disability income benefits with Social Security disability benefits has long been recognized by regulators, the insurance industry and employers as an important tool in reducing the cost of disability insurance coverage and keeping it affordable so that the maximum number of employees receive coverage. Disability income insurers carefully screen their long term disability claimants to determine if it is reasonable to expect them to receive Social Security benefits. For those who are expected to qualify, insurers dedicate significant resources to help with the application process.

Furthermore, helping qualified claimants apply for SSDI provides them with important benefits beyond a simple monthly income check. These benefits include cost of living adjustments, continuing credit toward Social Security retirement benefits, and, in time, eligibility for Medicare coverage. These SSDI benefits are in addition to what disability insurers pay to help cover living expenses while a person is unable to work and earn an income.

Basics of Disability Income Insurance

The principal purpose of disability income insurance is to provide replacement income to eligible individuals who become temporarily or permanently disabled and cannot work. The benefit is equal to some pre-designated percentage of the claimant's pre-disability income. In order to ensure that over-insurance does not exist, it is not intended that disabled employees receive an aggregate replacement income from all sources in excess of that predetermined amount.

Disability income insurance is not coverage for the diagnosis or treatment of medical conditions, nor does disability income insurance provide reimbursement of expenses incurred for medical conditions.

Disability versus Impairment

As part of understanding how an individual is determined to be disabled for disability income insurance, it is important to understand the distinction between disability and impairment.

Impairment is the degree to which an individual's ability to work is effected by a change in health status. The level of impairment is evaluated in the context of the medical and other relevant documentation gathered during the claim administration process. Impairment is an important contributing factor in determining disability; by itself, it is not sufficient to determine disability.

Disability is an administrative/legal determination. The definition(s) of disability in a contract describes the extent to which an insured must be unable to perform occupational duties as a result of impairment in order to be considered disabled.

Distinguishing between impairment and disability is imperative. One individual can be impaired significantly and have no disability, while another individual can be quite disabled with only limited impairment.

For example, a paraplegic who works full-time successfully as an actuary may have an impairment but is not disabled from employment. On the other extreme, someone could have a minor impairment and be disabled, such as a concert pianist with an injury to a digital nerve that severely limits her ability to perform her basic work activities, playing piano.

A medical diagnosis and resulting impairment are not the sole factors in determining disability benefits. The decision as to whether a person is disabled under a policy involves an integrated evaluation of multiple facets. In addition to a skilled judgment regarding an insured's impairment (medical diagnosis and any resulting mental or physical limitations or restriction), a disability assessment includes an appropriate and consistent interpretation and application of contract provisions and a vocational analysis of the insured's occupational experience, training and educational circumstances. Furthermore, many disability policies contain a financial loss component within the definition of disability that necessitates a comprehensive review and analysis of an insured's pre- and post-disability financial circumstances.

Eligibility determinations for disability benefits are not static; rather, they are often made on an ongoing basis in recognition of the fact that an insured's circumstances may improve, deteriorate or remain the same. Disability income contracts typically require an eligibility determination on an ongoing basis as the insured's circumstances evolve and a different definition of disability may become applicable. An eligibility determination, whether made by the insurance carrier or other fiduciary, is only valid based on the contractual requirements and information available at that point in time.

Policy Features – Some Key Terms

When considering a disability income policy or receiving coverage as part of an individual's employment package, there are key policy features and definitions to consider.

Definition of disability: Some policies pay benefits if an individual is unable to perform the major duties of their *own* occupation. Other policies pay benefits if an individual is unable to perform the duties of *any* occupation for which they are reasonably qualified by education, training, and experience.

Many policies, primarily employer-sponsored group policies, combine these features, providing "own occupation" coverage for one or two years and "any occupation" coverage after that time frame. Employers are the decision makers in deciding the terms and provisions in the disability policies offered to their employees. Many employers choose policies with a change in definition provision because this provision makes the policy affordable. Some of the benefits of a two-year *own* occupation provision are that for the first two years, the own occupation provision is a more generous standard than SSDI's standard. After two years, many group policies then require a determination of whether an insured can perform "any *gainful* occupation." When this change in definition occurs, private insurance will continue to pay even if the person can work and yet is unable to earn a gainful wage. Thus, private insurers do not require people who have work capacity to work at a job that would pay below gainful wages.

Extent of disability: Some policies require total disability before beginning payments while other policies cover partial disability. Others may cover partial disability for a limited time, but only when it follows a period of total disability for the same cause.

Benefit level: The benefit amount an individual would receive if disabled varies by policy. The most common policy benefit pays between 60-66⅔ percent of monthly salary. Policies purchased by individual consumers generally afford the opportunity to protect a higher percentage of earned income, either as stand alone coverage or as a supplement to employer sponsored plans.

Benefit period: How long an individual receive benefits varies by policy. Some individual policies pay benefits for a specified period, such as two or five years, while others may pay benefits until age 65 or your retirement age under Social Security.

Elimination period: Policies have different waiting periods (elimination periods) before benefits begin. Typically the elimination period can be 90 days to 180 days for a long-term disability policy. The length of the insured's disability must exceed the elimination period in order to qualify for any benefits. In a group setting, the elimination period of the long-term disability benefit is often equal to the duration of the short-term disability benefit.

These are just some of the major policy features that would be in a state-approved disability policy. These features are also outlined in the certificate of coverage provided to employees covered under employer sponsored plans.

Current Federal and State Regulatory Framework for Disability Claims

In an ERISA plan, the insurer that is acting as administrator has fiduciary responsibility. As previously mentioned, eligibility determinations may be complex and require a multitude of professional opinions for benefit decisions. In addition, these benefit eligibility determinations are not static: they are often made on an ongoing basis in recognition of the fact that an insured's circumstances may change over time. Disability income contracts typically require an eligibility determination on an ongoing basis as the insured's circumstances evolve and different contractual provisions may apply over time.

It should be noted that, unfortunately, disability income insurance can be susceptible to fraud and abuse. Many states have passed regulations that require short-term and long-term disability companies to be alert to and report claims on when fraud is suspected. While fulfilling their contractual and regulatory responsibilities, insurers need to remain attentive to potentially fraudulent claims. Therefore, an eligibility determination, whether made by the insurance carrier or other fiduciary, is only valid for the information at that point in time and must be periodically re-evaluated to account for changes in the claimant's condition.

A 2008 industry study representing the majority of group disability carriers indicated that 78.8% of submitted claims were approved.[3] Of those claims not approved, over 25% were not paid because the claimant had never met the elimination period; that is they apparently recovered before the typical 90 or 180 day elimination period expired.

Most private sector disability income coverage is provided by employer-sponsored plans. These group disability policies, like all private employer-sponsored health and welfare benefits, are governed by federal law under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA regulations specify that a plan fiduciary (generally the insurance carrier in this instance) is required to act in the best interest of the plan participants and beneficiaries.

For the protection of consumers, ERISA additionally sets out detailed and specific requirements for the fair, transparent and timely handling of disability claims. These requirements address timeframes for claim decisions; requirements for keeping claimants informed and apprised of claim actions and the reasons for them; and the appeal rights afforded claimants whose claims are denied.

For initial consideration of a disability claim, ERISA:

- Requires that the insurers reach a claim decision within a "reasonable time," but at the latest 45 days from initial notice.
- Provides for up to two 30-day extensions, but only if the insurer can show reason for the extension is "beyond the control of the plan."

[3] JHA's 2008 U.S. Group Disability Rate and Risk Management Survey

- Requires the insurer to send notice of the extension to the claimant before the prior deadline passes.

- Requires the insurer to explain circumstances requiring extension.

- Requires the insurer to provide date by which a claim decision is expected (if required information is provided).

For a decision on an appeal of a claim denial, ERISA:

- Requires the insurer to reach a decision within "reasonable time," but at the latest 45 days from receipt of request for appeal.

- Allows one 45-day extension, but only if the insurer can show "special circumstances" require such extension.

- Requires notice to the claimant of the extension that explains the "special circumstances" requiring the extension and the date by which a decision is expected.

ERISA requires that, for an appeal of a claim denial:

- The review must be conducted with "no deference" to the initial claim decision.

- The insurer personnel reviewing the appeal did not make the initial claim decision and is not a subordinate of the initial decision-maker.

- If the appeal is based in part on medical judgment, the reviewer must consult health care professionals with appropriate training and experience. This consultation cannot be with health care professionals consulted for the initial decision – or a subordinate thereof.

- If claimants disagree with claim decisions, and exhaust their appeal rights as enumerated above, they also have the right to appeal denials to the federal courts.

Additional State Consumer Protections for Disability Claimants

States have also established requirements to ensure that claims are handled promptly and properly. In 1990, the National Association of Insurance Commissioners (NAIC) adopted the Unfair Claims Settlement Practices Act, which has since been adopted in various forms in 48 jurisdictions. Specifically, the Unfair Claims Settlement Practices Act outlines protections including, but not limited, to the following:

- An insurance company may not knowingly misrepresent material facts or relevant policy provisions in connection with a claim;

- An insurance company should adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
- An insurance company should affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claims;
- An insurance company must provide claim forms, and process claims, within certain outlined time periods;
- An insurance company shall provide reference to the policy provision, condition or exclusion upon which the denial is based;
- An insurance company shall notify the claimant in writing of his or her right to have the matter reviewed by the Department of Insurance if the claimant opposes a rejected claim; and
- An insurance company shall maintain adequate files for review and examination by the commissioner of insurance.

These are just a few provisions of the NAIC Unfair Claims Settlement Practices Act and the NAIC Unfair Trade Practices Act that disability income insurers are required to follow to ensure claims are paid promptly and properly. In addition, these models set out enforcement procedures that Commissioners can use to sanction companies failing to follow the law. It should be noted that the U.S. Supreme Court has upheld state laws that regulate the substance of insurance coverage as well as state insurance laws that are aimed at the insurance claims review process.

As mentioned, the consumer is made aware that he or she may file a complaint with the insurance departments, which have resources allocated to handle complaints. In addition, insurance departments also conduct periodic market conduct exams where the overall review of the insurer is performed, including the claims review department. Any pattern of abuse discovered, either through market conduct exams and other regulatory means, can and have led to corrective actions.

Conclusion

In summary, employers want to attract and retain the best employees. Employees recognize that long-term disability coverage, as a part of their benefit package, provides a valuable measure of protection in the event of a disabling injury or illness. While most people are able to return to work following a short period of recovery, some people find themselves unable to return to work within six months, and need long-term disability insurance to assist them and their families during this difficult time. A combination of public and private coverage can provide critical financial support.

The private disability income insurance industry has for many decades played an integral role in providing for the financial well-being of and peace of mind for American workers and their families. The current framework of federal and state consumer protections affords the all important balance of providing a reasonable cost of coverage and appropriate handling of claims.

Once again, the ACLI appreciates this opportunity to appear before this Committee to discuss the importance of private disability income insurance.

Statement of Senator Chuck Grassley
Hearing Before the Senate Committee on Finance
Do Private Long-Term Disability Policies Provide the Protection They Promise?
September 28, 2010

The loss of wages due to illness or injury can be devastating, both emotionally and financially. That is why Congress created the Social Security Disability Insurance and the Supplemental Security Income (SSI) programs.

In addition to these public programs, Congress has encouraged employers to provide additional protection to workers and their families through the Employee Retirement Income Security Act, known as ERISA.

Much of today's testimony focuses of the alleged failure of ERISA to protect workers from unscrupulous practices of private insurance companies. But I would caution my colleagues that legislative jurisdiction over ERISA resides in the HELP Committee, not the Finance Committee.

I agreed to this hearing based on the fact that private disability affects Social Security. Those with private insurance are often required to apply for Social Security which potentially adds to the backlog of pending applications. Moreover, changes in private disability could be viewed by some as a green light for similar changes in Social Security.

Any changes to ERISA must be carefully reviewed in terms of their impact on Social Security.

There are both differences and similarities between Social Security and private disability – ranging from the definition of disability to the standard of judicial review. Whether or not all of these parallels and distinctions are entirely justified remains to be seen.

Our goal should be to make the disability application process faster, fairer, and easier to understand. But given the looming insolvency of the Social Security disability trust fund in 2018, we must also be mindful of the need to protect this vital program for future generations.

WRITTEN TESTIMONY
BY RONALD LEEBOVE, CRC, DABFC
FOR THE U.S. SENATE FINANCE COMMITTEE
September 24, 2010

Key Findings

Do private long-term disability group policies provide the protection they promise?" The answer is "No."

There are many tricks and tactics used by the insurance companies to deny claims.

This testimony discusses two cases. In one case, a nurse with severe psychiatric problems was denied benefits, even though the Human Resource Manager said that patients would be put at risk if the claimant was allowed to return to her job.

In the other case, the insurance company continues to investigate whether the claimant can work even though Social Security – which has the strictest criteria in the industry – has concluded that she cannot work.

Private long-term disability insurance for groups of employees of an employer are covered under ERISA. It is evident that ERISA limits due process, and that legal remedies under it are extremely limited. For example, the claimant is not entitled to a jury trial.

Introduction

I hereby submit written testimony to the U.S. Senate Finance Committee. This document and its contents represent my understanding of rehabilitation management and the vocational rehabilitation process, including, but not limited to, career counseling and job placement services for the physically and/or mentally challenged individual.

I have been working in the field of vocational rehabilitation for approximately 30 years and have maintained a private practice in Scottsdale, Arizona since 1989. I perform comprehensive vocational rehabilitation evaluations of patients who have disabilities with limitations/ restrictions. The limitations and/or restrictions are severe enough to limit the individual's ability to perform life activities, including employment.

Frequently, I have rendered vocational opinions that a patient would be unable to return to their usual and customary occupation but would benefit from vocational exploration, training and job placement services. On the other hand, there are those individuals who are so severely disabled that they are unable to perform the essential functions of any occupation in the U.S. labor market. I cannot stress enough the importance of a team approach to evaluating the needs for

people with disabilities. The professionals that I use for completing an evaluation can include, but are not limited to, physicians, therapists, vocational test evaluators, special needs counselors, and human resource people.

From an ethical and professional standpoint, I have always strived to provide the very best services to the people I serve with passion, humility and respect. Patients are advised from the outset of their rights and responsibilities in completing the vocational rehabilitation evaluation process. I always let them know how important they are to me, their friends and family.

An individual can sustain a disability at any time of their life without notice. Disability can occur as a result of an illness, disease and/or by physical trauma.

The Americans With Disability Act (ADA) and People With Physical Disabilities

The Americans With Disabilities Act (ADA) has a three-part definition of *disability*. Under ADA, an individual with a disability is "a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities; or (2) has a record of such an impairment; or (3) is regarded as having such an impairment."

A *physical impairment* is defined by ADA as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine."

The definition of *work disability* is "a loss or reduction in functional capacity to meet behavioral expectations, e.g., employment as a result of impairment and functional capacity limitations attributed to a condition beyond the control of the individual, such as a medically definable impairment." The different categories of work disability include the following:

1. No work disability (absence of disability)
2. Secondary work disability, (aka secondary work limitations), i.e., limited in the kind and amount of work that can be performed, but able to work regularly at a full time job and able to do the same kind of work as previously done.
3. Occupational work disability. Able to work regularly but unable to do the same work as before the onset of limitations or unable to work full time.
4. Severe work disability. Unable to work altogether or unable to work regularly.

(Source of reference: U.S. Census Bureau)

As part of my vocational rehabilitation practice, there are five very important questions that need to be answered to determine whether a person has a "work disability" and what type. They are as follows:

1. Does the health or condition limit the kind and/or amount of work the person can perform?
2. Does the person's health or condition keep them from working altogether?
3. Is the individual able to do the same kind of work that was performed before the onset of their health or condition?
4. Is the individual able to work full time, or can they work only part time?
5. Is the individual able to work regularly, or can they only work occasionally or irregularly?

The answers to these questions, including the definition of "work disability" can be traced back to the vocational rehabilitation evaluation that is objectively performed by me on a daily basis with the patients that I serve.

Prior to submitting this written testimony to the U.S. Senate Finance Committee, I provided substantial evidence, including patient case files, regarding people with disabilities who have long-term disability claims with private insurance companies. These materials identify the abusive behavior and disregard for people with disabilities. In my written testimony to follow, I will identify the dirty secrets and various tactics used by these companies to deny claims. Moreover, these large insurance carriers operate under a shroud of secrecy and deceit.

Non-ERISA Versus ERISA Disability Policies

In order to understand the ramifications of ERISA, it is important to identify the differences between non-ERISA and ERISA long-term disability policies.

An article entitled "Disability Benefit Claims" at www.disabilitybenefitattorneys.com explains the differences between non-ERISA and ERISA, quoted as follows:

1. *Non-ERISA disability cases are governed by state law.*

   Holders of individual disability policies have significant advantages over those whose benefits are provided through an employee benefit plan. When you purchase a disability insurance policy from an insurance broker, you are entering into a contract with an insurance company. If the insurance company later denies your claim for benefits, your claim is governed by state law. You have the right to file a lawsuit in state or federal court, and the dispute will be resolved by a jury of your peers. You have the right to bring witnesses to the court to support your claim. In addition to the claim for breach of contract, you might be able to raise

additional claims if the insurer's refusal to pay constitutes bad faith. Many states, including North Carolina, have state consumer protection statutes that allow recovery of treble damages and attorney's fees. Punitive damages may be available if the insurance company's conduct is bad enough.

2. *Employee benefits are controlled by ERISA.*

   A different law applies when disability benefits are provided by an employer. Disputes are governed by a federal law, called ERISA, which stands for the Employee Retirement Income Security Act of 1974. A law that deals with "employee retirement security" sounds friendly, but in reality ERISA provides significant advantages for the employer or insurance company. The claimant is not entitled to a jury trial. Usually, there is no trial at all.

   In an ERISA case, the court typically does not decide whether the claimant is disabled. Rather, the court's role is limited to reviewing the plan document and the claim file to determine whether the claims administrator abused his or her discretion. Under this limited standard of review, the claims administrator's decision will be upheld if it is reasonable. The claims administrator does not have to give greater weight to the claimant's treating physician, and may decide to accept the evaluation of one of its own staff physicians, even if that doctor never examined the claimant.

   ERISA restricts the court's review to documents that were available to the claims administrator at the time it issued its final decision. Evidence obtained after the claimant has exhausted his or her administrative appeal cannot be considered by the court. Therefore, it is of paramount importance that the claimant fully develop the evidence in support of his claim, and submit such evidence to the claims administrator during the claim process.

To summarize, the differences between non-ERISA and ERISA, it is evident that ERISA limits due process, and that legal remedies are extremely limited.

It is important to point out that the claimant in most cases is responsible for providing proof that they are totally disabled and unable to work. In contrast, unfortunately, the private long-term disability insurance companies and, more specifically, their claims departments will, in most cases, use deceptive and dirty tactics to deny claims.

The article further states:

> *Generally, disability coverage offered by an employer will provide that a claimant will be considered disabled if he is unable to perform "the material and substantial duties of his occupation," or sometimes "each and every material duty of his occupation." The meaning of those phrases is sometimes not readily apparent. The term "occupation" is broader than "job." Job duties that are not*

generally required to perform the occupation will be disregarded in assessing disability. The definitions of total disability are sometimes construed so that the claimant will not be considered disabled if he is able to perform some, but not all of his job duties. Therefore, when the appeal involves the "own occupation" definition, the starting point should be a detailed job description and an assessment of whether the claimant is unable to perform each of the duties on a full time basis.

Employee benefit plans usually provide that after two years the claimant will be considered disabled only if he is unable to perform "any occupation for which he is reasonably suited by reason of age, education or experience." This is a harder definition to meet, as it requires proof that there is no job that the claimant can do.

Insurance policies frequently limit benefits for mental illnesses to two years. It is important to distinguish between true mental illnesses and cognitive problems caused by physical conditions such as traumatic brain injury, hypoxia or stroke syndrome. The terms of the coverage will differ depending on the policy language.

The terms and limits for long-term disability policies are similar from one company to the next.

Social Security Administration Definition of Disability

The Social Security Act defines disability (for adults) as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or expected to last for a continuous period of not less than 12 months" (Section 223 [d][1]). Amendments to the Act in 1967 further specified that an individual's physical and mental impairment(s) must be ". . . of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work" (Section 223 and 1614 of the Act). Social Security disability programs only pay for total disability and not partial or short-term disability.

Therefore, there are substantial differences with regard to the definition of disability by the Social Security Administration and the one that is offered by private long-term disability insurance companies. Social Security's criteria are the strictest in the industry.

"Do Private Long-Term Disability Policies Provide the Protection They Promise?"

I am in receipt of a letter from the Senate Finance Committee confirming my testimony on September 28, 2010 at 10 a.m. The subject to be discussed is "Do private long-term disability policies provide the protection they promise?" In order to answer this specific question, there needs to be an understanding of how private long-term disability insurance companies operate their claims departments. More specifically, "Do they act responsibly in evaluating each claim?" My response to that question is "No." There are many tricks and tactics used by the insurance companies to deny claims. They may include, but are not limited to, the following:

1. The medical records are not completely reviewed by the claim examiner and/or records are omitted.

2. Insurance companies hire physicians to perform Independent Medical Exams (IMEs). These examinations are performed by physicians who are paid by the insurance companies to write negative reports and identify that there is no permanent disability that warrants benefits. I have attended and observed over 100 IMEs in the past 15 years. The interviews and physical exams are extremely limited. In comparison, I had one case with 400 pages of medical records to review, whereas the doctor performing the IME had only 30 pages to review, and the insurance company selected the 30 pages that they wanted the doctor to read.

3. It is a common practice for insurance claims examiners to bombard patients and their treating physicians with claim forms to be filled out. The patient is unaware that on many of these forms, there are trick questions and that their responses likely will result in denial or termination of benefits. Many of the questions that are asked of treating physicians on claim forms are very suspicious and are leading questions. An example of a leading question may be, "Doctor, you would agree that your patient will be able to return to work within a short period of time, correct?"

4. Another tactic used by claims examiners to deny claims is to send a disability report form to the treating physician and require a response within 14 days. If the physician has not responded in that period of time, the claims examiner will likely omit and/or not include those medical records as part of the claim review.

5. It is always the responsibility of the patient to prove their disability status. More specifically, claims examiners will tell the patient, "You must prove to us your functionality or lack of." In contrast, when a patient visits a medical doctor, the doctor does not begin by assuming that the patient is disabled or not disabled.

6. Insurance companies will refer claimants for Functional Capacity Evaluations (FCEs). This form of testing takes approximately three to four hours to complete and requires the patient to perform various types of physical activity over a three to four hour period. Sometimes, the patient is required to return for a second day of testing. It is important to point out that Functional Capacity Evaluations are

frequently used by insurance companies as a tool to distort a patient's true functional limitations. More specifically, there is actually a component of the testing that purportedly identifies if the patient is a malingerer. Moreover, claims examiners will schedule patients for FCEs with very little advance notice and will not notify the treating physician that the testing has been scheduled. If the patient does not show up, the patient can be deemed noncompliant and charged for a no-show.

7. One of the most grievous tactics used against a claimant is surveillance. Even though the claimant has demonstrated that they have a severe disability with limitations and restrictions, the carrier will use hidden cameras and electronic devices to devise some scheme that purports to show the individual is faking their medical conditions, so that benefits can be denied or terminated.

8. It is interesting to point out that some, if not all, long-term disability insurance companies are having claimants fill out and sign a supplemental information form. What the claimant may not know is that by signing the document, they are giving blanket authorization to the insurance company to request and obtain all records from any source without the claimant's knowledge. These can include medical, psychiatric, drug, alcohol, employment, financial, credit, Social Security, and all other forms of data pertaining to activities. The claimant is advised when reading the form that if they do not sign and date it, their benefits can, or likely would be, terminated. Therefore, the claimant is faced with a very difficult choice. Moreover, some claimants who are not capable of understanding the form are asked to sign it.

9. Claims examiners or representatives of the insurance companies have been known to contact claimants and/or their families and chastise or harass them. In one of the cases that I submitted to the committee for review, the individual was contacted telephonically and was told, "You are not disabled. You can work and you had better go out and find a job." This caused the patient great fear and consternation. This patient remains totally disabled and unable to work. He has not been cleared by any of his treating physicians to engage in work activities.

10. I mentioned earlier in my written testimony that insurance company claims departments operate in a shroud of secrecy and deceit. Over the past couple of years, I have tried to find out the credentials and background for claims examiners, including their education. I have directly asked one claims examiner for his credentials and that person refused to give me any information. That being said, I ask what are the qualifications and credentials that enable claims examiners to be judge and jury for insurance companies.

11. Long-term disability insurance companies, and more specifically their claim departments, use the term "noncompliance" for purposes of intimidation, to demoralize, confuse and outright threaten with denial or termination of benefits.

There are two distinct definitions for the term "noncompliance" that apply to insurance company usage.

They read as follows:

The situation in which an applicant/recipient fails to cooperate or comply with program requirements (i.e., work or child support requirements).
(Source: www.dhs.dc.gov/dhs/cwp/view.a.1345.g.605720.dhsNay_GID.1728.asp)

The failure to achieve performance criteria of a regulation or authority.
(Source: www.shedsrus.com.au/v/vspfiles/assets/images/diy%20glosary.htm)

I have personal knowledge, verbal and written, from patients and their families regarding the aggressive use of the term "noncompliance." Here is an example. John Smith receives notice from a claims examiner that he must appear for a Functional Capacity Evaluation (FCE). At the same time, the patient's treating physician has not been notified that the testing has been scheduled. Moreover, I am contacted by the treating physician who recommends that the testing not be administered because it could cause significant physical harm and exacerbation of symptoms for his patient. Even though permission was not granted for the testing to be administered, the assigned claims examiner informs John that unless he appears for the evaluation, benefits may be terminated or denied. The explanation for termination or denial of benefits is that John was "noncompliant for not attending a scheduled and mandatory examination."

All of the information that I have just disclosed clearly demonstrates the ruthless and inhumane treatment of people with disabilities. Later in this written testimony, there will be a discussion of two case files that have already been submitted to the committee for review. These case files further indicate my concern with how claims are processed and evaluated at long-term disability insurance companies and, more specifically, in their claims departments.

Allsup, Inc.

I have conducted research regarding Allsup, Inc. On their website (www.allsupinc.com/disability-insurance.aspx), they state:

Allsup is the first and largest company to provide nationwide Social Security representation services. Our understanding of the complex Social Security process, coupled with our system capabilities and operational scope, has yielded outstanding results for our clients over the years.

Since 1984, we have recovered over $490 million in benefit overpayments and reduced future plan liabilities by more than $5.1 billion for our clients.

Allsup wins SSDI awards for 98 percent of the people represented through all levels of appeal. And more than 60 percent of our awards are granted at the Initial

and Reconsideration levels, resulting in faster SSDI offsets and smaller overpayments.

We recover 86 percent of disability plan overpayments within an average of 14 days from the time the Social Security Administration releases funds to the employee.

The company goes on to say:

Allsup Gets It℠

Maximizing Social Security Disability Insurance (SSDI) offsets and overpayment reimbursement can reduce your annual disability claims costs by millions of dollars.

However, the process to realize these gains is full of challenges. Employees are ill-equipped to apply on their own. Claims personnel have heavy workloads and limited SSDI experience. Employees often forget they must repay overpayment funds. And recent court cases have further reduced a plan's ability to recover overpayments under ERISA.

Since 1984, Allsup Inc. has helped hundreds of companies, local governments, insurance carriers, third-party administrators and law firms properly coordinate employee benefits and workers' compensation plans with Social Security and Medicare.

Another information section by Allsup at the same website says:

A Source of Hidden Profitability Overlooked in Thousands of Companies

Literally, hundreds of millions of dollars are at stake. You can significantly reduce disability, group health and workers' compensation plan liability by properly coordinating with Social Security and Medicare. By transferring liability to these federal programs, employee benefits and workers' compensation costs are significantly minimized.

Even if you have a process in place for managing SSDI offsets and overpayment recovery, we can find room for improvement. Our Seamless ORS® process will help you recover the maximum in SSDI offsets. And you only pay for results. We only charge a fee when we win an SSDI award.

Allsup provides what it calls "Overpayment Reimbursement Service." Under this heading on their website, it says:

Maximize Social Security offsets and overpayment reimbursements for disabled participants. With our Overpayment Reimbursement Service, we will:

Screen:	*Using proven criteria, we will determine if claimants are suitable for pursuing SSDI benefits.*
Represent:	*Complete SSDI application forms, compile medical documentation and represent claimants through appropriate levels of appeal.*
Reimburse:	*Withdraw overpayment funds directly from claimant's bank account using our patented electronic process.*
Track:	*Monitor the disposition of all claimants who have applied for SSDI without Allsup's assistance or who have return-to-work potential.*
Report:	*Inform you of the SSDI application and overpayment reimbursement status for all claimants being represented or tracked by Allsup.*

I find Allsup's information that I have quoted from their website to be extremely troubling. This appears to be a violation of privacy. Moreover, Allsup is telling corporate America, and more specifically the insurance industry, that they are able to manage more effectively SSDI offsets and overpayments recovery. This, they say, can be accomplished by transferring liability to federal programs. What Allsup is really saying is that corporate America can reduce their expenses and at the same time increase profits for stockholders at the expense of the taxpayer.

Long-Term Disability Insurance Company Referrals To the Social Security Administration (SSA)

It has been widely publicized in the media that the Social Security Administration faces financial challenges in the future and that lawmakers are looking to find financial relief for the system. On the other hand, long-term disability insurance companies are looking for ways to reduce their liability while, at the same time, increase profits. Claimants are being forced to apply for Social Security Disability Income (SSDI) even though, in many cases, the carrier knows that the claimant does not meet SSA's requirements for benefits. As a result, the Social Security Administration is being charged with the costs for processing these applications. This is unfair to the taxpayer.

In the event that some of the referrals to the Social Security Administration are approved for SSDI, the long-term disability carrier will reduce their own monthly payout by the amount of the Social Security award. This is called an "offset." Additionally, the long-term disability company will request to receive any retroactive monies that are owed to the claimant from Social Security. These monies are described by the insurance company as "overpayments," but are they

really overpayments? The answer is "No." I believe these monies should be rightfully returned to the taxpayer.

It has been brought to my attention that the average cost (at taxpayer expense) to evaluate a Social Security claim is in the range of $600 to $1,500 and that the cost is based on how far along in the system the case is evaluated.

The subject of the hearing is "Do Private Long-Term Disability Policies Provide the Protection They Promise?" Taking into consideration the monies that are recouped by long-term disability insurance companies for offsets and what they describe as overpayments, one has to seriously question whether the insurance carriers are providing protection for disabled claimants, or is the Federal Government covering the price tag at taxpayer expense?

I mentioned earlier that long-term disability insurance companies were flooding the Social Security Administration offices with referrals and that the cost of evaluating each claim ranged from $600 to $1,500. If the insurance companies were required to reimburse the Federal Government for referral and evaluation of claims, would they still make the same large number of referrals to SSA offices? I don't know. It is my opinion that if they continue to request offsets and overpayments, then they should be required to reimburse the Federal Government for Social Security referrals and evaluation of claims.

Case File Reviews

Case No. 1 – Mary F.

Mary F. is a 59-year-old female who was referred to me for a vocational rehabilitation assessment and evaluation. She has a long history of treatment for psychiatric/psychological issues. In May of 2005, Mary was hospitalized in a behavioral health hospital for a suicidal attempt by overdosing on prescription medications. My review of the medical records indicate that the patient has struggled with depression, anxiety and stress for many years. Her treatment for major depression has included psychotherapy and medication. In April of 2009, Mary was hospitalized again in a behavioral health hospital for a major depressive episode with suicidal thoughts.

From a vocational rehabilitation standpoint, Mary has had difficulty maintaining employment. Her most recent job was as a Telephone Nurse Case Manager. A review of the personnel file from the employer identified critical problems with Mary's employment. They included difficulties with concentration, attention, memory and stress. The Human Resource Manager at the company informed me that Mary had to be terminated from employment because of her inability to work with patients and to complete tasks on a timely basis. *The most critical issue expressed by the Human Resource Manager was that Mary would be putting patients at risk.*

Mary had a short- and long-term disability policy with Cigna Group Insurance. She applied for the short-term disability and was terminated after approximately 25 weeks. She appealed for

benefits to be reinstated and, if this were to occur, she would subsequently be entitled to long-term disability benefits. Unfortunately, Cigna Group Insurance denied her appeal on the grounds that her condition is episodic. In other words, she is not permanently disabled. There is a lengthy report from Ms. Susan Heliker, Appeal Claim Manager at Cigna, that contains mistruths and inaccurate or missing information, including omitted psychotherapy treatment notes. The omitted psychotherapy notes are used to argue that her illness was only episodic. I have furnished the Senate Finance Committee two binders with records, including comprehensive psychological and psychiatric records, including my vocational rehabilitation assessment and evaluation report dated March 30, 2010.

Based on the psychological and psychiatric evidence, including my vocational rehabilitation assessment and evaluation, this patient is not capable of performing the usual and customary functions of her job as a nurse. Her treating psychologist and psychiatrist have clearly identified the critical issues that would prevent her from returning to any type of work activity for up to 12 months. Yet, Cigna was willing to put patients at risk and deny Mary her critical income in order to save money.

I will respectfully respond to questions during the hearing regarding Mary F.'s case file and the issues that prevail today regarding her health and denial of benefits by the Cigna Group Insurance Company.

Case No. 2 – Jamie F.

Jamie F. is a 45-year-old female who was referred to me by her ophthalmologist. She has for some time been diagnosed and treated for "optic atrophy and severe visual loss secondary to multiple sclerosis and optic neuritis."

Jamie's distance visual acuity with correction is 20/400 right eye and 20/200 left eye. Thus, she is legally blind. She is only able to read large printed material with the use of visual aids. Her visual fields are limited, as reported by her treating physicians.

Initially, I performed a vocational assessment/evaluation to determine Jamie's functionality and ability to perform competitive work activity. After reviewing the medical evidence, including a consultation with her ophthalmologist and conducting a rehabilitation interview with the patient, it was my opinion that she was too disabled and unable to work.

At the time that Jamie was referred to me, she was receiving long-term disability benefits through The Hartford Insurance Company. Coincidentally, the last job that she performed was for The Hartford Insurance Company.

Jamie was entitled to receive long-term disability benefits from The Hartford Insurance Company, based on her severe physical limitations/restrictions and the fact that she could not perform the essential functions of her usual and customary job. It is also important to point out that she was required by The Hartford Insurance Company to apply for Social Security Disability benefits. Social Security's criteria are the strictest in the industry. She was approved for

benefits by Social Security, and the long-term disability carrier deducted the amount of her Social Security payments from the total amount she would have received for her long-term disability (offset).

At this point in time, Jamie has been informed by The Hartford that there is an investigation being conducted to determine whether she remains totally disabled and unable to work. This is outrageous. From a vocational rehabilitation standpoint, The Hartford Insurance Company is more or less saying that a person receiving Social Security Disability Income (SSDI) is not necessarily disabled under The Hartford's own criteria, even though Social Security's criteria are the strictest in the industry. This is unfair to the claimant.

To summarize, I have submitted to the Senate Finance Committee the file of Jamie F. The medical evidence and documentation is complete, and I will be available to answer questions regarding Jamie's medical status and her inability to perform any competitive work activity at this time.

Responses to Questions Submitted for the Record From Ronald Leebove

Questions from Senator Baucus:

1. **Mr. Leebove, do you believe that the abuses you described in your opening statement are systemic, or are the problems with one or two companies?**

   Answer:
   It is my opinion that the abuses that I have addressed in my oral and written testimony are systemic. More specifically, these abuses are widespread and are conducted against disabled individuals continuously all the time.

2. **Social Security has a stricter definition of disability than most insurance companies. In view of this, do you think it is reasonable that many insurance companies terminate benefits under their policies shortly after the social security administration awards disability benefits?**

   Answer:
   No, it is not reasonable that insurers terminate benefits shortly after the Social Security Administration awards benefits. I find this very troubling that the insurers consider the claimant "disabled" when the insurers require the claimant to apply for Social Security Disability Income (SSDI). Shortly after approval for SSDI, the insurance company takes a different position and will typically say that the claimant is no longer disabled even though the Social Security Administration has deemed the claimant to be totally disabled and unable to work. It is common practice that the insurance company will terminate benefits for the claimant only after they have collected the retroactive monies owed to the claimant, whereas the insurance companies consider these monies to be an overpayment.

3. **Mr. Leebove, please comment on the personal experiences you have witnessed on the tactics that insurance companies have been accused of employing.**

   Answer:
   Please refer to my written and oral testimony that clearly identifies the tricks and tactics that are used against claimants that are disabled.

4. **Mr. Leebove, please tell us your experience with Allsup. Do you believe that the representation they offer is adequate and has the claimant's interests in mind?**

   Answer:
   In response to this question, please refer to pages 9 through 11 of my written testimony that clearly identifies the inappropriate role that Allsup maintains. More specifically, Allsup has a dual role, in referencing claimants to apply for SSDI benefits while at the same time working diligently for the insurers to collect the retroactive monies owed to the claimant by utilizing their overpayment recovery system (ORS), which is patented. Allsup's dual role does not have the claimant's best interest in mind. Allsup is telling corporate America, and more specifically the insurance industry, that they are able to manage more effectively SSDI offsets and overpayment recovery.

5. **In your testimony, you discuss a number of cases of claims being unfairly denied by log-term disability insurance companies. You also suggest that these kinds of actions by the insurance companies are prevalent in your professional practices and nationwide. Could you specifically tell us now if the issues and cases you have presented in your testimony are replicated throughout your professional practices? What about nationwide?**

   Answer:
   Yes, the practices of claimants being unfairly denied benefits by long-term disability insurance companies are prevalent and nationwide.

"Do Private Long-Term Disability Policies Provide the Protection They Promise?"

Statement of

David A. Rust

Deputy Commissioner

Retirement and Disability Policy

Social Security Administration

Before the

Senate Finance Committee

September 28, 2010

Introduction

Chairman Baucus, Ranking Member Grassley, and Members of the Committee:

Thank you for inviting me to discuss our disability claims process and the scope of review at each level of the process. The Social Security Act (Act) provides cash benefits to persons with disabling physical and mental disorders under two major programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

SSDI provides benefits to workers with disabilities and to their dependents and survivors. Workers become insured under the SSDI program based on contributions to the Social Security trust funds through taxes on their wages and self-employment income. Under the Act, most disability beneficiaries must be entitled to SSDI benefits for 24 months before they may receive Medicare.

As defined by the Act, we can find claimants disabled only if their medical condition(s):

- Prevents them from performing their previous work;
- Prevents them from performing other work that exists in significant numbers in the national economy, considering their age, education, and past work experience; and
- Their disability has lasted or is expected to last for at least one year or result in death.

SSI is a Federal program funded by general tax revenues (not wage and self-employment income taxes) designed to provide cash assistance to aged, blind, and disabled persons with little or no income to meet their basic needs for food, clothing, and shelter. When determining whether an adult claimant for SSI is disabled, we use the same definition of disability as we do for SSDI. In 1996, Congress enacted a unique definition of disability for children.

In addition to cash payments, most SSI beneficiaries receive Medicaid health insurance coverage from the States.

Our disability programs assist some of the most vulnerable members of our society. In fiscal year (FY) 2009, we paid $115 billion in SSDI benefits and over $40 billion in Federal SSI benefits based on disability or blindness. As of December 2009, over 9 million Americans were collecting SSDI benefits and over

6 million Americans were collecting SSI based on disability or blindness. Indeed, our disability programs constitute a crucial part of the fabric of the Nation's social safety net.

Disability Claims Process

Our disability process consists of several stages. When we receive a disability claim, we generally send the claim to a State disability determination service (DDS), which is responsible for developing medical evidence and making the initial determination of whether a claimant meets our definition of disability. We fully fund all costs associated with making these determinations, including the salary and benefits of DDS employees.

If the claimant is dissatisfied with the initial disability determination, our regulations provide for three levels of administrative review. The levels are as follows: a reconsideration by the DDS; a hearing before an administrative law judge (ALJ); and a request for review by our Appeals Council. If the Appeals Council denies the request for review (or if the Appeals Council issues a decision), the claimant may appeal to Federal district court. We are currently testing a prototype project in ten states that authorizes the disability examiner to make the initial disability determination alone (instead of working with a medical or psychological consultant) in some cases and eliminates the reconsideration step.

I will explain each of these steps in more detail. As you know, we face a surge in disability claims due to the economic downturn and the aging of the baby boomers. Therefore, I will also briefly touch upon the steps we are taking to address these workload issues. Thanks to Congress' support, we are currently on-track to reduce pending initial disability claims to a pre-recession level by 2014 and to eliminate the hearings backlog in 2013.

Initial Determination

A claimant can apply for disability benefits online, by telephone, or in a field office. An SSA claims representative interviews all claimants filing their claims by telephone or in a field office. During this interview, the claims representative explains the definition of disability and our disability claims process and obtains all required applications and forms. When claimants file online, our system provides the definition of disability and an explanation of the claims process, and a field office employee reviews the information the claimant provided. Our system will generate alerts when the information appears incomplete or incorrect, and a

claims representative may contact the claimant. If a claim does not require a medical determination, the claims representative may make an initial determination; however, in most cases, the claims representative forwards both paper and electronic claims to the DDS to make a disability determination.

When a disability claim reaches the DDS, a disability examiner handles the claim. The examiner requests evidence, schedules follow-ups, verifies that all medical documentation is complete, and verifies that there is enough medical evidence to make a disability determination. If the examiner needs additional medical evidence, he or she will re-contact the claimant, re-contact the medical source, or schedule a consultative exam.

Once there is sufficient medical evidence to make a determination, the examiner works with a medical or psychological consultant to determine whether the claimant is disabled. Depending on the nature of the disability alleged by the claimant, this medical consultant is a licensed physician, optometrist, podiatrist, or a qualified speech language pathologist. A psychological consultant is a psychologist who has the same responsibilities as a medical consultant, but who can evaluate only mental impairments. When deciding the claim, the examiner and medical or psychological consultant must consider all of the evidence in the file and make a determination based on a preponderance of the evidence. In some States, experienced examiners, known as single decision makers, may make certain disability determinations on their own.

If the DDS finds the claimant to be disabled, we notify the claimant and alert the field office to begin payment effectuation. If the DDS does not find the claimant disabled, the DDS sends the claimant a denial notice that explains the determination and provides the claimant with additional information, such as how to appeal the determination. Any claimant dissatisfied with the initial determination may appeal it by requesting reconsideration.

Nationwide, we expect to receive more than 3.2 million initial disability applications in FY 2010, which represents over 600,000 more than in FY 2008. Through our hard work and improved processes, we will keep initial disability claims pending below the FY 2010 target. However, there will still be approximately 860,000 claims pending at the end of FY 2010.

To keep pace with our increasing initial workloads, we implemented technology solutions, updated and simplified program rules, and adopted initiatives that are helping us reduce our hearings backlog. For example, in FY 2009, we

implemented our easy-to-use online application, iClaim, which allows claimants to file for benefits online at their own pace and at their own convenience. iClaim helps us adjudicate more claims and reduces field office waiting times. We also expanded our adjudicative capacity by hiring additional front-line staff and creating extended service teams to help States keep pace with the increase in disability claims.

Under the President's FY 2011 Budget, we expect to decide over 3.3 million initial disability claims in FY 2011 and begin to reduce the initial claims disability backlog.

As I explained earlier, we fully fund all costs associated with making disability determinations, including salaries and benefits of DDS employees. Nevertheless, some States have furloughed or imposed hiring restrictions on these employees in a misguided attempt to respond to their financial crises. These furloughs succeed only in slowing benefits to some of our most vulnerable citizens, while providing no fiscal relief to the States. We believe the furloughs are unwarranted and would be pleased to further discuss the issue with you.

Reconsideration

The reconsideration stage is the first level of appeal in our disability claims process. A team consisting of a disability examiner and a medical or psychological consultant, neither of whom were involved in making the initial determination, reviews the claimant's case. If necessary, the team will request additional evidence or a new consultative examination.

Like the team that makes the initial determination, the team that makes the reconsideration determination bases the determination on a preponderance of the evidence. The team is not bound by the determination made at the initial level, but rather reviews the evidence *de novo*, with a fresh set of eyes. The reconsideration determination is independent, made without reference to the initial determination.

If the claimant is dissatisfied with the reconsidered determination, the claimant has 60 days after the date he or she receives notice of the determination to request a hearing before an ALJ.

We are seeing a steady increase in our reconsideration workload, which is a direct result of the increase in the number of initial disability claims. Reconsideration

filings rose about 14.3 percent, or 88,897, over this time last year. Despite these challenges, the DDSs have handled 698,071 reconsiderations through August 2010. We fully expect to handle the budgeted level of approximately 722,000 reconsideration claims by fiscal year-end. We are encouraged that we have dramatically increased the number of average weekly reconsideration cases handled throughout the fiscal year from 11,800 in October 2009 to 14,000 in August 2010, an increase of 18.6 percent.

As I noted earlier, we currently are running a prototype project in ten States that eliminates the reconsideration step. The States using this prototype are: Alaska, Alabama, California (Los Angeles West and North Branches), Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania. In these States, a claimant dissatisfied with his or her initial determination may proceed directly to the hearing level by requesting a hearing before an ALJ.

Hearing Level

When a hearing office receives a request for a hearing, the hearing office staff prepares a case file, assigns the case to an ALJ and schedules a hearing. If review of the evidence suggests that we can issue a fully favorable decision without holding a hearing, an ALJ or attorney adjudicator may issue an on-the-record fully favorable decision.

At the hearing, all testimony is taken under oath or affirmation. The claimant may appear in person at the hearing or, under appropriate circumstances, via video. The claimant may have a representative (either an attorney or non-attorney) who can submit evidence and arguments on the claimant's behalf, may testify, and may call witnesses to testify. The ALJ may call vocational and medical experts to offer opinion evidence, and the claimant or the claimant's representative may ask these witnesses questions. An ALJ hearing is a non-adversarial proceeding; the agency is not represented at the hearing.

Following the hearing, the ALJ will take all necessary post-hearing development steps, such as ordering a consultative exam. The ALJ considers all of the evidence in the file when making a decision, including newly submitted evidence and hearing testimony and decides the case based on a preponderance of the evidence. The ALJ decides the case *de novo*; he or she is not bound by the determinations made at the initial and reconsideration levels.

If the claimant is dissatisfied with the ALJ's decision, the claimant has 60 days after he or she receives the decision to request that the Appeals Council review the decision.

Over the last 20 months, we have reduced the number of pending hearings by almost 9 percent despite an increase in hearing requests. Through August 2010, we received over 30,000 more hearing requests in FY 2010 than we received in all of FY 2009. As of August 2010, we had slightly more than 700,000 pending cases, and earlier this year, we reduced the number of pending cases pending below 700,000 cases for the first time since 2005. Over the last four years, we have decided more than half a million cases that were 825 days or older. Even as we eliminated the oldest, most time-consuming cases, we reduced the average time it takes to issue a decision by more than four months. Through August 2010, it has taken us an average of 429 days in FY 2010 to decide a case, which is 56 days below our projected end-of-year target.

Much of our success in reducing the number of pending hearing requests flows from our efforts to hire more employees and open new offices. Congressional support plays an especially critical role in this regard. To date this year, we have hired 229 ALJs and approximately 1,300 additional support staff, allowing us to complete significantly more hearings. With full funding under the President's FY 2011 Budget, we will continue to hire ALJs to maintain an ALJ corps of over 1,400 and to hire the necessary support staff to allow us to eliminate the hearings backlog by the end of FY 2013. To accommodate this additional staff, we opened 18 new offices this year and plan to open 16 new offices next year. Our goal is to reduce the hearings backlog by another 50,000 cases next fiscal year.

Appeals Council

Upon receiving a request for review, the Appeals Council evaluates the ALJ decision, all of the evidence of record, including any new and material evidence that relates to the period on or before the date of the ALJ's decision, and any arguments the claimant or his or her representative submits. The Appeals Council may grant review of the ALJ's decision or it may deny or dismiss a claimant's request for review. The Appeals Council will grant review in a case if there appears to be an abuse of discretion by the ALJ; there is an error of law; the actions, findings, or conclusions of the ALJ are not supported by substantial evidence; or if there is a broad policy or procedural issue that may affect the general public interest.

If the Appeals Council grants a request for review, it may issue a new decision, remand the case to an ALJ, or issue a dismissal of the request for hearing for any reason the ALJ could have dismissed the request. When it reviews a case, the Appeals Council considers all the evidence in the ALJ hearing record (as well as any new and material evidence in certain cases), and when it issues its own decision, it bases the decision on a preponderance of the evidence.

The Appeals Council is also beginning to see a rise in its workload. Through August 2010, the Appeals Council received 114,159 requests for review, which is more than a 6 percent increase over FY 2009. To address this increase, we authorized substantial recruitment and hiring for the Appeals Council during the second half of FY 2009. We revamped our training programs to take advantage of recent technological improvements, and many of our employees have exceeded performance expectations during their training period. As the newly hired employees have become more productive, Appeals Council dispositions have begun to approach the level of requests for review. We expect dispositions to outpace receipts during FY 2011. We are also striving to reduce court orders of remand by improving the overall quality and legal sufficiency of our decisions through training, quality assurance efforts, and the expanded use of electronic case analysis tools.

If the claimant has completed our administrative review process and is dissatisfied with our final decision, and the final decision is not an Appeals Council dismissal, the claimant may seek review of that final decision by filing a complaint in Federal district court.

Federal District Court

If the Appeals Council makes a decision, that decision is the final agency decision. If the Appeals Council denies the claimant's request for review of the ALJ's decision, the ALJ's decision becomes our final decision. A claimant who wishes to appeal a decision by the Appeals Council or its denial of a request for review has 60 days after receipt of notice of the Appeals Council's action to file a complaint in Federal district court. When we file our answer to that complaint, we also file with the court a certified copy of the administrative record developed during our adjudication of the claim for benefits.

The Federal district court considers two broad inquiries when reviewing one of our decisions: whether we have followed the correct legal standard and whether our decision is supported by substantial evidence of record. On the first inquiry –

whether we have applied the correct law – the court will consider issues such as whether the ALJ applied the correct legal standard for evaluating credibility or a treating physician's opinion, whether we followed the correct procedures, or whether our interpretation of a relevant statutory provision is correct. Since these issues are issues of law, the court will consider them *de novo*, but should give our views on these issues substantial deference.

The court will also consider whether our decision is supported by the factual evidence developed during the administrative proceedings. The court does not review our findings of fact *de novo,* but rather considers whether those findings are supported by substantial evidence. This "substantial evidence" standard is prescribed by the Act, which provides that, on judicial review of our decisions, our findings "as to any fact, if supported by substantial evidence, shall be conclusive." The Supreme Court has defined substantial evidence as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion," and characterized it as more than a mere scintilla, but less than a preponderance. The reviewing court will consider evidence that supports the ALJ's findings as well as evidence that detracts from the ALJ's decision. However, if the court finds there is conflicting evidence which could allow reasonable minds to differ as to the claimant's disability, and the ALJ's findings are one of those possible interpretations of the evidence, the court must affirm the ALJ's findings of fact.

If, after reviewing the record as a whole, the court concludes that substantial evidence supports the ALJ's findings of fact and the ALJ applied the correct legal standards, the court will affirm our final decision. If the court finds either that we failed to follow the correct legal standards or that the our findings of fact are not supported by substantial evidence, the court may remand the case back to us for further administrative proceedings, or in some instances, reverse our final decision and find the claimant disabled.

Conclusion

Since 1956, Social Security disability benefits have provided a vital safety net for those Americans who constitute the most vulnerable segment of society. Our administrative review process has been described by the Supreme Court as "unusually protective" of the claimant and strives to ensure that a person who truly needs disability benefits receives them.

Reducing the disability claims backlog remains our top priority. Full funding under the President's FY 2011 Budget will allow us to take the next step in reducing our backlog over the next several years.

Responses to Questions Submitted for the Record From David Rust
For the September 28, 2010 Hearing
On Long-Term Disability Policies

Question from Chairman Baucus

1. **Mr. Rust, would it be helpful to the agency if it received evidence of an individual's alleged medical improvement or fraud from the private insurance companies?**

   Yes. While we cannot take action based solely on information from a private insurance company, we always appreciate any evidence from credible sources that can help us arrive at the correct disability determination, including medical evidence that would support discontinuing Social Security benefits or evidence of fraud.

Questions from Senator Grassley

1. **A number of comparisons could be made between Social Security and private disability insurance.**

   I would like to quickly run through a list of questions to clarify current Social Security policies. I believe a simple "yes" or "no" answer will suffice. But feel free to expand on your answers if necessary.

   Finally, for all of the questions you answered "yes" could you give us some idea of what the impact would be on Social Security if the answers had been "no" instead?

   (1) Is it true SSA has a medical release Form 827 that provides blanket authorization to obtain all medical records from any source, and failure to sign this form means the application will not be processed and benefits will be denied?

   It is true that our Form SSA-827 is a standard release form that a claimant can voluntarily sign to authorize release of information, such as medical records, to us. We developed the SSA-827 to comply with Federal and State provisions (such as the Health Insurance Portability and Accountability Act) regarding the disclosure of medical, educational, and other information.

   It is not true, however, that we will not process the application of a claimant who does not sign the SSA-827. In some cases, the claimant or his or her representative will provide us copies of medical evidence, which may be sufficient to make a disability determination. In these cases, we do not need to collect further evidence from outside sources.

Signing the SSA-827 is voluntary. If a claimant fails to sign the SSA-827 or revokes his or her authorization before we receive the information needed to make a disability determination, we could have difficulty obtaining that information. If we were unable to obtain the needed information, we likely would deny the claim.

(2) Is it true SSA often requires applicants to submit forms or schedule consultative exams, and failure to cooperate or comply with these requirements can result in the denial of benefits?

Yes, failure to cooperate can, but does not necessarily, result in the denial of benefits.

There are several reasons why we may need to send a claimant for a consultative examination (CE). A claimant may not have a regular medical provider who can submit evidence (for example, the claimant may be homeless and not have a primary care provider). Sometimes a claimant identifies a primary care provider, but that primary care provider is unable to provide any medical records or does not respond to our request for medical records. Sometimes the evidence we receive is incomplete or contradictory, and we must resolve those issues before we can make a determination. We may also need information from claimants regarding how their impairments affect their functioning. If a claimant fails to attend the examination or provide the required information, we may be unable to make a determination with the information we have in the file.

Under our regulations, if a claimant applies for benefits and does not have a good reason for failing or refusing to take part in a CE, we may find that the claimant is not entitled to benefits. If a claimant is already receiving benefits and does not have a good reason for not participating in a CE, we may determine that his or her disability or blindness has stopped. During the first eight months of calendar year 2010, we denied approximately seven percent of the initial disability claims we received due to the claimant's failure to cooperate in developing evidence for the claim.

We advise claimants that if there is any reason why they cannot go to a scheduled examination, they should tell us as soon as possible. We will reschedule the examination if the claimant has a good reason for not attending the CE. We will consider the claimant's mental, educational, and language limitations when we determine if the claimant has a good reason for failing to attend a CE.

<u>If the Answer Had Been "No"</u> – Under certain circumstances, if a claimant fails to cooperate, we will adjudicate a claim based on the evidence we have available. For example, we may be able to get the information we need from other sources (family members, medical providers) that will allow us to make a determination without the claimant's cooperation. However, if we cannot obtain the information needed to assess the medical severity of the claimant's impairments, we will deny the claim based on our "failure to cooperate" policy. Without this policy, these claims would remain open indefinitely.

(3) Is it true SSA often makes disability determinations based solely on the record without ever examining the applicant directly?

Yes. We require evidence from acceptable medical sources to evaluate whether the claimant has a medically determinable impairment. Medical reports should include a medical history, clinical findings, laboratory findings, diagnosis, treatment prescribed and the prognosis, and a medical source statement indicating what the claimant can do despite his or her medical impairment. If the evidence we receive is sufficient, we can make a disability determination based on that evidence.

If the disability determination services (DDS) does not receive evidence that is adequate to determine whether the claimant is disabled, the DDS will contact the claimant, contact medical sources, or schedule a CE. Generally, DDSs do not request a CE until they have made every reasonable effort to obtain evidence from the claimant's own medical sources.

In some cases, our adjudicators meet with the claimant before they make a reconsideration determination. If the claimant is appealing an initial determination that he or she is no longer entitled to disability benefits, we will provide the claimant with the opportunity for a face-to-face "disability hearing" at the reconsideration step of the administrative review process. A disability hearing officer in the DDS conducts this hearing. This review is in addition to the hearing a claimant may have before an administrative law judge (ALJ).

If the Answer Had Been "No" – Examining each applicant would considerably increase claim processing times and would also cause a substantial rise in our administrative costs, including additional costs for CEs. As many claimants "meet" our medical listings due to the severity of their impairments, further examining these claimants would have no bearing on the outcome except to delay the disability determination and payment of benefits.

(4) Is it true SSA has established Cooperative Disability Investigation – or CDI Teams – that often conduct surveillance to investigate cases of alleged disability fraud?

Yes. The CDI program is a joint effort between Federal and State agencies to pool resources to prevent fraud in our disability programs and related Federal and State programs. In some instances, the investigators will conduct surveillance of disability applicants during their investigations. According to our Inspector General, since the CDI program began in 1998, it has accounted for approximately $1.5 billion in Social Security program savings and approximately $900 million in non-Social Security program savings. These savings are the result of CDI units opening over 29,000 cases and developing evidence to support over 23,000 actions, resulting in denial, suspension, or termination of disability benefits.

If the Answer Had Been "No" – Without the CDIs, we would be paying benefits to persons who are defrauding the Government.

(5) Is it true SSA requires blind individuals under age 55 to establish proof that they are unable to engage in substantial gainful activity? In other words, benefits are not awarded solely on the basis of blindness?

Yes. To receive Social Security Disability Insurance (SSDI) benefits, blind persons under age 55 must be unable to engage in substantial gainful activity (SGA). A blind person under age 55 who is engaging in SGA is not disabled under the Social Security Act.[1] We use a higher earnings standard for blind persons to determine whether work activity is SGA.[2]

If the Answer Had Been "No" – SSDI benefits would be paid to blind persons regardless of their ability to engage in SGA, which would increase program costs.

(6) Is it true SSA disability cases reviewed by the federal courts are often remanded back to the agency?

Yes. Federal courts remand nearly one-half of the cases where claimants challenge our disability decisions.

If the Answer Had Been "No" – If courts remanded fewer cases, resources at the hearings and Appeals Council levels would be freed up to deal with the backlog of initial hearings requests and requests for review.

(7) Is it true SSA disability cases reviewed by the federal courts are not subject to a jury trial or treble damages?

Yes. Under the Social Security Act, Federal district court review of our final decisions is limited to a review of the administrative record by the judge. The review is essentially an appellate review, and there is no trial by either a judge or a jury. Judges are to determine whether our decisions are supported by substantial evidence, which is a deferential standard of review. District court judges may affirm, reverse, or modify our decisions, with or without remanding for a rehearing. There is no provision for damages; however, a claimant may be awarded attorney fees under the Equal Access to Justice Act.

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[1] A blind person may be eligible for SSDI benefits even though he or she is still engaging in SGA only if he or she is 55 or older and is unable to use the skills or abilities like the ones he or she used in any SGA that he or she did regularly and for a substantial period of time.

[2] However, we do not use SGA to determine initial eligibility for Supplemental Security Income (SSI) benefits. A blind individual may be eligible for SSI benefits even if they are performing SGA, provided they meet all other eligibility requirements.

If the Answer Had Been "No" – Presumably, a review by jury trial would result in a de novo review of our decisions with additional evidence outside the administrative record being admissible. This type of system for court review would result in little, or possibly no, deference being given to the highly skilled agency adjudicators and would leave to lay juries the ultimate determination of benefits and damages. Obviously, such a system would turn the entire process on its head and likely would result in higher costs to the disability program.

2. **I would like to explore the different standards of judicial review. As I understand it, Social Security is subject to a substantial evidence test.**

   When there is conflicting evidence, the court must defer to Social Security as long as its decision was supported by the evidence.

   Could you elaborate on this in terms of how the court would view different types of evidence? For example, would it give different weight to a treating physician report, as compared to a consultative exam, or another physician who only reviewed the medical records without directly examining the applicant?

   Our regulations describe how to weigh opinion evidence from various medical sources. Under these rules, we determine the weight to give a medical source opinion by considering a number of factors. We generally give more weight to an opinion from a treating source. We may even give the treating source opinion controlling weight if we find that the opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record. If the treating source opinion is not given controlling weight, we evaluate that treating source opinion along with all of the medical opinion evidence we receive, using several factors set out in our regulations. We consider the nature and extent of any treatment relationship. We also generally give more weight to an opinion from a medical source who has examined the claimant than to an opinion from a non-examining source, and we may weigh the opinion of a specialist in the field more heavily than an opinion from one who is not a specialist. When we weigh opinion evidence, we consider the evidence the source provides to support his or her opinion, any explanation the source offers to support the opinion, and the extent to which the opinion is consistent with the record as a whole.

   When a court reviews one of our decisions, it considers two broad inquiries: whether we have applied the correct legal standards and whether our decision is supported by substantial evidence in the administrative record. The reviewing court does not re-weigh the evidence as it would if it were the finder of fact. However, in determining whether we applied the correct legal standards, the court will review issues such as whether the ALJ properly applied our rules on weighing medical opinion evidence. If the court were to conclude that the ALJ did not weigh the evidence in the manner required by our regulations or that the ALJ did not provide a sufficient rationale in his or her decision to enable the court to determine how the evidence was weighed, the court may remand the case to have that deficiency

corrected. This type of remand, due to a perceived failure to follow the correct legal standard, is separate from the substantial evidence inquiry. The substantial evidence inquiry considers only whether, after properly weighing the evidence in the case, the ALJ's decision is supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Substantial evidence is more than a mere scintilla, but less than a preponderance of evidence.

Questions from Senator Snowe

1. **Mr. Rust, the 2010 Annual Report from the Social Security Trustees indicated a serious funding problem with the Disability Insurance program. In fact the report stated "However, the DI Trust Fund is projected to become exhausted in 2018, so some action will be needed in the next few years." By this it meant that the disability insurance fund would no longer be able to pay full benefits to claimants and that Congress would need to take legislative action in the next few years to provide additional revenue or that benefit payments would have to be reduced.**

   While this committee has, at best, a tenuous jurisdictional association with the private disability insurance market, the potentially devastating impending exhaustion of the DI Trust Fund is clearly an imperative for us.

   Also of modest jurisdiction to the Senate Finance Committee is the new disability/long-term care insurance system being set up under the Patient Protection and Affordable Care Act (PPACA). Under the Community Living Assistance Services and Support (CLASS) Program provisions of health reform, the disabled and those with chronic illnesses who are still able to work and to participate everyday in their communities, and therefore may not be eligible for SSDI benefits, would be provided income to help cover their everyday expenses. Whether it is the Actuary for the Center on Medicare and Medicaid or the Congressional Budget Office, projections for the CLASS Program are that it will generate deficits relatively quickly after it is implemented.

   Mr. Rust, thank you for providing us with the ability to compare and contrast the claims process between private disability insurance and the SSDI process. Since you are the Deputy Commissioner for Retirement and Disability Policy, can you tell me whether there has been any discussion about whether there would be coordination of claims or benefit policies between the SSDI program and the new CLASS Program? If so, please provide us with information on how claims and benefits would be coordinated.

   We are still analyzing the provisions of the Affordable Care Act, and to date there have been no discussions about coordination of claims or benefit policies between the SSDI program and the CLASS program. We understand that the Department of Health and Human Services (HHS) has the responsibility for implementing the

CLASS program, and we will be sure to coordinate with HHS on this issue, as necessary.

The CLASS Act requires that the Secretary of HHS must seek out three actuarial soundness analyses prior to the creation of the CLASS Independence Benefit Plan. Has the Social Security Administration been asked to provide one of the three analyses?

No. Our Chief Actuary has not been asked to provide this analysis.

Have there been any discussions with states' Protective and Advocacy Systems as to whether any state will use the SSDI state offices?

No. To date we have had no discussions with any Protection and Advocacy Systems about this issue.

Will anyone from the policy office or other divisions within the Social Security Disability Insurance Program be involved in the implementation of the CLASS Act program and how these expanded responsibilities affect the administrative funding needs of the DI program?

No. There are currently no plans for SSA to be involved in CLASS implementation.

The Affordable Care Act includes a provision that excludes benefits received under the CLASS Act from consideration when determining a person's eligibility for the means-tested SSI program. We are developing instructions reminding our employees of this provision. Based on our understanding of the CLASS Act, we estimate its effects on our funding needs for administering the SSDI, SSI, and Old Age and Survivors Insurance programs to be negligible.

SUBMITTED BY SENATOR SNOWE

Impact of Disability Insurance Policy Mandates Proposed by the California Department of Insurance

Robert W. Beal, FSA, MAAA
Daniel D. Skwire, FSA, MAAA

Milliman, Inc.

Date: November 14, 2005

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Attachment A. The Department's October 3, 2005 Notice A-1

Section I. Introduction

Milliman, Inc. has been engaged by America's Health Insurance Plans ("AHIP") on behalf of member companies who are licensed to sell disability income ("DI") insurance in California to prepare a report discussing the actuarial impact of the DI policy language changes that the California Department of Insurance ("the Department") has proposed. The policy language changes are discussed both qualitatively and quantitatively. This report does not assess the legal authority of the Department to impose such changes.

The authors are consulting actuaries employed by Milliman, Inc., who have extensive experience working with insurers and employers regarding disability insurance plans. In preparing this report, we were guided by the Actuarial Standards of Practice (ASOP's) that are promulgated by the Actuarial Standards Board of the American Academy of Actuaries. Specifically, we were guided by ASOP No. 5, "Incurred Health Claim Liabilities", ASOP No. 17, "Expert Testimony by Actuaries," and ASOP No. 41, "Actuarial Communications."

The cost estimates in this report are based on actuarial assumptions derived from historical data, premium rates currently charged by DI insurers in the competitive marketplace, and anticipated future experience. For items which could not be directly derived from historical data or current premium rates, we used actuarial judgment and professional experience to develop the estimates. As with any actuarial estimates, it is likely that future experience will vary from these assumptions. To the extent that such variation occurs, the actual cost impact may vary from our estimates.

To support our analysis, we surveyed a number of AHIP member companies who write group or individual DI insurance, regarding their DI product provisions, their claims experience and litigation costs, as well as consulted with a number of actuarial experts from these companies. Those survey data were aggregated and de-identified when summarized to encourage full responses and assure compliance with antitrust guidelines. The authors did not audit or independently verify the survey responses, except that they did review the responses for reasonableness and consistency. To the extent that any of the data or other information supplied was incorrect or inaccurate, the results of our analysis could be affected.

AHIP has Milliman's permission to submit this report to the Department. In doing so, we expect that the report will become a public document. Milliman does not intend to benefit any third party recipient of its work product. If distributed, we request that this report be distributed in its entirety.

This work product was prepared solely to provide assistance to the America's Health Insurance Plans. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Milliman recommends recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product.

Section II. Executive Summary

In its October 3, 2005, notice to insurers, the Department has proposed a number of significant changes to which DI insurance policies must conform in the state of California. (A copy of the October 3 notice is provided in Attachment A.) These changes would not only affect new product filings but also apply retroactively to policies that the Department has previously approved. The purchasers of group and individual DI insurance, both employers and individuals, will be the ones most affected by the Department's proposed policy language changes for DI policies.

Specifically, the proposed changes will:

- Significantly increase the cost of group and individual DI insurance;
- Limit the range of DI insurance products available to California consumers;
- Reduce the total amount of DI protection per life that Californians may access; and
- Discourage some DI claimants from returning to work.

More than most insurance products, the ultimate cost of DI insurance is affected by the personal motivation of insureds. Most insureds who become disabled want to return to a productive life as soon as medically possible, and DI insurance allows them to restore a portion of their lost income while they are recovering. However, past experience demonstrates that many personal or non-medical (e.g., economic) factors can adversely influence some claimants' motivation to return to work, even after they are medically able. As a result, the cost of DI insurance increases for all consumers.

DI insurers have introduced a number of contractual provisions to encourage consumers to return to productive work so as to provide valuable coverage at the lowest possible cost. The policy language changes proposed by the Department weaken many of these provisions. For example, under the Department's proposal:

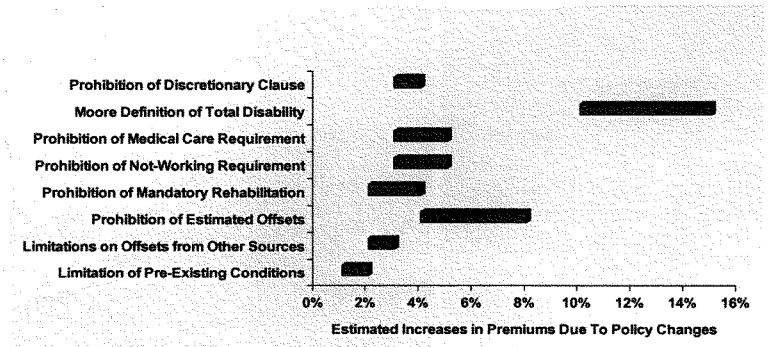
- Consumers of DI insurance, whether group or individual, will only be able to purchase a more expensive form of DI coverage known as "Pure Own Occupation" or the least expensive form known as "Any Occupation." Consumers will be unable to purchase other currently available options that fall between these two extremes and may better serve their needs.

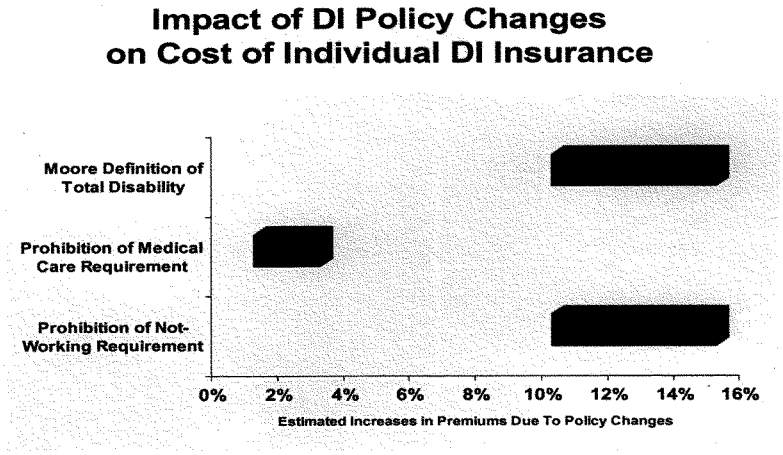
- The requirement that claimants receive regular and appropriate medical care will be prohibited. This requirement was designed to reduce the average duration of claims, the cost of administering those claims, and the resulting cost of insurance.

- Group DI benefits will no longer be reduced by estimated Social Security disability benefits. This prohibition reduces claimants' incentive to apply for Social Security benefits, which both the employer and employee have funded through their payroll taxes, and consequently further increases the cost of insurance.

We estimate that the Department's proposed policy language changes could increase the cost of insurance from 28% to 46% for group DI and 21% to 33% for individual DI, on polices that currently contain all of the prohibited provisions. The anticipated premium increases would be lower for DI policies that currently contain some but not all of the prohibited language. The following charts show the anticipated premium increases, separately for group DI and individual DI, for the specific proposed policy language changes contributing to the increases.

Impact of DI Policy Changes on Cost of Group DI Insurance





These anticipated premium increases will be in addition to the significantly higher-than-average premiums currently paid by most California DI consumers. California consumers typically pay 20-70% more for individual DI and 10-15% more for group DI than do consumers in other states. These higher premiums are warranted by historically higher disability claims in California as evidenced by a recent industry study by the Society of Actuaries[1].

In addition to causing substantially higher costs for DI insurance, the Department's proposed policy changes will limit the DI insurance product choices available to California consumers. For example, the Department would prohibit the following types of DI benefits and policies, which are commonly available to consumers in other states:

- Loss of Income contracts, which reduce disability benefits for earned income during disabilities but which do not distinguish between Total and Residual or Partial disabilities;

- Additional benefits for insureds who are so severely disabled that they cannot perform certain activities of daily living;

[1] "Report of the Individual Disability Income Experience Committee – Analysis of Experience from 1990 to 1999," (IDEC Report), Society of Actuaries, January 2005, pp. 79-84.

- Additional benefits to claimants' 401(k) or pension plans while they are disabled;
- Individual DI buy-out policies, which facilitate the transfer of business ownership between partners resulting from the permanent disablement of one of the partners;
- Individual Key Person policies, which are designed to compensate businesses for the loss of key employees due to disabilities; and
- Survivor Income provisions, which typically pay three months of benefits to the spouse, children or estate of an insured following the death of the insured while disabled.

Should these proposals go into effect, DI insurers, in addition to raising premiums and restricting product options, will be likely to implement more restrictive underwriting rules and reduce the total amount of DI insurance per life that California consumers can purchase, since many of the proposed policy language changes serve to reduce claimants' motivation to return to work. Thus, insureds who are personally motivated to return to work, regardless of the policy provisions, may have lower portions of their incomes covered while disabled.

Although DI insurance provides valuable protection against loss of income due to a disability, relatively few people have this coverage. The U.S. Department of Labor reports in the 2005 National Compensation Survey that only 39% of workers are covered by short-term disability and 29% of workers are covered by long-term disability[2]. The portion of consumers who purchase individual DI insurance is lower. Employers today are facing the increasing cost of healthcare and are, in turn, sharing a greater portion of the cost burden with their employees. When group DI premiums increase, fewer employers may be willing to pay for this coverage. In these cases, some portion of employers will drop the coverage altogether or expect their employees to purchase it. Employees are likewise paying for the higher cost of health care, as well as incurring other financial demands on their disposable income, and consequently, they will be less willing or able to purchase DI coverage on their own.

The likely impact of the Department's imposed policy changes on the California DI consumer is significantly higher premiums, fewer product options, and more restrictive underwriting. The Department's proposal will likely result in fewer insured California residents, and, therefore, decreased financial security.

[2] "National Compensation Survey: Employee Benefits in Private Industry in the United States," U.S. Department of Labor, U.S. Bureau of Labor Statistics, August 2005, p. 9.

Section III. The Nature of the Disability Risk

If a person is unable to perform his or her occupation due to an accident or sickness, then that person will most likely suffer an income loss. The purpose of disability insurance is to restore a portion of that lost income while the person remains disabled.

This simple product concept is complicated by a number of factors:

- Difficulties in establishing the existence and extent of the medical condition and the causative relationship between the condition and the disability.
- The potential for adverse selection arising from "asymmetric information", where applicants or employees have material information concerning their personal circumstances that is not available to the insurer.
- The impact of personal motivation on an insured's ability or willingness to perform his or her occupation.
- The risk of overinsurance by which a claimant may receive more income while disabled than before.

Industry studies have shown that the level of benefits relative to pre-disability earnings, the richness of contractual provisions and economic factors can influence both the frequency that insureds become claimants and the duration of the resulting claims.

1. The Transactions of the Society of Actuaries Reports for 1982-84 show that group DI claim costs per dollar of benefit increase as the percentage of income insured increases[3].
2. The 2005 IDEC Report of the Society of Actuaries provides evidence of how certain contractual provisions and subjective factors affect both claim incidence and claim recovery[4].

[3] Transactions of the Society of Actuaries, Reports 1982 and 1984, p. 286 (1982), p. 254 (1984).
[4] IDEC Report, pp. 59-70.

The challenge for group and individual DI insurers is three-fold:

1. Offer DI insurance products that provide valuable protection against income loss due to disability.

   DI insurers must provide products that meet the critical needs of the insureds and administer their contractual obligations fairly.

2. Make the products available and affordable to as many people as possible.

   DI insurance, sold either on an individual or group basis, is a crucial part of the financial security for working Americans. By including appropriate risk management provisions within their policies, insurers who provide these coverages are able to offer protection to a larger number of customers at more affordable rates.

3. Maintain the financial soundness of the insurance plan.

   In order for DI insurance to remain a viable product, it must be profitable for the insurers who provide it. If the product cannot be written profitably, then most insurers will refuse to offer it, and those who remain in the market may face threats to their financial soundness and claim-paying ability.

The remainder of this report reviews in detail the changes to DI policy language that the Department is proposing. Specifically, the report discusses how the proposed changes will reduce the protection that DI products will be able to provide in California, and will substantially increase the cost of DI coverage.

Section IV. The Department's Proposed DI Policy Language Changes

This section covers each of the categories of policy language changes which the Department outlined in its October 3 notice to insurers.

1. Discretionary Clauses

The Department proposes prohibiting the use of the discretionary clause in DI contracts.

The discretionary clause, which is included in DI plans subject to the Employee Retirement Income Security Act (ERISA), vests in the insurer, in its role as plan fiduciary, the responsibility to review all the evidence and documentation submitted by the beneficiary seeking coverage from the plan. The fiduciary is **required by law** to use a level of discretion in interpreting the plan documents, a role formalized in the plan documents through the discretionary clause. This role was reiterated in two Supreme Court decisions, *Firestone v. Bruch (1989)* and *Aetna Health Inc. v. Davila (2004)*. Discretionary clauses do not allow the insurer "unfettered" discretion, but are consistent with federal law by which the interpretation of the plan's terms must be grounded on a "reasonable basis," and cannot be arbitrary, capricious or an abuse of discretion.

The presence or absence of the discretionary clause does not affect contractual entitlement for benefits or calculation of benefits. However, without the discretionary clause, the standard of review if a claim is contested will change. Under a discretionary clause, the administrator's claim decision can be overruled only if it is found to be "arbitrary and capricious." Without the discretionary clause, the standard of review is the same "de novo" standard applicable to individual DI plans where a jury can determine whether an insured qualifies for disability benefits.

We estimate that the removal of the discretionary clause would increase group DI premiums between 3% and 4%, based on the following three factors:

a. <u>Higher incidence of litigation</u>

   Based upon results from the survey of AHIP member DI carriers, the ratio of litigated claims relative to all active claims was 0.6% for group DI carriers and 0.9% for individual DI carriers. Although a number of factors could contribute to the different ratios, we believe the absence of a discretionary clause in individual DI policies is a significant consideration.

b. Higher cost per litigated claim

Based upon results from the survey of AHIP member DI carriers, the average cost to litigate individual DI claims is over 260% of the average cost to litigate group DI claims. We expect that in the absence of the discretionary clause, the cost to litigate group DI claims will be similar to the cost to litigate individual DI claims.

c. Lower claim recovery rates

A more litigious environment could result in DI insurers being more overly cautious in managing claims, allowing some insureds to remain on disability although the preponderance of evidence indicates that they are no longer disabled. We have assumed a 2-3% reduction in recovery rates as an estimate of this effect.

2. *Definition of Total Disability*

There is no definition of Total Disability contained in California insurance statutes or regulations that applies to individual and group DI contracts[5]. The Department's notice states that the definition of Total Disability must be "at least as advantageous to the insured" as the definition arising from *Moore v. American United Life Ins. Co. (1984) 150 CalApp3d 610, 632; 197 Cal.Rptr. 878, 892*, which was an interpretation of the definition of California case law from 1942. Under the *Moore* definition, Total Disability is a disability that "renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity." This is considered an "Any Occupation" definition of Total Disability, and insurers wishing to use an "Own Occupation" definition of disability must use the first part of the definition pertaining to "Usual Occupation."

Recent documents produced by the Department suggest that it is interpreting the material and substantial duties of an insured's Usual Occupation to mean the duties performed by the claimant in a specific employment setting prior to the disability rather than the duties based on a more standardized definition of the same occupation. In other words, the Department's interpretation of this definition of Total Disability incorporates the concept of "Own Job" versus Own Occupation.

[5] The only definition of Total Disability contained in California insurance statutes or regulations applies to the California State Disability Insurance (SDI), a state-mandated program funded through payroll deductions. For the purpose of qualifying for benefits under the California SDI: "An individual shall be deemed to be disabled on any day in which, because of his or her physical or mental condition, he or she is unable to perform his or her regular or customary work."

Although insurers typically take into account the duties of a claimant's job to some degree, the Own Job definition of disability is substantially more expansive than Own Occupation. For example, an engineer whose job requires frequent air travel to off-site locations and who suffers from an inner ear problem that makes flying extremely painful may be eligible for Own Job benefits although he or she may be able to perform all of the duties of an engineer at another firm in the same city that did not require air travel. Few group DI insurers and fewer individual DI insurers, if any, offer an explicit Own Job definition in their policies.

Of the group DI carriers who offer an Own Job definition, one charges between 8% and 15% more, although it limits the Own Job period to 18 months. Some group DI carriers will offer "Own Specialty" definitions of disability to attorney and physician groups with additional ranging between 15% and 20%. Based on what the group DI carriers are currently charging for similar definitions of disability, we estimate that the cost of insurance will increase between 10% and 15% on average as a result of requiring the Own Job definition of disability.

3. *Additional Benefit Criteria*

The Department proposes prohibiting additional criteria to those stated in the *Moore* definition of Total Disability and gives examples of the criteria that would no longer be permitted. Each example is discussed below.

Regular Medical Care and Appropriate Medical Care

The Department proposes requiring that definitions of Total Disability can no longer require the claimant to be receiving regular or appropriate medical care.

Requiring claimants to be receiving regular or appropriate medical care has been a common feature in disability contracts for many years[6]. Insurers will typically waive this requirement if they receive written proof that ongoing medical care would be of no benefit to the insured.

Although most claimants seek regular and appropriate medical care as a normal course of action, removal of this requirement makes it easier for those claimants who do not want to return to work or to seek appropriate care to remain disabled. In addition, not requiring regular and appropriate medical care makes adjudicating claims more difficult. For example, a claimant who is suffering from back pain or depression, which could be

[6] Black, Kenneth and Harold D. Skipper. Life and Health Insurance, 13th edition. Upper Saddle River, NJ: Prentice Hall, 2000, p. 153

easily treated with prescribed medications, but who is not receiving appropriate medical care, could possibly remain disabled indefinitely with little chance of improvement in his or her medical condition.

The Department's proposed restriction does not prohibit the insurer from requiring ongoing certification of the condition by a physician. However, in the absence of the medical care requirement, insurers will likely request more independent medical examinations (IME's) in order to monitor the claimant's medical condition.

The impact of removing a regular and appropriate medical care requirement from the definition of Total Disability is two-fold:

a. Higher volume of IME's

   We expect that additional IME's may be required at least every 6 months for the first 2 years and annually for the next 8 years. This higher volume of IME's will increase group DI costs by 2-3% and individual DI costs by 0.5-1%.

b. Lower recovery rates

   We anticipate that between 8-10% of claimants may not receive regular or appropriate medical care with the Department's proposed policy language change and, as a result, that both group and individual claim recovery rates will decrease 1-2%, with a corresponding increase in costs of 1-2%.

We estimate the combined effect will increase the cost of insurance by 3-5% for group DI insurance and 1-3% for individual DI insurance. In addition to increasing premiums due to higher costs from this prohibition, DI insurers may choose to limit the amount of coverage they will provide to individuals in order to provide a greater financial incentive for claimants to return to work in the absence of such benefits criteria as regular and appropriate medical care.

ADL's and Cognitive Impairments

The Department proposes prohibiting the use of activities of daily living (ADL's) and cognitive impairments as criteria for Total Disability. Some insurers have used such definitions of disability in contracts designed for people who do not have well-defined occupations, such as homemakers or those who are unemployed at the date of disability. Other insurers have developed optional riders which provide additional benefits to claimants who are receiving regular disability benefits but who are also so severely disabled as to be unable to perform two out of six ADL's or to be suffering from a cognitive impairment. It is assumed that claimants suffering from these more

catastrophic conditions may need the additional benefits to help in covering the extra costs that they incur as a result of these conditions.

By prohibiting these criteria, the Department will not add to the cost of DI coverage but rather will limit potentially valuable options and restrict access to coverage for California consumers.

Not-working Requirement

The Department proposes excluding the "Not-working" requirement in the definition of Total Disability.

The typical definition of disability for individual policies sold in the 1980s and early 1990s was labeled "Pure Own Occupation." It allowed an insured to work in another occupation while disabled from his or her Own Occupation and receiving benefits. The potential for overinsurance was significant. For example, a surgeon may be able to earn considerable income as an internist or teaching physician while unable to perform his or her normal surgical duties. Many insurers chose to include a "Not-working" requirement in their Own Occupation definition of disability, thus limiting their exposure to overinsurance and reducing the cost of insurance.

Without the Not-working requirement, the Own Occupation definition of Total Disability is equivalent to the Pure Own Occupation definition. (The Not Working requirement has no impact on an Any Occupation definition.) Some individual DI insurers will remove the Not Working requirement, increasing the premium for the more common long-term Own Occupation definition by 10% and 15%. Many companies will not allow occupations such as physicians (who have very precise manual duties) to purchase the Pure Own Occupation coverage. Although group DI carriers generally do not remove the Not Working requirement, we estimate that a corresponding increase in group premiums for removing this requirement would be 3-5%, reflecting the more typical two-year Own Occupation and Any Occupation thereafter definition for group DI.

In addition to increasing premiums due to the higher costs, DI insurers may choose to limit the amount of coverage to individuals and to offer only an Any Occupation definition to high risk occupations, which is not as beneficial to the insured as an Own Occupation but Not-working definition.

Loss of Income Standards

The Department proposes prohibiting any loss of income criterion (e.g., a minimum 20% loss of income due to the accident or sickness) in the definition of Total Disability. Our survey of DI insurers shows that most individual DI contracts that define Total Disability

do not include a loss of income criterion, while most group DI contracts that define Total Disability do include this criterion.

The Department's proposal would prevent "Loss of Income" DI contracts from being offered in California. A Loss of Income DI contract, which is favored by many group DI policies, defines a person as disabled if (1) unable to perform the material and substantial duties of his or her occupation due to an accident or sickness and (2) experiencing a loss of income as a result of the accident or sickness (often at least a 20% loss). The benefit formula, which adjusts the benefit for the presence of earned income, is applied to all claimants regardless of the extent that the insured cannot perform the duties.

Loss of Income contracts do not distinguish between Total Disability and Partial or Residual Disability since the same loss of income benefit formula applies to all disabilities. Because the benefits are reduced due to income earned while the insured is disabled, these contracts have the advantage of controlling the risk of over-insurance more effectively than Pure Own Occupation contracts. Conceptually, these contracts are more consistent with the fundamental purpose of DI insurance, which is to pay disability benefits when the insured incurs an economic loss due to an accident or sickness. There is less opportunity for overinsurance to occur under Loss of Income contracts, which reduces the cost of insurance.

Under the Department's proposal, the Loss of Income contract would be prohibited in California because its provisions would require a claimant, who might satisfy the *Moore* definition of Total Disability, to satisfy a loss of income criterion as well. In lieu of offering Loss of Income, insurers would be compelled to offer only DI contracts that distinguish between Total Disability and Partial or Residual Disability and to apply a loss of income trigger only when the insured is Partially or Residually Disabled. The effect is to force insurers to offer the more expensive Pure Own Occupation coverage and prohibit the access of the California consumer to lower cost forms of disability coverage.

For this cost analysis, the higher costs arising from the Department's proposed prohibition of the loss of income criteria in Total Disabilities are reflected in the cost of prohibiting the Not-working requirement during a Total Disability. Thus, they are not treated as additional costs beyond what has already been considered in our analysis.

Mandatory Vocational Rehabilitation

The Department proposes eliminating mandatory vocational rehabilitation requirements from DI contracts. Many group DI contracts currently require a claimant to participate in a vocational rehabilitation plan if approved by the insurer as a condition for receiving disability benefits. The vocational rehabilitation plan is designed to enable the employee to return to work, if possible, even if on a part-time basis. If the employee refuses

participate in the plan without a just cause, then disability benefits will terminate. Such programs are expected to shorten the duration of disabilities by encouraging disabled workers to return to productive employment. Mandatory vocational rehabilitation is not typically found in individual DI policies.

Currently, insurers will typically increase premiums by 2% to 4% when a mandatory vocational rehabilitation program is removed from the group DI plan. Thus, we estimate that cost of group DI plans that currently have mandatory vocational rehabilitation requirements would increase by comparable amounts if those programs are prohibited as the Department is proposing.

National Economy Standard

The Department proposes prohibiting the use of a National Economy standard to define one's usual occupation within the context of Total Disability. Currently some carriers use this language to clarify that they are providing Own Occupation coverage rather than the more costly and specific Own Job coverage.

It is unclear whether the Department might permit the use of a definition of disability that refers to occupational duties in the Local Economy. However, as discussed earlier, we believe that the Department interprets Usual Occupation in the definition of Total Disability as Own Job, and the prohibition on using a National Economy standard reinforces this position. Thus, the additional cost of insurance associated with this prohibition is reflected in the additional cost of insurance arising from interpreting Usual Occupation as Own Job, which is discussed in the section on Total Disability.

4. *Offsets in Group Disability Income Insurance*

Group DI benefits are typically reduced by applying offsets for income received by the claimant from a variety of sources. This is done to prevent overinsurance. The Department proposes imposing limits on the types of other income that are deductible.

No Deductions for Estimated Income

The Department proposes prohibiting insurers from deducting estimated amounts of income. This applies primarily to Social Security disability benefits where a common practice amount group DI carriers is to deduct an estimated Social Security disability benefit until the claimant's application for Social Security disability benefits is denied or approved. Ultimately, disability benefits and offsets are trued up so only the actual Social Security benefits will have reduced the disability benefits.

Some group DI insurers allow the claimant to forego the reduction of DI benefits from estimated Social Security amounts if the claimant (1) provides proof of application for Social Security disability benefits, and (2) signs a reimbursement agreement promising repayment of any group DI overpayments to the insurer. Other group DI insurers deduct the estimated Social Security disability benefit only if the claimant refuses to cooperate with or participate in the insurer's Social Security assistance program designed to help claimants apply for and receive Social Security disability benefits.

In general, 70% to 80% of group long-term disability claimants, who remain disabled for at least five years, ultimately qualify for Social Security disability benefits and the resulting benefit offsets lower the cost of insurance by 40% to 45%. Removing the insurer's ability to offset estimated Social Security benefits increases the cost of insurance in two ways:

a. Fewer claimants will be approved for Social Security benefits because, if their group DI benefits are not reduced for estimated Social Security amounts, they will have less incentive to apply for Social Security and pursue appeals, if necessary. We estimate approval rates could decrease by 5-10%.

b. There will be more overpayments of group DI benefits when companies are unable to reduce disability benefits by the estimated offsets during the Social Security approval process. Companies can only recover these past over-payments by reducing ongoing group DI benefits, which are already reduced by the regular Social Security offset. We estimate that 15-25% of the overpayments may not be recovered.

We estimate that the resulting increase in the cost of insurance from lower Social Security approval rates and higher unrecoverable Social Security payments will be 4% to 8%. Lower Social Security approval rates result in a shifting of some disability benefit payments from the Social Security program to group DI insurers. The total amount of benefits received by claimants (from Social Security and private insurance combined) would be unchanged. Because insurers would need to increase premium rates to cover their higher benefit payments, however, and because it is highly unlikely that Social Security payroll taxes would decrease due to lower approval rates for Social Security disability claims, the combined cost of public and private disability protection would increase for consumers.

Income Offsets from Other Sources

The Department proposes prohibiting other income offsets to disability benefits unless they arise from the same loss for which the disability benefits are being paid. This prohibition mainly affects three types of offsets:

1. Non-disability Related Retirement Income

   Under this prohibition, claimants who elect early retirement from their employers while receiving disability benefits may potentially receive more income while disabled than they earned prior to the disability.

2. Worker's Compensation Permanent Disability Benefits

   The Department would permit the offset from Worker's Compensation temporary disability benefits. Apparently, the Department bases its rationale on *Russell v Bankers Life Co.*, where the judge ruled that Worker's Compensation permanent disability benefits from the same loss may not be offset, although such benefits are paid when the employee is considered permanently disabled and unable to work in gainful employment. Although the Department would prohibit offsets for Worker's Compensation Permanent Disability Benefit for DI contracts, eligibility or receipt of permanent Worker's Compensation permanent disability benefits does, however, disqualify claimants receiving benefits under California's SDI program.

3. Insurance Proceeds

   The Department reminds group DI insurers that disability benefits cannot be offset by insurance proceeds from other DI policies, according to 10 Cal. Code Regs. Section 2232.34. Group DI contracts typically offset for disability benefit proceeds from other group contracts, but do not usually offset for proceeds from individual DI contracts.

In general, benefit offsets from sources other than Social Security come from Worker's Compensation awards and, to a lesser extent, retirement income plans. Whereas Social Security offsets reduce the cost of insurance by 40% to 45%, these other types of benefit offsets reduce the cost by 4% to 5%. If offsets from permanent Worker's Compensation awards and retirement income plans are prohibited, we estimate that the cost of insurance will increase between 2% and 3%.

Beyond just the impact of higher costs, this prohibition, along with the prohibition on a loss of income standard while totally disabled, serves to increase the total income that individuals can receive during a disability, raising the risk of overinsurance. In other words, the combined effect of these three prohibitions can reduce return-to-work rates, not just the amount of benefits paid to claimants.

5. *Definition of Pre-existing Condition*

The Department proposes to prohibit DI contracts from defining pre-existing conditions that use terms such as "consultation" and "diagnostic measures" or other similar terms, "unless the definition makes it clear that a condition or disease was diagnosed or actually pre-existed the effective date of the contract."

This prohibition would have a greater effect on group DI coverage than individual DI, because group DI plans must rely more on pre-existing conditions for protection against adverse selection, in the absence of medical underwriting. The Department's proposal limits the protective value of pre-existing condition exclusions by prohibiting exclusions of any medical condition for which a person may have sought consultation and diagnostic measures but never received any treatment, care, services, or prescribed medicines.

The cost impact of this requirement varies by the size of the group. The protective value of the pre-existing condition limitation is greater for smaller size groups. Based on premiums that group DI insurers charge for different pre-existing condition options, we estimate the cost of this prohibition to be approximately 0.5% of the total cost of insurance for cases of 100 lives or more, but possibly 3% for smaller cases. For the purpose of deriving an average estimate covering all group DI policies, we anticipate that this proposed limitation on the definition of pre-existing conditions will increase the cost of group DI insurance by 1-2%. Individual insurers, who have the option of expanding their applications to cover pre-existing situations such as those prohibited by the Department, should incur no significant additional cost.

6. *Compulsory Uniform Provisions*

The Department requires every disability contract to contain the Compulsory Uniform provisions contained in California regulations and prohibits any provisions that are less favorable in any respect to the insured than the statutory provisions. Since these statutory provisions are not new, there should be no issues from the insurers' or consumers' perspective.

7. *All Benefits Must Be Paid to the Insured*

The Department intends to require that all benefits be paid directly to the insured. As a result of this provision, the Workplace Modification Benefit and Pension Contribution Benefit are not permitted.

This restriction prohibits several valuable benefits available in many DI contracts:

- The Workplace Modification Benefit pays for certain modifications to a disabled employee's work location that would facilitate their return to work. Employers are required to make reasonable accommodations for employees' disabilities under the ADA. Thus, the Workplace Modification Benefit is valuable for both employees and employers who may not have the resources to make the necessary modifications.

- The Pension Contribution Benefit pays benefits to a 401(k) plan or annuity while the insured is disabled in addition to the regular disability benefits that are paid directly to the insured. These additional benefits help insureds to continue funding a portion of their retirement when disabled and less able to make such contributions on their own. In the absence of this benefit, disabled employees may have no means of saving for retirement.

Although they are not specifically mentioned in the Department's October 3 notice, the following benefits or coverages would also be prohibited because benefits are paid to parties other than the insureds:

- Disability Buy-out policies, which are designed to provide funds to the business partner of a disabled insured to allow a buy out of the insured's share of business;

- Key Person policies, which are designed to protect a business against losses resulting from the disability of a key employee;

- Voluntary Rehabilitation Programs, which many individual DI policies offer, could be prohibited because the insurer would be paying for expenses incurred by someone (e.g., physical or vocational therapists) other than the insured; and

- Survivor Income provisions, which typically pay three months of benefits to the spouse, children or estate of an insured following the death of the insured while disabled.

There are no direct financial costs incurred due to a prohibition of benefits that are not paid directly to the insured. However, this prohibition may be seen as harming California consumers by preventing their access to a wide range of valuable benefits that are available to residents of other states.

8. Summary of the Impact of DI Policy Changes on the Cost of Insurance

The following table summarizes the various DI policy changes that were discussed above. Some of the proposed policy changes (not included in the table) limit the availability of certain benefits to California consumers but do not appear to add to the overall cost of insurance. Since some of the policy changes listed in the table apply only to group DI insurance, the cost impacts shown below were split between group and individual DI policies.

Impact of DI Policy Changes on Cost of Insurance				
	Group DI Policies		Individual DI Policies	
DI Policy Language Changes:	Low	High	Low	High
Prohibition of Discretionary Clause	3.0%	4.0%		
CA Definition of Total Disability	10.0%	15.0%	10.0%	15.0%
Prohibition of Medical Care Requirement	3.0%	5.0%	1.0%	3.0%
Prohibition of Not-working Requirement	3.0%	5.0%	10.0%	15.0%
Prohibition of Mandatory Rehabilitation	2.0%	4.0%		
Prohibition of Estimated Offsets	4.0%	8.0%		
Offsets from Other Sources	2.0%	3.0%		
Limitation of Pre-existing Conditions	1.0%	2.0%		

The combined increase from all of the proposed DI policy language changes is estimated to be between 28% and 46% for group insurance and 21% to 33% for individual insurance, for policies that currently contain all of the prohibited language. The expected combined increase would be lower for DI policies that currently contain some but not all of the prohibited language.

In addition to creating higher costs of insurance and limited product availability, most of the Department's proposed changes will exacerbate one or more of the factors discussed earlier in this report that complicate DI insurance: difficulties associated with the medical determination of disabilities, adverse selection, overinsurance and the insured's motivation. These changes will disproportionately benefit the small number of claimants who do not wish to return to work or who elect not to receive appropriate medical care for their disabilities. The costs, however, will be significant, and they will be borne by all insurance consumers in California.

Attachment A

The Department's October 3, 2005 Notice

STATE OF CALIFORNIA JOHN GARAMENDI, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
Legal Division, Office of the Commissioner
45 Fremont Street, 23rd Floor
San Francisco, CA 94105

Gary M. Cohen
General Counsel
TEL: 415-538-4375
FAX: 415-904-5889
E-Mail: coheng@insurance.ca.gov
www.insurance.ca.gov

October 3, 2005

SUBJECT: Disability Income Insurance Policy Language

The Department is concerned that there are provisions of disability income insurance products which would not be approved if they were submitted to us today, and in many cases have not been approved for many years, but which nevertheless are contained in policy forms that the Department approved in the past, and are therefore being sold in policies to individuals and employers in California.

This letter is the beginning of the process of determining how we are going to address these concerns and of providing an opportunity for the recipients of this letter to provide input into that process. Our goal is that at the end of the process, provisions that are determined to be lawful and appropriate to be in existing policies that are being offered for sale in California will henceforth be approved in new policy forms filed with the Department, and provisions that are determined not to be lawful and appropriate will no longer be offered for sale in California. One course of action that the Department is considering is to withdraw approval, pursuant to Insurance Code §§ 10291.5(f) and 12957 of all previously-approved policy forms that contain provisions that are determined not to be lawful and appropriate.

The process will work as follows. We will direct all insurers holding a Class 6 license from the Department to provide us with an electronic copy of each of its individual and group disability income policy forms, riders and insert pages as well as any later revised forms that have been approved by the Department and approval of which has not been withdrawn.

Attached to this letter is a description of those policy provisions that the Department does not currently approve, but which are contained in policy forms previously approved by the Department. Interested parties are invited to submit written comments up to 20 pages concerning the legality and appropriateness of these policy provisions, and/or concerning the steps the Department should take to address the concerns described herein.

In addition, the recipients of this letter are invited to attend a meeting with me and other Department staff to discuss these issues on November 17, 2005 in the Administrative Hearing Room at the Department's offices, 45 Fremont Street, San Francisco, 22nd floor. In order to

assure sufficient seating, please register to attend this meeting by November 10, 2005 by contacting Jean Hipon at hiponj@insurance.ca.gov or 415-538-4088.

Questions about this letter may be addressed to:

Alice Gates, Senior Staff Counsel
45 Fremont Street, 21st Floor
San Francisco, CA 94105

Email – gatesa@insurance.ca.gov

Sincerely,

Gary M. Cohen
General Counsel

Addendum

1. Discretionary Clauses may not be used These are contract provisions purporting to confer on the insurer discretionary authority to determine eligibility for benefits and to interpret the terms and provisions of the policy. The use of discretionary clauses render the contract "fraudulent or unsound insurance" within the meaning of Insurance Code §10291.5. Discretionary clauses were the subject of a previous Notice to Withdraw Approval of 8 contracts in February, 2004. The Commissioner's decision following hearing on that notice can be found at http://www.insurance.ca.gov/docs/FS-Legal.htm, File No. AHB-PF-04-01.
In addition, language such as "satisfactory to the insurer" which may create an illusory provision is also precluded under Cal. Ins. Code §10291.5(b).

2. The definition of Total Disability used as a benefit trigger in disability income coverage must be at least as advantageous to the insured as the following: "The term 'total disability' is defined as a disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity." *Moore v. American United Life Ins. Co. (1984) 150 CalApp3d 610, 632; 197 Cal.Rptr. 878, 892.* This is an "any occupation" definition. Insurers wishing to use an "own occupation" standard must use the first portion of the above definition.

3. Additional benefit triggers may not be used: The contract may require no additional criteria to those stated in the California definition of Total Disability cited above. For example, conditions such as regular medical care, appropriate medical care, impairments in Activities of Daily Living (ADL's), cognitive impairments, no-working requirements, loss of income standards or vocational rehabilitation may not be required as benefit triggers or pre-conditions to receiving the benefit. Likewise, benefits may not be discontinued or coverage terminated for such reasons. A "national economy" or other similar standard may not be used to evaluate the insured's occupation under the California definition of Total Disability cited above.

4. Offsets in Group Disability Income Insurance: We interpret 10 Cal. Code Regs §2232.4 to mean that the insured is entitled to receive all periodic payments promised in the contract. Moreover, the amount of the benefit payment may not be stated in a way that is uncertain or ambiguous. CIC §10291.5(b)(1). Therefore, so long as benefit reductions by offset remain lawful, reductions of the promised benefit for "other income" are permissible only: (1) when the insured has received other income (For example, insurers may not reduce benefits by "estimated" amounts or amounts for which an insured "may be eligible"); and (2) when the "other income" is paid in compensation for the same loss as the benefits under the contract. (For example, under *Russell v Bankers Life Co. (1975) 46 Cal.App.3d 405,* "temporary disability benefits are the only workers compensation benefits that may be offset." Unrelated vacation or sick pay, retirement,

inheritance, lottery winnings, etc... may not be used to offset); and (3) if it can be demonstrated that the resulting amount will be specific and unambiguous.
Insurance proceeds may not be used to offset in group insurance. 10 Cal. Code Regs. §2232.34. Offsets for monies paid to spouse or children are appropriate only when the spouse or children are dependents of the insured.
In individual insurance, benefit offsets are not permissible at all. Cal. Ins. Code §10401.

5. Definition of pre-existing condition: Contracts containing limitations for pre-existing conditions may not define "pre-existing condition" using terms such as "consultation" and "diagnostic measures" or other similar terms unless the definition makes it clear that a condition or disease was diagnosed or actually pre-existed the effective date of the contract.

6. Compulsory Uniform Provisions: Every disability contract must contain the Compulsory Uniform provisions. For group products, the compulsory provisions are set forth in 10 Cal. Code Regs. §2232.16 et seq. An exception is that the Incontestability period is 2 years as required in 10350.2. For individual policies, see Cal. Ins. Code § 10350 et seq. Further, contracts may not contain other provisions that "...make a policy or any portion thereof less favorable in any respect to the insured...than the [statutory] provisions..." *Galanty v. Paul Revere Life Ins. Co. (2000),* 23 Cal. 4th 368,387; 97 Cal. Reptr. 2nd 67.

7. All benefits must be paid to the insured: Under 10 CCR 2232.24, all benefits are paid directly to the insured. Therefore, provisions such as Workplace Modification Benefit or Pension Contribution are not permissible unless the benefit is paid directly to the insured.

COMMUNICATIONS

FOR THE RECORD

Statement
on
Private Disability Income Coverage, Consumer Protections, and How Private Coverage and SSDI Work Together

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Submitted to the
Senate Finance Committee

September 28, 2010

I. Introduction

America's Health Insurance Plans (AHIP) is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of products, including private disability income insurance to help consumers replace lost income in the event that a disabling condition forces them to leave the workforce for an extended period of time.

We appreciate the committee's interest in issues surrounding the protection provided by private disability income insurance. In an effort to contribute to the dialogue at today's hearing, our statement provides an overview of private disability insurance and also discusses:

- the value this coverage offers to policyholders;
- our members' collaborations with the Social Security Administration (SSA);
- the private-public partnership between group long-term disability coverage and the Social Security Disability Insurance (SSDI) program; and
- consumer protections for disability claimants.

II. Overview of Disability Income Insurance

Private disability income insurance provides tens of millions of Americans with protection that complements the safety net provided by the SSDI program. Approximately 38 percent of U.S. workers in private industry are covered by employer-sponsored short-term disability coverage, while 31 percent receive long-term disability insurance through their employers[1]. This coverage provides a level of disability income benefits that spares many Americans from financial hardship.

Private short-term disability coverage typically pays benefits for 13 to 26 weeks based on a specified percentage of the employee's pre-disability income – typically 60 percent – after sick leave has been exhausted. Circumstances that may trigger the payment of short-term disability benefits include temporary musculoskeletal or connective tissue conditions, pregnancies, and other illnesses or conditions that are resolved within a relatively short timeframe, thus allowing the employee to return to work before benefits are exhausted.

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[1] National Compensation Survey: Employee Benefits in Private Industry in the United States, U.S. Department of Labor, Bureau of Labor Statistics, March 2009

The valuable protection offered by short-term disability coverage can be purchased at a reasonable price – an average of $205 annually when purchased as group coverage by employers[2]. This short-term protection can be purchased in combination with long-term disability coverage as part of a seamless package, with the short-term and long-term benefits coordinated to ensure that disabled workers can meet their daily expenses and avoid financial hardship.

Additional protection is offered by long-term disability coverage that begins to pay benefits when an individual's sick leave and short-term benefits are exhausted. These long-term disability benefits continue anywhere from five years to the remainder of an individual's life. Long-term disability insurance allows policyholders to sustain themselves financially if a catastrophic illness, injury, or disability takes them out of the workplace for an extended period of time.

III. Value for Consumers

A survey of group disability insurers comprising approximately 75 percent of the commercial disability insurance marketplace showed that more than 627,000 individuals received long-term disability payments from these private insurers in 2009. These companies paid a total of $8.1 billion in long-term disability benefits that year. One-third of these individuals did not qualify for SSDI. Moreover, 95 percent of reported disabilities were not work-related and, therefore, not eligible for benefits under workers compensation[3].

Private group disability insurers resolve claims within 30 days or less for approximately 75 to 80 percent of claimants, thus ensuring that benefits can be paid promptly to replace an eligible claimant's lost wages. Our members' track record exceeds the requirements set by federal regulations, which establish a 45-day timeframe for the initial resolution of private disability claims and allow an extension – of up to a total of 105 days – if, for reasons beyond the control of the insurer, more time is required to gather information.

A 2008 Harris Interactive survey, published by AHIP, reveals that a large majority of disability insurance claimants are satisfied with their policy and their experience filing a claim and

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[2] JHA 2009 Group Disability Market Survey
[3] 2010 Council for Disability Awareness Claims Review

receiving benefits. Overall, four out of five claimants (82 percent) said that they were satisfied with their disability income insurance policy. Specifically, claimants were satisfied with the process for filing a claim (81 percent), the promptness of the payments (79 percent), the responsiveness of the insurer (75 percent), and the overall communication from their insurer (71 percent).

Other key findings from the Harris Interactive survey include:

- Two-thirds of claimants (66 percent) did not encounter any problems with the claims process and for those that did, the vast majority (84 percent) had their problem resolved satisfactorily.
- The vast majority of claimants (96 percent) say it is at least somewhat likely they would have suffered financial hardship if they did not have disability income protection. Furthermore, two-thirds (67 percent) say it would have been very or extremely likely that they would have suffered financial hardship.
- Most claimants who utilized innovative programs offered by insurers, such as return-to-work, rehabilitation, workplace accommodations, education benefits, and help starting a business, were satisfied with these programs.
- Most private disability insurance claimants who also received SSDI benefits (79 percent) said they were satisfied with the process for filing and receiving benefits.
- Ninety-seven (97) percent of SSDI claimants said it was at least somewhat likely they would have suffered financial hardship if they had received only their SSDI benefits and not private disability insurance benefits.

In addition to replacing lost income for claimants in a timely fashion, private disability insurers play a key role in restoring disabled workers to financial self-sufficiency and maintaining productivity for America's businesses. By investing in rehabilitation and return-to-work programs, private disability insurers are actively engaged in helping workers with disabilities return to the workforce. In fact, a survey by Milliman, Inc. found that private disability insurers spent an average of $3,200 in 2005 on each disabled employee receiving rehabilitation and return-to-work services[4].

These innovative programs include a wide range of strategies in recognition of the fact that persons with disabilities are highly diverse and face varying circumstances. Services offered by

[4] Survey of Rehabilitation and Return-to-Work Practices Among U.S. Disability Carriers, Milliman, Inc., May 2007

rehabilitation and return-to-work programs include medical case management, vocational and employment assessment, worksite modification, purchase of adaptive equipment, business and financial planning, retraining for a new occupation, and education expenses. The Milliman survey found that annual budgets for these programs, which vary by size of company, range from $450,000 to more than $10 million.

Additionally, private disability insurers have been very proactive in designing policies that help claimants return to work. As a result, persons receiving private disability payments often have access to work incentive benefits, rehabilitation benefits, workplace accommodation benefits, and child or dependent care benefits during rehabilitation. These innovative benefits reflect our members' strong commitment to promoting employment and self-sufficiency among persons with disabilities.

IV. Private Disability Insurer Cooperation With SSA

Our private disability insurer members have demonstrated leadership by offering assistance to help the SSA speed and improve the adjudication of claims under the SSDI program.

For privately-covered workers who become short-term disability and/or long-term disability claimants, private disability insurers have disability claim information that is also of significant potential relevance and value to the SSDI claim adjudication process. SSA and a group of AHIP's private disability insurer members have implemented a pilot program that, with appropriate claimant consent, facilitates SSA access to key claim information that will help SSA speed and improve the adjudication of private claimants who apply for SSDI. This effort is focused on providing the agency with objective medical evidence, such as attending physician statements and lab and test results, for claims expedited based on presumptive diagnoses and/or terminal prognosis.

By providing the SSA with quality medical evidence already stored in private disability claim files, we can begin to demonstrate the benefits of enhanced cooperation between private disability insurers and the nation's primary public disability income assistance program. These steps can lead to even more robust information sharing and other enhanced public-private cooperation in the future.

We also are pursuing a dialogue with SSA officials on opportunities for improving program integrity in the Supplemental Security Income (SSI) program. We believe that we can help the agency develop a protocol for the verification of eligibility for SSI benefits of beneficiaries who are also receiving private disability income benefits. Savings from improving SSI program integrity through agency cooperation with private insurers could amount to tens of millions of dollars each year.

V. Group Long-Term Disability Coverage and SSDI: A Private-Public Partnership

Disability insurers play a key role in helping consumers exercise their rights under the Social Security program. Specifically, disability insurers provide assistance in the application process to beneficiaries who may be eligible to apply for SSDI benefits. Claimants with expected long-term disabilities are encouraged to apply for SSDI benefits and, according to one study, 69 percent of individuals receiving private long-term disability income benefits also qualify for SSDI benefits.[5]

By encouraging and assisting claimants in pursuing SSDI benefits, disability insurers help them gain access to benefits beyond disability income payments. This includes additional benefits for a spouse and/or dependents, access to vocational assistance and other support from the SSA, and eligibility for Medicare benefits after a period of 24 months.

It is important to recognize that public entities, such as the Federal Employee Retirement System, require disabled beneficiaries to file for SSDI benefits. A requirement to apply for SSDI benefits is also part of many states' workers' compensation systems, as well as public employee retirement systems. These policies demonstrate that it is entirely appropriate for private disability insurers to assist beneficiaries in taking advantage of their rights under the Social Security program.

Moreover, the coordination of benefits with SSDI also keeps disability income protection more affordable for consumers and employers. One study shows that such coordination lowers the cost of private long-term disability insurance by about 40 percent.[6]

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[5] Council for Disability Awareness, 2010 Long-Term Disability Claims Review
[6] Milliman, Inc., November 2005

VI. Consumer Protections for Disability Claimants

The federal Employee Retirement Income Security Act (ERISA) provides important protections for employees, including clear procedures for resolving claims with respect to private disability income insurance.

Under ERISA, claimants must be notified of the reasons for a denial (generally within 45 days) and if any additional information is needed to evaluate the claim. The claimants are given access to the claims file so they can evaluate the evidence behind the denial and if the claim is denied based on medical policies, the claimant must be given a copy of those policies. Claimants must also be told how the appeals process works and their rights to bring a legal action. If claimants disagree with claim decisions, they have the right to appeal any denials to the federal courts.

In addition to these federal protections, nearly all states have established requirements for insurers in making claim decisions and handling internal appeals of claim denials. In 1990, the NAIC adopted a model "Unfair Claims Settlement Practices Act." The scope of this Model Act includes disability income policies and its purpose is "to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance." Forty-four states have adopted this Model Act or some variation of it.

Additional protections, for both consumers and employers, are provided by discretionary clauses in employer-sponsored coverage that authorize plan administrators to interpret policy terms and decide questions of benefit eligibility. These clauses are beneficial to employers and consumers in two important ways. First, discretionary clauses provide consistency to benefit eligibility determinations and to the overall interpretation of policy terms. Second, they enhance the ability of employers to offer coverage that provides reliable, uniform, and affordable benefits to employees.

Discretionary clauses simply describe the standard of judicial review that federal courts must use in litigation about disputed benefit determinations, and they are only activated when an insured challenges a denial of benefits in a lawsuit. If a claim is denied, the claimant has the right to a review of the decision under the federal rules established by the U.S. Department of Labor (DOL) and under state internal appeals and external review laws. If, after this review, the claimant remains dissatisfied with the decision, the claimant may file a lawsuit in federal court to appeal the plan administrator's decision.

The continued use of discretionary clauses is important to ensure that beneficiaries can obtain benefits quickly without facing years of litigation, to allow employers to administer national uniform plans, and to protect against differential treatment for individual employees covered under the same plan.

VII. Conclusion

AHIP and our members look forward to maintaining a dialogue with committee members about the role of private disability insurance in providing consumers with financial protection against the high costs associated with disability.

October 12, 2010

The Honorable Max Baucus
Chairman, United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Charles Grassley
Ranking Member, United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: September 28, 2010 Hearing on Private Long-Term Disability Policies

Dear Senators Baucus and Grassley:

We are writing on behalf of the American Benefits Council ("Council") and the U.S. Chamber of Commerce to submit written comments for the record in connection with the September 28, 2010 Senate Finance Committee hearing on long-term disability ("LTD") policies. The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly, or provide services to, retirement and health plans that cover more than 100 million Americans. The Council and its members seek to advance the continuation, growth and maintenance of employer-sponsored benefit plans.

The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business -- manufacturing, retailing, services, construction, wholesaling, and finance – is represented. Also, the Chamber has substantial membership in all 50 states.

The Council and the Chamber attended the Committee hearing and reviewed the written testimony. Much of the oral and written testimony from the hearing was critical of the legal framework currently in place under ERISA for employer-sponsored plans that provide LTD benefits. In particular, a number of witnesses criticized (i) the use of "discretionary clauses" in LTD plans and insurance policies, and (ii) the unavailability of jury trials and punitive or other "extra-contractual" damage awards in ERISA benefit claims litigation.

Such criticism is misguided because it does not recognize existing safeguards or the impact of the above changes on workers. If legislation were adopted to address the criticism, the nation's voluntary system of employer-sponsored benefit plans and the workers who participate in them would be substantially harmed. To ensure that the Committee has a balanced view on the issues framed by the hearing, we respectfully request that the Committee consider the written comments sets forth below.

America's Voluntary System of Employer-Sponsored Plans

As a threshold matter, it is important to remember that America relies on a *voluntary* system of employer-sponsored employee benefit plans. The voluntary system as it applies to disability programs is rooted in the recognition by employers that they could provide disability insurance on a group basis more cost effectively than individuals in the market place could obtain it on their own, and that if workers relied on the individual market then some workers might end up with insufficient or no income if they became disabled because they might not select to purchase enough or even any such insurance.

ERISA does not mandate that employers provide LTD benefits or any other kind of welfare benefits. "Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Shoonejongen*, 514 U.S. 73, 78 (1995). Congress has wisely supported the principle that a voluntary system of employer-sponsored benefit programs optimizes benefits for America's workers.

Within this voluntary system, an employer or other plan sponsor must make a number of design choices that will impact the overall cost of its LTD benefit program. The employer might establish an LTD plan that pays generous benefit amounts or, instead, one that pays less generous amounts. An employer might decide that the LTD plan should pay benefits whenever an employee is unable to perform his or her own job or, instead, pay benefits only when the employee is unable to perform *any* job, not just his or her current job. Similarly, an employer may or may not include a "discretionary clause."

A discretionary clause gives the plan fiduciary (which may be the insurer) discretionary authority to determine eligibility for benefits or to construe plan or policy terms. When such discretionary authority is granted, federal common law under ERISA generally requires a reviewing court to defer to the fiduciary's determination so long as that determination is reasonable, even if the court might have made a different decision.[1] So long as the underlying decision is reasonable, the decision of the plan fiduciary is upheld. This type of deference to a fiduciary's determination is common in trust law and it reduces uncertainty and, hence, costs, including litigation costs for an employer's LTD plan.

ERISA Gives Every Plan Participant the Right to Have an Impartial Federal Judge Review Benefit Claim Denials

Certain witnesses at the September 28 hearing accused some insurers and plan fiduciaries of slanting their eligibility decisions against deserving claimants and in favor of a short-term interest in minimizing benefit expense. These witnesses further argued that discretionary clauses insulate biased eligibility decisions from meaningful judicial review.

Those arguments ignore the legal safeguards already in place for LTD benefit claimants under ERISA. As you know, ERISA § 502(a)(1)(B) gives every plan participant the right to have a federal judge review a final benefit claim denial. If the federal judge concludes that the claim was wrongfully denied, the judge may award the disputed benefit and also order the plan or insurer to pay pre-judgment interest plus the participant's reasonable attorney's fees and costs.

Importantly, current law under ERISA also allows the federal judge to factor into his or her decision the impact of any alleged bias on the part of the LTD insurer or plan administrator. The Supreme Court's recent decision in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. __, 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008) confirms that a reviewing court may consider conflicts of interest on the part of the claims fiduciary in determining whether the fiduciary's decision was an abuse of discretion. Thus, if a discretionary clause is being abused by an insurer (or other plan fiduciary) that is operating under a conflict of interest, that conflict of interest is "weighed as a factor in determining whether there is an abuse of discretion." *Id.*, 127 S.Ct at 2360.

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[1] The law in some States bans discretionary clauses from insurance policies sold in that State. Federal courts of appeals have split on whether these State-law bans are preempted by ERISA and, hence, unenforceable with respect to self-funded ERISA plans. *Compare Hancock v. Metropolitan Life Ins. Co.*, 590 F.3d 1141 (10th Cir. 2009) (holding that ERISA preempted State's rule); *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009) (holding that State's rule is saved from preemption).

Critics of discretionary clauses would bar their use even though in the vast majority of cases the plan fiduciary has acted faithfully and without bias. Eliminating the deference accorded to plan decisions would increase uncertainty and litigation cost for plans unnecessarily.

The two other measures advocated by those same critics – jury trials and enhanced damage awards in benefit claims litigation – would be devastating to employers that voluntarily sponsor plans and are not needed. As noted above, participants in ERISA-covered plans already enjoy the right to have a federal judge review final benefit claim denials. There is no evidence, nor any reason to believe, that federal judges are deciding benefit claim disputes unfairly. Nor is there anything unusual in having judges rather than juries decide disputes of this nature. Much of ERISA is modeled on the law of trusts, and trust law has always relied on judges sitting in equity, rather than on juries, to resolve disputes over trust administration. *See Graham v. Hartford Life & Acc. Ins. Co.*, 589 F.3d 1345, 1355-56 (10th Cir. 2009) (explaining why Seventh Amendment right to a trial by jury does not extend to ERISA benefit claims because such claims are equitable in character rather than the kind of claims traditionally heard in courts of law).

Presumably, proponents of jury-tried benefit litigation believe that juries will be more sympathetic to LTD claimants than are federal judges. But advocating jury trials on that basis is just another way of saying that the legal playing field should be tilted in favor of granting or settling claims in favor of claimants even if the claim is questionable. This would only serve to increase costs of obtaining disability insurance, thereby hurting workers.

Allowing for open ended punitive and compensatory damage awards would tilt the legal playing field in an even more biased way. Such damages raise the stakes in litigation, but create no offsetting balance of costs for the insurer or plan (and in turn the workers and employers who are bearing the costs) if it wins. Raising the stakes in a one-sided fashion would force employers and insurers to capitulate on claims rather than litigate even very questionable or weak claims because capitulation would be less expensive than the risk of defending such claims. These costs will be borne by employers that sponsor LTD plans and their employees, either directly where the plan is self-insured, or indirectly though higher premiums, if the plan is insured.

In sum, outlawing discretionary clauses, mandating jury trials, and enhancing damage awards would all have the effect of encouraging plan fiduciaries to pay claims that have no merit. This outcome might work to the short-term advantage of those participants who have questionable claims. But such an outcome would necessarily work to the disadvantage of plan participants overall if the result is to increase costs that causes employers and/pr employees to reduce LTD benefits.

In a voluntary system of employee benefits, each employer has a finite amount to spend on compensation and benefits, including LTD plans. If the playing field is tilted in ways that require the employer's LTD plan pay a greater number of questionable claims, the employer will have to recoup those increased costs through offsetting changes to the LTD benefit, or other aspects of the compensation and benefit package. For example, the employer may be forced to adopt a less generous benefit formula that reduces the overall amount of every eligible participant's benefit. Those participants with solid and undisputed claims end up paying for the benefit dollars that are rerouted to participants with weak and questionable claims. That outcome plainly is not a good one for America's workers.

We thank the Committee for considering our views on these important issues.

American Benefits Council

U.S. Chamber of Commerce

STATEMENT OF MICHAEL CAPENER
SENATE FINANCE COMMITTEE HEARING OF SEPTEMBER 28, 2010
"DO PRIVATE LONG-TERM DISABILITY POLICIES PROVIDE THE PROTECTION THEY PROMISE?

Dear Chairman Baucus and Finance Committee,

I wish to express my thanks for advocating for the professionals who are now disabled. You have my support. I hope my case study will help enlighten the need for consumer protection in the ERISA law and stronger regulatory oversight.

Background: I served the community for over 20 years in the High Tech Field. As an adjunct Professor at Weber State University, I taught my students with the vision that they are the next generation that will make this country technologically great. I served as the engineer that connected Thiokol and NASA together to work on the Space Shuttle Project. I built networks that connect the US, Canada, Europe, Taiwan, Hong Kong, and China for Internet commerce. Silicon Valley Companies asked me to design and secure their worldwide networks. Through policy change, I pioneer consumer protection of credit card information though secure network design.

Today, I am Medically Disabled. I am losing more function every day. The Private LTD Policy sold to me by my employer Unisys and their insurance company Aetna did not provide any of the benefit they promised. The constant run around and denial resulted in worsened symptoms and caused my health to spiral dangerously downward over worry for my family's welfare.

In the early 1990s, when I was working as the Campus Network Manager, I pioneered the network that connected 60 University of Utah research buildings to the Internet Research Community. Ironically, I am now in one of the case studies that is tracked through this research network that I help pioneer over a decade ago. Now the U of U in conjunction with Dr. Bateman, Drs. Light, national university research teams, CDC, and NIH are working tirelessly on a research cure to keep me and millions like me alive. Our research biomarker work has been published in The *Journal of Pain*.

I invite the finance committee to help focus time and funding toward a regulation of ERISA Insurance and research toward a cure for chronic illnesses like CFS. Imagine if a cure was discovered, it could put millions of professionals like me, back to work building a great Country.

Let us not waste the precious time of national research doctors' in dealing with the endless insurance paperwork that result in cursory denials to the disabled of these much needed benefits. It is in everyone's best interest to find a cure. Let new legislation protect the disabled, and free our professionals to find a cure, improve health, and protect the Health of our Nation.

Recommendations: I would like to share my recommendations to improve the ERISA Law:

1. Defer to the Treating Physician like the in SSDI Administrative Standard.
2. Require employers to offer multi-competitive LTD choices to employees.
3. Require mandatory disclosure of insurance price, ratings, and percentage of "claims paid on 1st request" stats as part of employee benefit election process.
4. Clear Federal standards and consumer protection. Claims must be paid in 30 days. (Like existing medical claim law)

5. Establish a Federal Office to regulate and investigate consumer complaints. (Department of Labor Standard)
6. Federal regulator should have the right to overturn any insurer decision. Regulator should have the right to fine insurers for abuse.
7. If employee death/incapacitation, insurer must pay as if the employee lived to age 65.
8. Employee is entitled to disability claim if he/she cannot medically perform **all duties in** a reasonable time required by the employer to meet its reasonable satisfactory results.
9. Insurers should be held liable for bad faith, damages, back interest, etc.
10. Employees under ERISA should have all trial rights, including a Jury trial, damage awards, etc.

I am asking the Senate Committee to strengthen the ERISA law, regulation, and oversight funding. I invite the Senate Committee to create a shining example of consumer protection to ensure benefit payout to the hard working employees who later become disabled.

I hope this will help raise awareness for the thousands of people who live and die from chronic illnesses. If I can help in any way, please contact me.

Michael Capener

"Do Private Long-Term Disability Policies Provide the Protection they Promise"

Chairman Max Baucus

Hearing Time/Date: September 28th 2010, 10:00 am

Location: Room 216 Dirksen Senate Office Building

To:
Senate Committee on Finance
Attn: Editorial and Documentation Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

From:
David Craine

Through internet search I became aware of the above titled hearings being led by Chairman Baucas and the opportunity contact this committee and share my inputs.

I am also forwarding this document to Chairman Baucas and to Senator Grassley, my Iowa Senator.

It is very difficult for me to put together my thoughts and focus for an extended period of time in order to get my thoughts down for you to truly understand my situation. I worked for nearly 30 years in high technology industries, achieving senior levels within each of these

businesses and earning several hundred thousand dollars a year in salary and additional compensation.

I assumed as many others that when you become a member of a large global business (RFMD, Greensboro, North Carolina) with highly rated disability insurance (Hartford Disability) that if I were to become disabled that I would be covered and my family would be taken care of until I could recover.

But in my case, when I did become disabled and the seriousness of my illness required focusing on my health, my health took a back seat to my battles with Hartford Disability.

After more than 3 years of legal struggles Harford still continues to deny my claim, even though my 3 doctors have documented my disability, Hartford's own records show that they approved my claim but someone higher up in the company decided to bring in some doctor to review my record that I never met and had no medical expertise in treating my specific illness. In fact the group that this doctor belonged to advertises to the Insurance Industry that if you do business with them they will guarantee a higher claims denial rate.

After pursuing Harford Disability, thinking that it would be less of a hurdle to get approved, I applied for and received Social Security Disability less than 6 months after my application. Yet because of the games that the insurance companies play and our ERISA court system, Harford is the expert and has all of the money and time to fight this. Not because I am not disabled but because my claim is large and Hartford has nothing to lose.

Over and over I have read articles on the internet that state that all the insurers like Hartford have to do is deny the claims, run the people out of money, get them desperate, or have them DIE. The worst thing that

will happen to Hartford is it goes to court and they have to pay what they owed. No real penalties – ERISA is actually a system that enables the insurer to decide if they want to pay or not (actually anchorages them not to pay) and then anchorages them do everything evil to people like me and hope that I go away or better yet that I die.

At a time when my focus should have been on finding ways to recover my health but instead it has been focused on trying to survive, keep my family together and a place to live. And of course trying to Stay Alive...

After 3 years of no income, losing our home in North Carolina, living on food stamps and trying to just survive (with lots of support from family and Social Security Disability coming through) we had to file Bankruptcy last month in the state of Iowa.

Here I am, having made substantial amounts of money in my life with lots more potential for success just struggling to get by, a burden on our governmental systems for life support – all because of the EVIL that exists in the Disability Insurance Business – with Hartford Disability consistently being rate as #1 in denying disability claims.

Most people in my situation don't even make it to ERISA court for their claim, since it is a legal nightmare just navigating the ERISA system and unless your claim is of substantial value, not many lawyers sign up for the case. And just imagine a system where you get 66% of your income through Harford Disability and then 33% of that goes to the Lawyer for battling the Insurance company to get what you were owed. Being disabled is a family disaster already – now add the financial issues and stress and you get awfully close to death.

If you are interested in my case please let me know, or better yet contact my lawyer in North Carolina:

Robert McIver
Jim Miles
Higgins Benjamin Eagles & Adams, PLLC
101 West Friendly Avenue, Suite 500 (27401)
P.O. Box 20570
Greensboro, NC 27420
Telephone: 336-273-1600

The whole process I have experienced can be better explained by the article I have pasted below:

Daily Journal investigation sheds light on disability insurance's dark corner
By William Heisel
October 26, 2009

Employees everywhere sleep a little easier knowing that their company covers the bulk of the cost of their disability insurance. If they are hit by a car or fall of their roof or incur some other injury that prevents them from working, they can count at least a modest income from their insurance policy.

At least that's how the insurance company's brochures make it sound.

Evan George at the Los Angeles Daily Journal has exposed the hollow promises made by insurance giants like Metropolitan Life Insurance Co. with an investigative series published earlier this month.

Here are some of the key findings:

Insurance companies regularly deny, or terminate, benefits to people even after they are found disabled by the federal government and approved for Social Security checks. The companies hire contract

doctors who routinely reject the opinion of treating physicians without ever having seen the patients.

Some insurers provide incentives to employees to deny and terminate claims, tying performance evaluations to meeting money-saving goals.

No regulatory agency has taken responsibility for these cases. Consumers who complain to the Department of Insurance are ignored or told to contact the federal Department of Labor because workplace benefits are controlled by federal laws. But the Department of Labor does not investigate, or track, the complaints either. Officials say the only thing the law provides is the chance to sue in federal court.

Those who choose to fight the insurance companies wait years. Plaintiffs waited two years and eight months on average from the time they became disabled before their cases resolved, the Daily Journal found. One man has been waiting 10 years for benefits.

In nearly half the cases reviewed by the Daily Journal that reached court, judges find that the insurance companies had no basis to deny benefits. Judges who consider the companies' patterns of practice side with workers even more often, one survey found, nearly 70 percent of cases.

Because federal law does not allow for any damages, there is no peril for the insurance companies to repeatedly deny legitimate claims. Judges often find that the insurers wantonly denied or arbitrarily stopped paying benefits to disabled workers. Yet the most the companies will have to pay is the original amount, plus, in some cases, legal fees.

George tells the story of victim after victim with dispassionate detail. One woman, Jocelyn Guevarra, worked for the insurance company

CIGNA for 15 years, much of that time reviewing claims from people who were hoping to receive disability insurance payments. In a cruel irony, the company hired an investigator to help it deny Guevarra's claim for benefits after her doctors told her that her arthritis and chronic pain problems were too severe to allow her to continue to work. CIGNA said that footage of her helping her mother out of a car was proof positive that she was not disabled.

Donald Bauza, a 52-year-old military consultant, and retired soldier, suffers from a bowel disease that forced him to have his colon and rectum removed.

Five surgeries later, he had lost nearly a hundred pounds and said he was convinced that he was going to die.

"If I got any sleep it was because I decided to sleep in my own filth, which I did," Bauza said. "Psychologically I was wrecked. I was completely disabled."

His physicians and the Social Security Administration agreed.

His insurer, MetLife, did not. After initially paying the claim, it terminated his benefits saying he should be fully recovered.

The Daily Journal also provides powerful numbers to back up the story and quotes directly from company emails, memos and other internal records.

How did George get access to all this great material? He spent a lot of time in court, talked to attorneys and regulators on all sides of the issue and dug into the details of what these patients' policies promised and what they received.

It makes sense for a newspaper devoted to the legal industry to have strong connections in the legal community. But George went beyond what the lawyers told him. He took what he found in nearly 600 cases filed in federal court and made sense out of it by logging it in a database and calculating various trends. For example, he was able to show that MetLife had been sued more than any other company, 177 times between 2004 and June of 2009.

MetLife had 30 percent of the lawsuits filed recently against the seven most prolific disability insurers in the state, but only 12.2 percent of market share as measured by premiums this year.

The next most sued company was Unum with 109 complaints, 19 percent of filed against the busiest insurers and 17.8 percent of market share. The Hartford faced 95 lawsuits, 16 percent of the lawsuits reviewed, but 13.6 percent of the market.

Those three companies sell the most disability insurance policies nationwide, according to a 2008 study by industry research group JHA. George also found that, of the lawsuits that made it to a trial, judges found that insurers wrongly denied benefits in 45 percent of cases.

Disability insurance is a rich and mostly untapped area for health writers. The Daily Journal's investigation focuses on California. There are 49 other states. Go to it.

Margaret L. Crowell

October 13, 2010

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

Re: Do Private Long-Term Disability Policies Provide the Protection They Promise?

I recently viewed the above captioned hearing and wanted to share some comments with you. Unfortunately,I was unaware of the hearing until after the comment period had expired. I am an alumnus of the John Marshall Law School Employee Benefit LLM Program. I was a privileged to have Mr. Debofsky for a professor and I am ecstatic that the Legislature is looking into the present denial of due process that has been established by the Judicial interpretation of ERISA. As an avid constitutional law advocate, I was appalled when I first learned that plan beneficiaries were not allowed a fair trial and that insurance companies were given administrative agency status through the interpretation of *Bruch v. Firestone*. I know that you clearly heard the difference that Mr. Rust presented in the process afforded a claimant under an actual administrative agency, the Social Security Administration, versus the process afforded a claimant under the insurance company review process.

As you so aptly stated justice delayed is justice denied. Claimants who are denied benefits by insurance agencies under ERISA can often face three tiers of appeals to the same decision makers prior to being allowed to bring a court action. Then when the court action is commenced the claimant is not afforded the right to a trial, the right to a jury, or the right to

consequential damages. Rather the Judges decision can only be based on the record presented and the decision of insurance company is given the deference as if the claimant had the benefit of a fair trial and only over turned if the decision is found to be arbitrary and capricious.

Contrary to the statement made by Mr. Graham that the claimant can always just hire more experts to place testimony into to the record, most claimants run out resources long before they can ever reach the court. To state that the claimant, who is presently unemployed due to their disability and being denied the benefits they need to exist, is reasonably capable of bearing the extra financial burden of hiring more experts is ludicrous. Furthermore, the assertion of Mr. Graham that the present deferential review is a means of controlling the cost of litigation is also ridiculous. Presently the insurance companies are spending money on attorneys to delay and deny the benefits with the knowledge that in all likelihood the benefits will be denied by the court, and even where the claimant does manage to overcome the deferential standard there are no punitive or consequential damages for the claimant so the insurance company never has more to lose than the payment of the benefit.

The largest disability insurer in the United States had 40% of their claims overturned under the Maine review. I dispute Mr. Graham's statement that this was one bad actor, this was clearly the pattern and practice that allowed UNUM to become the largest disability insurer in the U.S. It was not paying claims. I would postulate that the best way to increase the market share of people purchasing disability insurance from 30% would be to allow them to collect the benefit that they bargained and paid for. It is certainly difficult to get a majority of people to purchase something they will most likely never receive. Clearly it is in the best interest of the public policy to encourage people to purchase disability insurance it prevents them from becoming a burden on society, if they can actually receive their benefit.

I agree with Judge Akins that the present climate of disparate treatment of group plans under ERISA will not change with out legislative intervention. Professor James Wooten of Buffalo Law School has written a series of articles on ERISA Preemption that are extremely informative, http://www.law.buffalo.edu/Faculty_And_Staff/submenu/Wooten/ERISAPreemptionPart1.pdf http://law.buffalo.edu/Faculty_And_Staff/dynamic_general_profile.asp?faculty=wooten_james. The preemption and deferential treatment of ERISA plan administrators decisions arose in an era when benefits where primarily self insured by company or union health plans. The deferential standard was meant to preserve the benefits for all plan participants. In the present climate of primarily insurance companies as plan insurers the deferential standard benefits only the insurance companies. In his articles Mr. Wooten discusses the failure of the legislature to appoint an administrative agency to administer ERISA as the result of power struggles between Labor, Business and Treasury. None of these groups wanted the other to gain too much power which resulted in enforcement of ERISA being spread between them and left the claimants with out an administrative agency to review benefits decisions.

The Judiciary, as Judge Acker discussed has taken a hands off view of these case, perhaps in an attempt to force the legislature to legislate or more essentially because it lacks the ability to legislate. In Judge Acker, I sense the frustration of a man committed to justice who is being forced to deny claimants their due process rights and render decisions that are unjust because he lacks the authority to serve justice. In his own words, he is forced to stand back and watch as the fox guards the hen house. Finally, in no way can I be convinced that Judge Acker or another Judge in his stead does not have the capability of understanding the complexity of a disability case or the testimony necessary to prove or disprove one.

As noted in the Hearing, this issue does not only impact the disability claimants but also health plan claimants and as Mr. Debofsky stated their situation is even more critical as they may die when benefits are denied. I recently had a friend who broke her foot. The doctor wrote on the order "patient should have a medical boot". The insurance company denied it as not medically necessary, I guess the doctor was suppose to say *must* have a medical boot, she walked around for a week with a broken foot and no brace. My pregnant sister-in-law was denied coverage for a doctor ordered ultrasound; she was told that insurance company would review the decision in 30 days. She was due in two weeks.

Also noted in the Hearing is the thought that these issues should be in the Health Committee, but the financial impact these denials of benefits have on the public results in a financial burden on the entire country and the government. In the interest of the public welfare we are forced to absorb the costs of these benefit denials in our social programs which end up providing for claimants who paid for insurance and are now being denied there right to receive it. New Health Reform Legislation does not address the fact that claimants are being denied their due process rights in claim reviews. It merely creates another delay in the claims process.

Claimants have a right to fair hearing, either in the courts or an administrative agency. In my thesis paper at John Marshall Law School, I proposed that the National Labor Relation Board would be an appropriate venue for the administrative review of benefit claims. The cost of denying a fair hearing is too high for claimants, society, and justice.

Sincerely,

Margaret Crowell, JD, LL.M.

September 28, 2010

Chairman Max Baucus
Ranking Member Charles E. Grassley
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Statement for the Record
The Hartford Financial Services Group, Inc.
"Do Private Long-Term Disability Policies Provide the Protection They Promise?"
United States Senate Finance Committee

Dear Chairman Baucus and Ranking Member Grassley:

As a national leader in the insuring and administering of employee benefit programs, The Hartford is compelled to respond to the misleading written testimony submitted by Ronald Leebove, Certified Rehabilitation Counselor, for today's hearing regarding disability policies. Specifically we need to respond to Mr. Leebove's claim on page 13 that an "investigation" of a Hartford Long Term Disability claimant's file subsequent to approval for Social Security Disability Insurance (SSDI) is "outrageous."

Our claimant's privacy is of the utmost importance, so we are restricting our comments to general practices. Under a disability policy or plan, a disability claimant's file is reviewed as a claimant approaches the end of his or her "own occupation" period to ensure that the claimant will meet the "test change," which is the transition of the definition of Disability to an inability to perform "any occupation" based upon the claimant's training, background or education. Irrespective of SSDI's approval, a test change review is required under the policy or plan and necessary to uniform and non-discriminatory administration. Moreover, claimants' conditions are not always static. Health can improve or worsen. Technologies and adaptive devices are developed. An insurer or administrator has a responsibility to review whether claimants continue to meet an employee benefits plan's Definition of Disability. It is an important and standard review within the industry.

We felt it was important to provide basic information for the committee and we would be pleased to answer questions for the committee with the appropriate privacy consent from the claimant.

Sincerely,

Marialise A Maroun

Marialise A. Maroun
Vice President Group Benefit Claim

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