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The Disability Dilemma: Difficulties Involving ERISA Claims for Subjective-Proof Diseases

Introduction

Imagine going to the doctor with an intense amount of pain. When he shows you the pain scale, you point to the most scrunched up, sweating face, indicating you're feeling a ten on a ten-point scale.¹ Imagine that your doctor tells you that you are not entitled to relief because he cannot objectively measure how much pain you are feeling. He cannot objectively find the cause of your pain, and so he cannot prescribe any medication that might help you manage that pain. Though this scenario would not happen in a doctor's office, this process is how some disability plans treat employee claims for benefits under employee benefit plans covered by the Employee Retirement Income Security Act (ERISA).² Claimants want disability benefits for diseases that doctors diagnose using subjective criteria, such as patient reports of pain or interviews, but employers do not want to grant these benefits because of the lack of objective proof of the disease.

Many claims for long-term disability benefits are denied, some because the subjective evidence the claimant presented, even by way of a treating physician, do not meet the criteria for which their plan provides.³ Since these claims are expensive to pay out, the employer may deny the claim early on, banking on the fact that the claimant may not want to expend the time and money to appeal the denial.⁴ In an obvious disability case, such as the result of a car accident, it may be easy to obtain disability benefits. If, on the other hand, "there is any dispute regarding a diagnosis or impairment and its disabling effects, the insurance company usually resolves that doubt

1. *Wong-Baker FACES Pain Rating Scale*, WONG-BAKER FACES FOUND., <http://wongbakerfaces.org> (last visited Jan. 17, 2020).

2. Employment Retirement Income Security Act of 1974 § 3(1), 29 U.S.C. §§ 1001–1461 (2012). "The terms 'employee welfare benefit plan' and 'welfare plan' mean any plan, fund, or program which was . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries . . . disability . . . benefits . . ." 29 U.S.C. § 1002(1).

3. See, e.g., *Hobson v. Metro. Life Ins. Co.*, 574 F.3d 75, 88 (2d Cir. 2009); *Billinger v. Bell Atl.*, 240 F. Supp. 2d 274, 282–83 (S.D.N.Y. 2003).

4. See Loren M. Lambert, *ERISA: License to Cheat, Lie, and Steal for the Disability Insurance Industry*, UTAH B.J., Sept.-Oct. 2008 at 14, 16 ("[A] reasonably sophisticated and careful insurance company can summarily deny almost all appeals and immunize their decision from reversal in federal district court.").

in its favor.”⁵ When a claim for disability is denied, it can be very difficult for a claimant to appeal the decision.⁶ A claimant must first file an administrative appeal and exhaust his administrative remedies.⁷ If the denial is affirmed, then the claimant must find a lawyer and appeal to the proper district court, creating an additional expense. Given the deferential standard of review for ERISA denials, it is likely that a district court will uphold the plan administrator’s decision.⁸

When plan administrators deny these claims, claimants may appeal the denial to the federal court that has jurisdiction and venue over the claim.⁹ In most cases, the federal court will review the claim to determine if the plan administrator abused its discretion in denying the claim for disability benefits.¹⁰ The abuse of discretion standard of review—used in most appeals of denial of disability claims—provides that the administrative denials of the claims are usually upheld.¹¹

Frequently, employees make benefits claims for disabilities that stem from diseases that are diagnosed using subjective evidence.¹² Plan

5. *Id.*

6. *See id.* (“[U]nder ERISA, regardless of the merits of a disability claim, to prevail a claimant must show that the insurance company’s decision was unreasonable, only supported by more than a scintilla of evidence, or both.”).

7. *See, e.g.,* Counts v. Am. Gen. Life & Accident Ins. Co., 111 F.3d 105, 108 (11th Cir. 1997); Weldon v. Kraft, Inc., 896 F.2d 793, 800 (3d Cir. 1990); Amato v. Bernard, 618 F.2d 559, 567–68 (9th Cir. 1980).

8. *See* Lambert, *supra* note 4, at 16.

9. *See infra* Section II.A.

10. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989); *see also* Christopher R. Stevenson, *Abusing Abuse of Discretion: Judicial Review of ERISA Fiduciaries’ Discretionary Decisions in Denial of Benefits Cases*, 27 HOFSTRA LAB. & EMP. L.J. 105, 106 (2009) (“Circuit courts erroneously imported the overly-deferential arbitrary and capricious standard of review into ERISA, making it unlikely for any but the most blatantly unreasonable administrator’s decisions to be overturned.”).

11. *See* Stevenson, *supra* note 10, at 106 (“Despite Congress’s good intentions, employees whose ERISA health claims had been denied still faced an uphill battle in federal court.”).

12. *See, e.g.,* Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 916 (7th Cir. 2003) (“[F]ibromyalgia, ‘also known as fibrositis [is] a common, but elusive and mysterious, disease, much like chronic fatigue syndrome, with which it shares a number of features. Its cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective.’”) (quoting Sarchet v. Chater, 78 F.3d 305, 306–07 (7th Cir. 1996)); Rodriguez v. McGraw-Hill Cos., Inc., 297 F. Supp. 2d 676, 677 (S.D.N.Y. 2004) (“The issue . . . is whether the malady known as ‘fibromyalgia’ is

administrators have denied long-term disability benefits because they deem the evidence for disability too subjective, therefore finding the claimant is not disabled.¹³ Administrators also include provisions in their contracts that prevent long-term disability coverage for diseases that involve certain “self-reported” symptoms.¹⁴

The standard of review in a judicial appeal for a denial of long-term disability benefits under ERISA in its current state does not allow a claimant full and fair review, especially if the claimant suffers from a subjective-proof disease. The medical perplexity involved in the etiology of these diseases and the discretion given to plan administrators under these claims make it very difficult for a claimant to overturn a denial of these benefits. This Comment examines the policy implications of the bias against subjective evidence as it is paired with the generous abuse of discretion standard of review implemented in most denial of disability benefits cases.

Part I of this Comment outlines the pathway of benefits claims under ERISA and the road to federal court review of administrative decisions. Part II discusses subjective-proof diseases and the types of evidence that claimants bring forward in their attempts to obtain disability benefits. Part III provides an overview of certain proof requirements in both ERISA litigation and other areas of the law and analyzes how courts are handling administrative denials for disability claims involving subjective proof. Finally, Part IV suggests reforms to ensure protections for claimants who apply for disability benefits for diseases and conditions that are only diagnosable using subjective proof.

medically determinable, notwithstanding the absence of a definitive objective test for its diagnosis.”).

13. *See, e.g.*, *Schnoor v. Walgreen Income Prot. Plan for Pharmacists & Registered Nurses*, 968 F. Supp. 2d 869, 873 (W.D. Mich. 2013).

14. *See, e.g.*, *Chronister v. Baptist Health*, 442 F.3d 648, 655 (8th Cir. 2006) (evaluating a provision limiting disability benefits to twenty-four months if based on self-reported symptoms, in this case fibromyalgia); *Hilton v. UNUM Life Ins. Co. of Am.*, 967 F. Supp. 2d 1114, 1116, 1120 (E.D. Va. 2013) (evaluating a provision limiting disability coverage to twenty-four months in the case of self-reported migraine headache symptoms).

I. The Disability Claims Process

A. The Cause of Action

In 1974, Congress passed the Employee Retirement Income Security Act (ERISA) to implement a uniform set of rules and protections for employees.¹⁵ Before its enactment, pension and other employee benefit plan claims disputes were resolved as breaches of contract.¹⁶ The impetus for ERISA was the “rapid and substantial” increase in the “size, scope, and numbers of employee benefit plans.”¹⁷ The primary goal of ERISA was to “protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries.”¹⁸

ERISA provides regulation for employer-provided welfare plans.¹⁹ Under ERISA, a welfare plan is a “plan, fund, or program” created or managed by an employer “for the purpose of providing” medical benefits to its participants “in the event of sickness, accident, *disability*, death, or unemployment.”²⁰ ERISA defines disability as “the inability to work for pay because of an injury or illness.”²¹ In a 2018 survey, the U.S. Bureau of Labor Statistics found that 34% of workers had access to employer-provided long-term disability insurance coverage, and that 97% of workers who had access to an employer-sponsored plan participated in it.²²

Many employers provide their employees with certain disability benefits, which are covered by ERISA.²³ Disability benefits can be either short-term or long-term and include “payments, usually monthly, to replace income

15. See Employment Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001–1461 (2012)).

16. See Mark D. DeBofsky, *A Critical Appraisal of the Current State of ERISA Civil Procedure – An Examination of How Courts Treat “Civil Actions” Brought Under the Employee Retirement Income Security Act*, 18 EMP. RTS. & EMP. POL’Y J. 203, 205 (2014).

17. 29 U.S.C. § 1001(a).

18. *Id.* § 1001(b).

19. STEVEN J. SACHER ET AL., ABA SECTION OF LABOR & EMP’T LAW, EMPLOYEE BENEFITS LAW 26 (2d ed. 2000).

20. *Id.* (quoting 29 U.S.C. § 1002(1)) (emphasis added).

21. Thomas Brown & Howard Hensley, *Disability Benefit Plans*, in EMPLOYEE BENEFITS HANDBOOK 18-2 (Fred K. Foulkes ed., 1982).

22. U.S. BUREAU OF LABOR STATISTICS, U.S. DEP’T OF LABOR, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN THE UNITED STATES tbl. 16 (Mar. 2018), <https://www.bls.gov/ncs/ebs/benefits/2018/employee-benefits-in-the-united-states-march-2018.pdf>.

23. See *id.* at tbl. 2.

lost due to inability to work as a result of illness, injury, or disease.”²⁴ Long-term Disability (LTD) insurance is a policy that protects an employee from loss of income if he can no longer perform his job.²⁵ LTD benefits begin paying out once short-term disability benefits have ended, typically after three to five months.²⁶ Employers typically provide LTD plans for their employees as part of their compensation package (i.e., as fringe benefits), but they are not required to do so.²⁷ Though short-term disability benefits generally expire within two years, long-term disability plans “pay extended benefits, generally until retirement age[.]”²⁸ Since they apply for an extended period, “LTD benefits are frequently payable only if the participant is unable to perform significant functions of *any* occupation for which he or she is reasonably suited by skill, education, and experience.”²⁹

LTD plans entail a large portion of disability claims because “[t]he present value of such claims can be substantial.”³⁰ The high value of these claims is due to the potentially large payout if a claimant is young or highly compensated, because the benefits will typically be awarded until the claimant reaches retirement age.³¹ Most employer-sponsored LTD plans pay a fixed percentage of annual earnings to a worker awarded benefits.³² According to the U.S. Department of Labor March 2018 survey, the median fixed percent of annual earnings is 60%.³³ The same survey showed that 88% of claimants awarded LTD benefits received the maximum benefit amount, with the ninetieth percentile receiving \$15,000 per month.³⁴

To obtain LTD benefits from his employer-provided plan, an employee must show that he meets the disability requirements provided by his

24. SACHER ET AL., *supra* note 19, at 358.

25. 1 PAUL J. ROUTH, WELFARE BENEFITS GUIDE § 2:28 (2019).

26. *Id.*

27. BALDWIN’S OHIO HANDBOOK SERIES: EMPLOYMENT PRACTICES LAW § 14:1 (Nov. 2019).

28. SACHER ET AL., *supra* note 19, at 358.

29. *Id.* at 358–59 n.17; *see also* Brown & Hensley, *supra* note 21, at 18-2 (“[M]ost long-term disability benefits are reserved for those who are unable to hold any substantial employment for which they are qualified.”).

30. SACHER ET AL., *supra* note 19, at 1087.

31. *Id.*

32. U.S. BUREAU OF LABOR STATISTICS, *supra* note 22, at tbl. 29.

33. *Id.* at tbl. 30.

34. *Id.* at tbl. 31.

employer's plan.³⁵ A participant files a claim with her plan administrator for benefits in accordance with plan procedures.³⁶ After a claim has been made, ERISA directs that plan administrators must "(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied . . . , and (2) afford a reasonable opportunity to any participant . . . for a full and fair review by the appropriate named fiduciary of the decision denying the claim."³⁷ Though not expressly required under ERISA, federal courts have held that a claimant must exhaust her administrative remedies before filing suit.³⁸

Under ERISA, plan administrators act as fiduciaries³⁹ because they exercise discretionary authority, control, or responsibility respecting both management and administration of employee welfare plans.⁴⁰ As a fiduciary, plan administrators have specific duties under ERISA:

A fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and – (A) for the exclusive purpose of: (i) providing benefits to participants and beneficiaries; and (ii) defraying reasonable expenses of administering the plan[.]⁴¹

The Employee Retirement Income Security Act provides for a private right of action for participants or beneficiaries "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."⁴² These plans include "employee welfare benefit plans" which encompass those plans that are "established or maintained by an employer or by an employee organization . . . for the purpose of providing for its

35. *See, e.g.*, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 108–09 (2008) (finding that claimant had to show a stricter standard—that she could not perform “‘the material duties of any gainful occupation for which’ she was ‘reasonably qualified’”).

36. ERISA mandates internal appeal procedures. 29 C.F.R. § 2560.503-1(b) (2018).

37. 29 U.S.C. § 1133(1)–(2) (2012).

38. *See, e.g.*, *Counts v. Am. Gen. Life & Accident Ins. Co.*, 111 F.3d 105, 108 (11th Cir. 1997); *Weldon v. Kraft, Inc.*, 896 F.2d 793, 800 (3d Cir. 1990); *Amato v. Bernard*, 618 F.2d 559, 567–68 (9th Cir. 1980).

39. 29 U.S.C. § 1002(14)(a) (“[A]ny fiduciary (including, but not limited to, any administrator . . .)”).

40. *Id.* § 1002(21)(A).

41. *Id.* § 1104(a)(1).

42. *Id.* § 1132(a)(1)(B).

participants . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability.”⁴³ When a claimant appeals the denial of an LTD benefit to the district court, he is exercising his right to a private action under ERISA.

B. Standard of Review

Though lengthy and elaborate, ERISA does not set forth a standard of review for appeals of claim denials.⁴⁴ Before the Supreme Court’s decision in *Firestone Tire & Rubber Co. v. Bruch*, federal courts imported the “arbitrary and capricious” standard found in the Labor Management Relations Act (LMRA) to claims under ERISA.⁴⁵ Under this standard, if a plan administrator is found to have acted arbitrarily and capriciously in denying a claim for benefits, then that denial is overturned on appeal.⁴⁶ In *Firestone*, the Court refused to import the entirety of LMRA’s “arbitrary and capricious” standard to ERISA, and attempted to provide guidance for federal courts as to how to review appeals for denial of benefits.⁴⁷

The Court determined that the correct standard of review analysis would be found in trust law, as “ERISA abounds with the language and terminology of trust law.”⁴⁸ The Court noted that “[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers.”⁴⁹ For example, plan administrators exercise

43. *Id.* § 1002(1).

44. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) (“ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations.”).

45. *Id.*

46. *See* *Beam v. Int’l Org. of Masters, Mates, & Pilots*, 511 F.2d 975, 979 (2d Cir. 1975); *see also* *Van Boxel v. Journal Co. Emps.’ Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) (describing arbitrary and capricious standard as imported from the FMLA) (“[W]hen a plan provision as interpreted had the effect of denying an application for benefits unreasonably, or, as it came to be said, arbitrarily and capriciously, courts would hold that the plan as ‘structured’ was not for the sole and exclusive benefit of the employees, so that the denial of benefits violated [§ 186(c)].”).

47. *See Firestone*, 489 U.S. at 109–10.

48. *Id.* at 111. “In determining the appropriate standard of review for actions under § 1132(a)(1)(B), we are guided by principles of trust law.” *Id.* at 110 (citing *Central States, Se. & Sw. Areas Pension Fund v. Cent. Transport, Inc.*, 472 U.S. 559, 570 (1985)).

49. *Id.* at 111 (noting that “[w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion”) (quoting RESTATEMENT (SECOND) OF TRUSTS: CONTROL OF DISCRETIONARY POWERS § 187 (AM. LAW INST. 1959)).

discretionary powers when a plan grants them authority to determine if a claimant is entitled to benefits.⁵⁰ The favorable standard of review toward fiduciaries and trustees comes from the idea that “a court of equity will not interfere to control [trustees] in the exercise of a *discretion vested in them by the instrument* under which they act.”⁵¹ The plan at issue in *Firestone* did not have a provision granting the plan administrator discretionary authority, but the Court determined that such a clause would lead to the more deferential standard of review.⁵² And now, almost all plans have such a clause.⁵³

The Restatement (Second) of Trusts lists six factors to consider when determining whether a fiduciary has abused his discretion:

(1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee’s conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; [and] (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.⁵⁴

50. *Id.* at 113.

51. *Id.* at 111 (quoting *Nichols v. Eaton*, 91 U.S. 716, 724–25 (1875)).

52. *Id.* at 111, 115.

53. See Peter A. Meyers, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 SEATTLE U. L. REV. 925, 927 (2005) (“In most circuits, however, evidence of abusive practices will not come to light; so long as the plan document explicitly gives the fiduciary discretion to make benefit determinations”); see, e.g., *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1146 (10th Cir. 2009) (providing an example of a reservation-of-discretion clause in an ERISA plan) (“Benefits under this plan will be paid only if (the plan administrator) decides in its discretion that (the claimant) is entitled to them. (The plan administrator) also has discretion to determine eligibility for benefits and to interpret the terms and conditions of the benefit plan.”) (quoting Utah Insurance Rule 590-218-5(3)).

54. RESTATEMENT (SECOND) OF TRUSTS: CONTROL OF DISCRETIONARY POWERS § 187 cmt. d (AM. LAW INST. 1959). Though Supreme Court case law references the Restatement (Second) of Trusts in its evaluation of ERISA appeals, the Restatement (Third) of Trusts was published in 2005. The principles of abuse of discretion review remain unchanged. RESTATEMENT (THIRD) OF TRUSTS: JUDICIAL CONTROL OF DISCRETIONARY POWERS § 87 cmt. d (AM. LAW INST. 2007).

For purposes of ERISA review, “the most important [factor] is the presence of any conflicts of interest on the part of the plan fiduciary.”⁵⁵

Although the Supreme Court instructed courts to contemplate a plan administrator’s conflict of interest in reviewing ERISA appeals, the lack of instruction led to circuits developing differing approaches.⁵⁶ One method, the “sliding scale” approach, was adopted by the Third, Fourth, Seventh, and Tenth Circuits.⁵⁷ Other approaches adopted by the circuit courts involved shifting the burden to the plan administrator to prove that the decision was not an abuse of discretion when a conflict of interest existed, or simply continuing to use the standards similar to the arbitrary and capricious review promulgated pre-*Firestone*.⁵⁸

Though drawing from trust law for the proper standard, the Court in “*Firestone* likely flipped the presumption of trust law, which traditionally assumes deference unless the trust says otherwise.”⁵⁹ The Court held “that a denial of benefits challenged under [ERISA] is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”⁶⁰ Under a *de novo* standard of review, a court “decid[es] the issues without reference to any legal conclusion or assumption made by the previous court to hear the case.”⁶¹ If the plan does grant the plan administrator authority to determine eligibility, then the court reviews the decision to determine if the plan administrator abused his discretion in denying benefits to the claimant.⁶² Though the Fifth Circuit had held that the *de novo* standard of review espoused in *Firestone* was limited to the construing of plan terms,⁶³ in *Ariana v. Humana Health Plan of Texas, Inc.*, it joined with the rest of the circuits in applying *de novo*

55. Stevenson, *supra* note 10, at 114.

56. Ryan M. LoRusso, Metropolitan Life Insurance Company v. Glenn: Will the Supreme Court Decision Reduce Confusion after Firestone?, 17 CONN. INS. L.J. 189, 197 (2010).

57. *Id.* at 199.

58. *Id.* at 197–200; see also Stevenson, *supra* note 10, at 115–30 (providing a breakdown of each circuit’s approach).

59. Ariana M. v. Humana Health Plan of Tex., Inc., 884 F.3d 246, 253 (5th Cir. 2018) (footnote omitted) (citing Ramsey v. Hercules Inc., 77 F.3d 199, 203–05 (7th Cir. 1996)).

60. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

61. *DeNovo*, LEGAL INFO. INST. (July 2017), https://www.law.cornell.edu/wex/de_novo.

62. See *Firestone*, 489 U.S. at 115.

63. See Pierre v. Conn. Gen. Life Ins. Co./Life Ins. Co. of N. Am., 932 F.2d 1552, 1561–62 (5th Cir. 1991).

review in all cases where the plan does not grant discretion.⁶⁴ Though a step in the right direction, the fact is that most plans will grant discretionary authority to plan administrators.

When determining whether a plan administrator has abused its discretion under ERISA, courts will typically look at whether there is substantial evidence to support the administrator's finding,⁶⁵ or whether the decision was arbitrary.⁶⁶ The Seventh Circuit, for example, has held that the abuse of discretion standard and the arbitrary and capricious standard are synonymous.⁶⁷ The Eighth Circuit has held that "if an administrator's decision 'is extraordinarily imprudent or extremely unreasonable, the court is likely to find that there has been an abuse of discretion.'"⁶⁸

Circuit courts evaluate for an abuse of discretion under differing factors.⁶⁹ When addressing the issue of a plan administrator's conflict of interest, the Supreme Court iterated that under the law of trusts, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r]' in determining whether there is an abuse of discretion."⁷⁰ Thus, when an "insurer acts as both funding source and administrator," courts will consider that conflict in their evaluation and adjust the leniency of the standard.⁷¹

64. *Ariana*, 884 F.3d at 250–53.

65. *See, e.g.*, *Johnson v. Bert Bell/Pete Rozelle NFL Player Retirement Plan*, 468 F.3d 1082, 1085 (8th Cir. 2006) ("To be reasonable [under the abuse of discretion standard], the decision must be supported by substantial evidence.") (citing *Norris v. Citibank, N.A. Disability Plan* (501), 308 F.3d 880, 883–84 (8th Cir. 2002)).

66. *Keller v. AT&T Disability Income Plan*, 664 F. Supp. 2d 689, 699–700 (W.D. Tex. 2009) ("An abuse of discretion exists if the administrator's factual determinations are arbitrary and are not supported by substantial evidence.") (citing *Meditrust Fin. Servs. Corp. v. Sterling Chem.*, 168 F.3d 211, 215 (5th Cir. 1999)).

67. *Holmstrom v. Metro. Life Ins. Co.*, 615 F.3d 758, 767 n.7 (7th Cir. 2010).

68. *Goewert v. Hartford Life & Accident Ins. Co.*, 442 F. Supp. 2d 724, 727 (E.D. Mo. 2006) (quoting *Cox v. Mid-Am. Dairymen, Inc.*, 965 F.2d 569, 572 (8th Cir. 1992)).

69. *See* Ann K. Wooster, Annotation, *Judicial Review of Denial of Disability Benefits Under Employee Benefit Plan Governed by Employee Retirement Income Security Act (ERISA)*, 29 U.S.C.A. § 1132(a)(1)(B) – *Fiduciary Conflict of Interest—Post-Firestone Cases*, 18 A.L.R. Fed. 2d 607, § 4 (2007) (compiling cases where circuit courts take fiduciary discretion into account).

70. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (quoting RESTATEMENT (SECOND) OF TRUSTS: CONTROL OF DISCRETIONARY POWERS § 187 cmt. d (AM. LAW INST. 1959)).

71. *See Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 674 (9th Cir. 2011) (citing *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965 (9th Cir. 2006)).

In *Metropolitan Life Insurance Co. v. Glenn*, the Supreme Court attempted to clarify how reviewing courts should take into account plan administrators' conflict of interest.⁷² The Court reiterated that plan administrators hold conflicting interests because they "both determine[] whether an employee is eligible for benefits and pay[] benefits out of [their] own pocket[s]."⁷³ In *Glenn*, the claimant was diagnosed with dilated cardiopathy, which presents through symptoms of "fatigue and shortness of breath."⁷⁴ She applied through her employer plan provider, MetLife, for disability benefits and was granted short-term disability for a term of twenty-four months.⁷⁵ MetLife then directed her to pursue a claim for Social Security Benefits, which MetLife could use to offset the amount they were paying out on the plan.⁷⁶ An administrative law court granted Glenn the Social Security benefits, as it "found that Glenn's illness prevented her . . . 'from performing any jobs [for which she could qualify] existing in significant numbers in the national economy.'"⁷⁷

To continue receiving disability payments from MetLife, Glenn had to show "that her medical condition rendered her incapable of performing . . . 'the material duties of any gainful occupation for which' she was 'reasonably qualified.'"⁷⁸ MetLife denied long-term disability benefits, and Glenn brought a federal suit in response.⁷⁹ The district court upheld the denial of benefits, and Glenn appealed to the Sixth Circuit.⁸⁰ The Sixth Circuit reviewed the denial under a deferential standard and treated the plan administrator's conflict of interest as a relevant factor, as MetLife both decided whether an employee was entitled to benefits and paid out those benefits.⁸¹

The Court of Appeals set aside the denial for a variety of reasons,⁸² and MetLife petitioned for certiorari to determine whether it acted under a

72. 554 U.S. 105, 112–19 (2008).

73. *Id.* at 108.

74. *Id.* at 109.

75. *Id.*

76. *Id.*

77. *Id.* (quoting the petition for certiorari).

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.* at 110.

82. The Sixth Circuit set aside the denial of benefits because

(1) the conflict of interest; (2) MetLife's failure to reconcile its own conclusion that Glenn could work in other jobs with the Social Security Administration's

conflict of interest.⁸³ The Solicitor General requested in an amicus curiae brief that the Court provide guidance on how these conflicts of interest should be treated and weighed on appeal.⁸⁴ The Court addressed both of these questions, in turn, in an attempt to bridge the divide between circuit courts in their interpretation of the holding in *Firestone*.⁸⁵

In interpreting *Firestone*'s use of administrative conflict of interest as a factor in evaluating ERISA determinations, the Court elaborated that this weighing does not change the standard of review from abuse of discretion to de novo review.⁸⁶ The Court refused to overturn *Firestone* and implement universal de novo review because it believed that Congress did not intend for such judicial oversight of plan administration.⁸⁷ The Court also noted that “[b]enefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts . . . for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review.”⁸⁸ The Court went on to approve the Sixth Circuit’s “combination-of-factors method of review,” in which the court weighs many different fact-specific factors, including a conflict of interest, in coming to its decision.⁸⁹

The Court noted that its “elucidation of *Firestone*’s standard d[id] not consist of a detailed set of instructions.”⁹⁰ The Court avoided providing a set procedural and reviewing process because of “the impalpable factors involved in judicial review.”⁹¹ In his concurrence in part, Chief Justice John Roberts disagreed with the majority’s treatment of a plan administrator’s

conclusion that she could not; (3) MetLife’s focus upon one treating physician report suggesting that Glenn could work in other jobs at the expense of other, more detailed treating physician reports indicating that she could not; (4) MetLife’s failure to provide all of the treating physician reports to its own hired experts; and (5) MetLife’s failure to take account of evidence indicating that stress aggravated Glenn’s condition.

Id. (citing *Glenn v. MetLife*, 461 F.3d 660, 674 (6th Cir. 2006)).

83. *Id.*

84. *Id.* (citing Brief for United States as Amicus Curiae Supporting Respondent at 22, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (No. 06-923)).

85. *Id.* at 112–19.

86. *Id.* at 115 (“We do not believe that *Firestone*’s statement implies a change in the standard of review, say, from deferential to *de novo* review.”).

87. *Id.* at 116.

88. *Id.*

89. *Id.* at 118.

90. *Id.* at 119.

91. *Id.* (quoting *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477 (1951)).

conflict of interest as a factor motivating more exacting scrutiny by the reviewing court.⁹² He wrote that the majority's focus on "the mere existence of a conflict" tempts courts to substitute their discretion in place of the plan administrator's.⁹³ He continued, "This problem is exacerbated because the majority is so imprecise about how the existence of a conflict should be treated in a reviewing court's analysis."⁹⁴

Even after the decision in *Glenn*, circuit courts have interpreted the holding in *Firestone* differently.⁹⁵ Many circuits that had used the "sliding-scale" test in formulating the standard of review rejected that approach.⁹⁶ This rebuff stems from the appellate court determination that *Glenn* instructed courts to "take the conflict into account not in formulating the standard of review, but in determining whether the administrator or fiduciary abused its discretion[.]"⁹⁷ Contrastingly, the Tenth Circuit has reconciled the Supreme Court's decision in *Glenn* with the "sliding-scale" approach.⁹⁸ The Tenth Circuit ruled that it "dial[ed] back" deference if the plan administrator operated under a conflict of interest.⁹⁹ Thus, the Tenth Circuit still applies an arbitrary and capricious standard, but "decreas[es] the level of deference given . . . in proportion to the seriousness of the conflict."¹⁰⁰

Though Supreme Court jurisprudence allows deference when a discretionary clause is present, many states have attempted to ensure claimant rights by outlawing the enforcement of discretionary clauses.¹⁰¹ State legislatures are trying to protect the claimant, but they are not always successful because of ERISA's preemption of state law.¹⁰² ERISA "supersede[s] any and all State laws insofar as they may . . . relate to any

92. *Id.* at 121 (Roberts, C.J., concurring in part and concurring in the judgment).

93. *Id.* (Roberts, C.J., concurring in part and concurring in the judgment).

94. *Id.* (Roberts, C.J., concurring in part and concurring in the judgment).

95. See Stevenson, *supra* note 10, at 114–32.

96. *Id.* at 134 (citing *Estate of Schwing v. Lilly Health Plan*, 562 F.3d 522, 525 (3d Cir. 2009); *Champion v. Black & Decker (U.S.) Inc.*, 550 F.3d 353, 358–59 (4th Cir. 2008)).

97. *Estate of Schwing*, 562 F.3d at 525.

98. *Weber v. GE Grp. Life Assurance Co.*, 541 F.3d 1002, 1010 (10th Cir. 2008).

99. *Id.*

100. *Id.* (quoting *Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co.*, 491 F.3d 1180, 1190 (10th Cir. 2007), *abrogated on other grounds by Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008)).

101. See, e.g., CAL. INS. CODE § 10110.6 (West 2019), *invalidated by Williby v. Aetna Life Ins. Co.*, 867 F.3d 1129 (9th Cir. 2017).

102. See, e.g., *Williby*, 867 F.3d at 1136–37.

employee benefit plan” ERISA covers.¹⁰³ For example, in *Williby v. Aetna Life Insurance Co.*, the Ninth Circuit found that California’s statute outlawing the enforcement of discretionary clauses did not apply to an ERISA short-term disability plan.¹⁰⁴ In this case, the district court reviewed Aetna’s denial of short-term disability under a de novo standard, finding that Aetna improperly denied Williby’s claim.¹⁰⁵ On appeal, the Ninth Circuit reversed and remanded “for reconsideration under the proper standard of review,” i.e., abuse of discretion.¹⁰⁶

Contrarily, the Seventh Circuit held that ERISA does not preempt an Illinois regulation prohibiting discretionary clauses in health and disability insurance policies.¹⁰⁷ The Illinois insurance regulation explained:

No policy, contract, certificate, endorsement, rider application or agreement offered or issued in this State, by a health carrier, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or of a disability may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State.¹⁰⁸

In *Fontaine v. Metropolitan Life Insurance Co.*, MetLife argued that ERISA preempted the Illinois regulation, and the court’s review should be under an arbitrary and capricious standard.¹⁰⁹ The Seventh Circuit rejected that argument, finding that the Illinois regulation was applicable because it fell under an exception to ERISA preemption that saves state laws “which regulate[] insurance.”¹¹⁰ By allowing the application of the Illinois regulation, the Seventh Circuit ensured that the Illinois state legislature’s attempt to protect claimant interests was effectuated.¹¹¹

103. 29 U.S.C. § 1144(a) (2012).

104. See *Williby*, 867 F.3d at 1137.

105. *Id.* at 1131.

106. *Id.*

107. *Fontaine v. Metro. Life Ins. Co.*, 800 F.3d 883, 886–87 (7th Cir. 2015).

108. *Id.* at 886 (quoting 50 ILL. ADMIN. CODE tit. 50, § 2001.3 (2002)).

109. *Id.*

110. *Id.* (quoting 29 U.S.C. § 1144(b)(2)(A)).

111. With the Seventh Circuit’s decision in *Fontaine*, it joined the Sixth Circuit in allowing application of state laws prohibiting discretionary clauses. *Id.*; see *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 607 (6th Cir. 2009).

II. Putting Fibromyalgia in the Patient Chair to Understand Subjective-Proof Diseases

Doctors diagnose many diseases today based on subjective reports.¹¹² These subjective reports might include complaints of pain, suicidal thoughts, and reports of extreme emotions, such as those that may lead to the diagnosis of a phobia.¹¹³ For example, agoraphobia, or the fear of people, does not have an objective medical test.¹¹⁴ A doctor does not test a vial of blood or perform an MRI to determine if a patient has an intense fear of crowds or strangers. Diagnosis of phobias occurs purely through an in-depth interview with the patient and an evaluation of medical, psychiatric, and familial histories.¹¹⁵ The diagnosis for diseases such as General Anxiety Disorder is similar.¹¹⁶ The doctor relies on the reports of the patient to determine a diagnosis, even if this disease would not typically be treated with medicine but with a form of psychotherapy.¹¹⁷

This Comment uses the term “subjective-proof” disease to refer to a disease for which there is no objective medical test to determine the diagnosis. An objective medical test would include measures such as an x-ray, which would clearly show a broken bone, or an MRI, which would show a tumor in an organ. For example, fibromyalgia is a subjective-proof disease because there is no viable objective medical test. Since “no underlying measurable or pathophysiological causes have been confirmed[,]” the condition is rendered “incompatible with medical/scientific models that emphasize measurable criteria.”¹¹⁸ Fibromyalgia is one subjective-proof disease that is common in disability

112. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 688–89 (4th ed. 2000) (discussing subjectivity of diagnosing personality disorders).

113. See *id.*

114. *Id.* at 432–33.

115. *Specific Phobias*, MAYO CLINIC (Oct. 19, 2016), <https://www.mayoclinic.org/diseases-conditions/specific-phobias/diagnosis-treatment/drc-20355162>.

116. AM. PSYCHIATRIC ASS’N, *supra* note 112, at 476 (indicating that diagnosis of Generalized Anxiety Disorder includes association with three of the following six symptoms: “(1) restlessness or feeling keyed up or on edge[;] (2) being easily fatigued[;] (3) difficulty concentrating or mind going blank[;] (4) irritability[;] (5) muscle tension[;] (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)”).

117. See *Specific Phobias*, *supra* note 115 (“The best treatment for specific phobias is a form of psychotherapy called exposure therapy.”).

118. Sean M. Hayes et al., *Fibromyalgia and the Therapeutic Relationship: Where Uncertainty Meets Attitude*, 15 PAIN RES. & MGMT. 385, 386 (2010).

appeals, but it is far from the only disease in which diagnosis is based on subjective evidence. Other subjective-proof diseases include chronic fatigue syndrome, schizophrenia, mental illnesses, and phobias.¹¹⁹ Classifying a diagnosis as a subjective-proof disease renders the disease incompatible with claims for long-term disability benefits and complicates the analysis for appellate courts. Some plan administrators have argued that diseases such as fibromyalgia are not “medically determinable,” and therefore claimants cannot show entitlement to disability benefits.¹²⁰

To examine the issues involved in appeals of denials of disability claims for subjective-proof diseases, this Comment will use fibromyalgia as its principal example. “Fibromyalgia is a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues.”¹²¹ Fibromyalgia is frequently litigated in disability appeals because of its subjective nature.¹²² An employee with fibromyalgia might pursue a disability claim because the pain is so great that she cannot work.¹²³ There is evidence that “fibromyalgia involves differences in the processing of pain, particularly in the processing of sensory input and painful stimuli.”¹²⁴ The Mayo Clinic notes that “[d]octors don’t know what causes fibromyalgia, but it most likely involves a variety of factors working together.”¹²⁵ The factors listed include genetics, infections, and physical or emotional trauma.¹²⁶

119. *See* Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666, 677–78 (9th Cir. 2011) (“There are no specific diagnostic studies (i.e., laboratory, radiography, psychosomatic or other testing) or physical findings that are specific to the diagnosis of [chronic fatigue syndrome].”) (quoting the Center for Disease Control criteria) (emphasis removed); *see also* AM. PSYCHIATRIC ASS’N, *supra* note 112, at 688.

120. *See, e.g.*, Rodriguez v. McGraw-Hill Cos., Inc., 297 F. Supp. 2d 676, 677–78 (S.D.N.Y. 2004).

121. *Fibromyalgia*, MAYO CLINIC (Aug. 11, 2017), <https://www.mayoclinic.org/diseases-conditions/fibromyalgia/symptoms-causes/syc-20354780>.

122. *See, e.g.*, Johnson v. Metro. Life Ins. Co., 437 F.3d 809, 812 (8th Cir. 2006); Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 916 (7th Cir. 2003).

123. *See, e.g.*, Huffaker v. Metro. Life Ins. Co., 271 F. App’x 493, 501 (6th Cir. 2008); Billinger v. Bell Atl., 240 F. Supp. 2d 274, 281, 287 (S.D.N.Y. 2003).

124. Hayes et al., *supra* note 118, at 386 (citations omitted).

125. *Fibromyalgia*, *supra* note 121.

126. *Id.*; *see* Hayes et al., *supra* note 118, at 386 (“A genetic basis for the syndrome has also been explored.”).

The methods of diagnosis for fibromyalgia have changed over the years.¹²⁷ One test frequently mentioned in cases evaluating a denial for disability benefits is the “tender-points test.”¹²⁸ The tender-points test involves a physician pressing on certain points on a patient’s body and determining the amount of pain felt by the patient through subjective responses.¹²⁹ Criticism of the “semi-objective” tender-points test alleges that “cervical tender points were almost impossible to assess” and “[w]hen physicians began the tender point examination, the patient’s interview had already provided clues as to what the examination results might be.”¹³⁰ Instead of an objectively diagnosable disease, “[f]ibromyalgia diagnosis often depended on physician referral, behavioral and emotional characteristics of patients, and the skill, interest, and beliefs of the physicians.”¹³¹

In recent years, the medical community has developed new ways to diagnose fibromyalgia.¹³² In 2010, the American College of Rheumatology developed new fibromyalgia criteria “that excluded tender points, but included a count of pain locations and the physician’s rating of the most discriminative symptoms.”¹³³ While the test’s criteria is not absolutely objective, about 50% of the criteria were accounted for with musculoskeletal pain, whereas “the other 50% came from fatigue, sleep, cognitive problems, and an estimate of the overall degree of somatic symptom severity.”¹³⁴ These new diagnostic tools are still criticized, as “[i]t seems certain that physicians will differ in their conscientiousness in making such assessments and their interpretation of the severity of patient complaints.”¹³⁵

127. Frederick Wolfe et al., *What Is Fibromyalgia, How Is It Diagnosed, and What Does It Really Mean?*, 66 *ARTHRITIS CARE & RES.* 969, 969–70 (2014).

128. *Id.* at 969; *see, e.g.*, *Rogers v. Comm’r of Social Sec.*, 486 F.3d 234, 238 (6th Cir. 2007); *Small v. Astrue*, 840 F. Supp. 2d 458, 460–61 (D. Mass. 2012).

129. *See Brown v. Barnhart*, 182 F. App’x 771, 773 n.1 (10th Cir. 2006) (“Clinical signs and symptoms supporting a diagnosis of fibromyalgia under the American College of Rheumatology Guidelines include ‘primarily widespread pain in all four quadrants of the body and at least 11 of the 18 specified tender points on the body.’”) (quoting *Green-Younger v. Barnhart*, 335 F.3d 99, 107 (2d Cir. 2003)).

130. Wolfe et al., *supra* note 127, at 969.

131. *Id.*

132. *See id.*

133. *Id.*

134. *Id.*

135. *Id.*

Doctors within the medical community have differing attitudes towards fibromyalgia.¹³⁶ There is still debate as to “whether fibromyalgia is a credible diagnosis at all.”¹³⁷ In one survey, doctors and medical students ranked fibromyalgia “among the lowest in credibility of conditions.”¹³⁸ In a study analyzing physician and specialist attitudes toward fibromyalgia, researchers found that “[a] total of 35% of [general practitioners] lacked confidence in using the American College of Rheumatology (ACR) criteria.”¹³⁹ In the same study, only “[t]wo-thirds of participants . . . characterized fibromyalgia as diagnosable” though most who did so “commented on the subjectivity of the assessment.”¹⁴⁰ Researchers presented a generalized view of fibromyalgia:

In summary, fibromyalgia is characterized by undefined pathophysiology, uncertainty about diagnostic criteria, lack of knowledge regarding effective and safe treatments, and the need for a broad range of support and intervention that physicians are ill equipped to provide. These factors combine to create a climate of mismatched perceptions and unmet needs on the parts of both patients and physicians in the treatment of fibromyalgia.¹⁴¹

The attitudes and medical processes involved in diagnosing diseases such as fibromyalgia produce difficulty when courts evaluate appeals from disability denials. This unease is true for both long-term disability claims and Social Security benefits claims. The Tenth Circuit has noted that “[w]hat makes fibromyalgia difficult to analyze . . . is the lack of objective symptoms[.]”¹⁴² In an appeal from a denial of Social Security benefits, the Tenth Circuit held that an administrative law judge’s failure to accord severe-impairment status to the claimant’s diagnosed fibromyalgia was reversible error.¹⁴³

136. See Hayes et al., *supra* note 118, at 385.

137. *Id.* at 386 (citation omitted).

138. *Id.*

139. *Id.* at 387.

140. *Id.* (“It’s very subjective, so this is just based on a faith in patients saying [. . .] ‘It hurts; my [. . .] is sore.’ But you don’t have a measure of how much you can press the [tender] point.”) (quoting a general practitioner from the study).

141. *Id.* at 389.

142. *Brown v. Barnhart*, 182 F. App’x 771, 773 n.1 (10th Cir. 2006).

143. *Id.* at 773.

Though fibromyalgia and other subjective-proof diseases produce difficulty for both the medical and legal communities, scientists are conducting studies to measure pain objectively.¹⁴⁴ Instead of using a “10-point scale” or “emoji-style charts” that convey different levels of pain through facial expression, scientists aim to measure pain using “brain scans, pupil reactions and other possible markers of pain.”¹⁴⁵ As one researcher puts bluntly, “If we can’t measure pain, we can’t fix it.”¹⁴⁶ Though incomplete, this research could potentially ease the burden of claimants attempting to obtain disability benefits, as it would provide objective evidence of their disease. It is unclear how long until any of these research efforts may provide usable results.¹⁴⁷

III. The Legal Landscape

A. The Objective Evidence Requirement

Fibromyalgia muddles a court’s evaluation, as “[t]he subjective and inherently self-reported nature of fibromyalgia’s primary symptoms of pain and fatigue complicate disability benefit decisions and the review of benefit denials.”¹⁴⁸ While recognizing that fibromyalgia’s “cause or causes are unknown” and “there is no cure,”¹⁴⁹ courts have still found that “the physical limitations imposed by the symptoms of such illnesses do lend themselves to objective analysis.”¹⁵⁰

While there may be some requirement for objective evidence of the limitations fibromyalgia may impose on a claimant, some “[c]ourts have held that it is *prima facie* unreasonable to require claimants to submit objective evidence of the etiology of the disease, given that there are no recognized objective laboratory tests.”¹⁵¹ Although it may be impossible to

144. Lauran Neergaard, *No Stethoscope for Pain: Scientists Seek Real Way to Measure*, APNEWS (Jan. 10, 2019), <https://apnews.com/c75e6a1185024a7c8892dacf56e6e308>.

145. *Id.*

146. *Id.* (quoting pediatric anesthesiologist at Children’s National Medical Center in Washington, Dr. Julia Finkel).

147. *See id.*

148. *Adams v. UNUM Life Ins. Co. of Am.*, No. Civ.A. H-04-2179, 2005 WL 2030840, at *31 (S.D. Tex. Aug. 23, 2005).

149. *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 872 (9th Cir. 2004) (citing *Rollins v. Massanari*, 261 F.3d 853, 855 (9th Cir. 2001)).

150. *Boardman v. Prudential Ins. Co. of Am.*, 337 F.3d 9, 16–17 n.5 (1st Cir. 2003).

151. *Adams*, 2005 WL 2030840, at *32 (citing *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433 (3d Cir. 1997); *Cook v. Liberty Life Assurance Co.*, 320 F.3d 11, 21–22 (1st Cir. 2003);

have objective proof of the disease itself, “courts have recognized that an insurer may insist on objective proof and measures of symptoms and of limits on the ability to work, even when, as with fibromyalgia, diagnosis is difficult and subjective complaints such as ‘fatigue’ or ‘pain’ are the signature of the disease.”¹⁵²

Objective evidence of disability that stems from a subjectively diagnosable disease may come from tests such as Functional Capacity Evaluations (FCEs), home assessments, occupational therapy appraisals, independent medical examinations, and ADL (Aids to Daily Living).¹⁵³ These tests give doctors an idea of the mobility and strength that a claimant may be able to exert during a workday.¹⁵⁴ If a claimant can perform some of the ADL, “then she is disabled partially; if she can’t do most of them she is severely disabled.”¹⁵⁵ In *Liebel v. Aetna Life Insurance Co.*, the claimant presented multiple doctors’ evaluations, an FCE, a home assessment, and an Independent Medical Evaluation (IME).¹⁵⁶ During the FCE, “while Ms.

Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 919 (7th Cir. 2003) (Posner, J.); *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1112 (9th Cir. 1999); *Burchill v. UNUM Life Ins. Co. of Am.*, 327 F. Supp. 2d 41, 51 (D. Me. 2004); *Pralutsky v. Metro. Life Ins. Co.*, 316 F. Supp. 2d 840, 852–53 (D. Minn. 2004); *Maronde v. Sumco USA Grp. Long-Term Disability Plan*, 322 F. Supp. 2d 1132, 1139 (D. Or. 2004); *Sansevera v. E.I. DuPont de Nemours & Co.*, 859 F. Supp. 106, 113 (S.D.N.Y. 1994)).

152. *Id.* (citing *Friedrich*, 181 F.3d at 1112; *Boardman*, 337 F.3d at 16–17 & n.5).

153. *See generally* *Liebel v. Aetna Life Ins. Co.*, 595 F. App’x 755, 759–61 (10th Cir. 2014); *Welch v. UNUM Life Ins. Co. of Am.*, No. 00-1439-DWB, 2007 WL 4374219 (D. Kan. Dec. 13, 2007), *vacated by* *Welch v. UNUM Life Ins. Co. of Am.*, 649 F. Supp. 2d 1220 (D. Kan. 2009). “A functional capacity evaluation (FCE) evaluates an individual’s capacity to perform work activities related to his or her participation in employment.” *Functional Capacity Evaluation*, AM. OCCUPATIONAL THERAPY ASS’N, INC., <https://www.aota.org/About-Occupational-Therapy/Professionals/WI/Capacity-Eval.aspx> (last visited Dec. 19, 2019) (citing Remko Soer et al., *Towards Consensus in Operational Definitions in Functional Capacity Evaluation: A Delphi Survey*, 18 J. OCCUPATIONAL REHABILITATION 389 (2008)). The evaluation procedure “compares the individual’s health status, and body functions and structures to the demands of the job and the work environment.” *Id.* An ADL assessment involves observing or evaluating a claimant’s ability to perform daily living activities, including for example, “(a) bathing, (b) continence, (c) dressing/grooming, (d) eating, (e) mobility, (f) toileting, and (g) transferring (i.e., ability to move from one place to another, including bed to chair and back, and into and out of a vehicle).” *Merie B. ex rel. Brayden O. v. Neb. Dep’t of Health & Human Servs.*, 863 N.W.2d 171, 178 (Neb. 2015).

154. *See Liebel*, 595 F. App’x at 757–61.

155. *Welch*, 2007 WL 4374219, at *9 (emphasis removed).

156. *Liebel*, 595 F. App’x at 759–61.

Liebel complained of pain during the evaluation, “[p]hysiological responses (heart rate and respiratory rate) did not correlate with [her] subjective complaints of severe pain.”¹⁵⁷ Although Ms. Liebel had diagnoses of fibromyalgia, radiculopathy, failed back syndrome, narcotic use, and complained of pain, the court upheld the administrator’s decision to deny benefits.¹⁵⁸ The court based its denial on the results of the functional evaluations and the evaluating doctors’ determinations that the claimant’s diseases did not render her unable to work at a sedentary level.¹⁵⁹

Courts have found it reasonable to weigh a claimant’s credibility when most of the evidence given to support a claim for disability is subjective.¹⁶⁰ These courts’ evaluation weighs more than just formal reports of motion and mobility, allowing the consideration of surveillance footage of the claimant when assessing the insurer’s denial.¹⁶¹ If subjective complaints of pain do not match with the surveillance footage, a court will likely uphold a denial for benefits.

In *Rizzi v. Hartford Life and Accident Insurance Co.*, the plan participant claimed disability because of “extreme pain and not being able to use [her] right extremities properly” and a diagnosis of Myofascial Pain Syndrome.¹⁶² The plan administrator initially granted Rizzi disability benefits, but Hartford conducted a follow-up evaluation three months after approval to check her condition.¹⁶³ After this interview, in which Rizzi stated “her average pain level was an 8-10 on a scale of 1 to 10,” Hartford began surveilling Rizzi.¹⁶⁴ Hartford observed Rizzi driving, bending at a ninety-degree angle, and clasping various items; she displayed no evidence

157. *Id.* at 759 (quoting the report).

158. *Id.* at 764–65.

159. *Id.*

160. *See Meraou v. Williams Co. Long Term Disability Plan*, 221 F. App’x 696, 705–06 (10th Cir. 2007).

161. Plan administrators may covertly surveil claimants to observe mobility or activity. The Tenth Circuit has “implicitly endorsed using surveillance footage to document abuse of total disability benefits.” Courtney Bru, *Big Brother’s Watching—And He Can Fire You, Too*, Okla. Emp. L. Letter, Apr. 2007, at 5 (vol. 15, no. 4); *see also* Jerel C. Dawson, *Subjective Tension: The Conundrum of Self-Reported Symptoms*, DRI for Def., Sept. 2008, at 70 (vol. 50, no. 9) (“Video surveillance[] . . . is a cost-effective and under-utilized tool that can assist insurers and courts by furnishing objective documentation of disparities between a claimant’s subjectively reported limitations and his or her actual capabilities.”).

162. 383 F. App’x 738, 741 (10th Cir. 2010) (quoting appellant’s application).

163. *Id.* at 742.

164. *Id.* at 742–43.

of pain.¹⁶⁵ Hartford then terminated Rizzi's disability benefits.¹⁶⁶ Rizzi appealed her denial of benefits, alleging that "Hartford's denial of benefits was arbitrary and capricious because of its . . . reliance on surveillance evidence[] [and] disregard of her subjective complaints of pain[,]” among other stated reasons.¹⁶⁷ One of the evaluating doctors found that “the lack of objective medical evidence coupled with the surveillance evidence raised questions concerning Rizzi's probity when self-reporting the level of her pain and functionality of her right arm.”¹⁶⁸ This determination was especially relevant because “no other treating physicians documented any physical symptoms (like muscle atrophy, hair loss or nail discoloration) associated with an inability to mobilize or use her extremities.”¹⁶⁹

Other courts have held that disability benefits denials may be arbitrary and capricious when an evaluating physician disregards a claimant's subjective complaints of pain.¹⁷⁰ The Ninth Circuit found in *Salomaa v. Honda Long Term Disability Plan* that a denial based solely on the lack of objective evidence was an abuse of discretion.¹⁷¹ The court applied the abuse of discretion standard instead of de novo review because the plan “expressly and unambiguously g[ave] the administrator discretion to determine eligibility.”¹⁷² The claimant was diagnosed with “chronic fatigue syndrome,” which is diagnosed “by exclusion of other underlying diseases.”¹⁷³ The reviewing court found the denial to be an abuse of discretion because “the plan administrator demanded objective tests to establish the existence of a condition for which there are no objective tests.”¹⁷⁴ The plan administrators also refused to conduct their own physical

165. *Id.* at 743.

166. *Id.* at 745.

167. *Id.* at 747.

168. *Id.*

169. *Id.* at 753.

170. See *Cruz-Baca v. Edison Int'l Long Term Disability Plan*, 708 F. App'x 313, 315 (9th Cir. 2017) (“It was arbitrary and capricious for Dr. Ramachandran Srinivasan to fail to discuss and consider Cruz-Baca's subjective complaints of pain as evidence of her chronic pain syndrome.”).

171. 642 F.3d 666, 680–81 (9th Cir. 2011).

172. *Id.* at 673; see also *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989).

173. *Salomaa*, 642 F.3d at 678 (quoting the Center for Disease Control criteria) (emphasis removed).

174. *Id.* at 676.

evaluations of the claimant and only paid medical professionals to review Salomaa's file.¹⁷⁵

Although courts have found it unreasonable to require claimants to show objective evidence regarding the diagnosis of a disease such as fibromyalgia, it is not unreasonable to require objective evidence of the disability that renders the claimant unable to work. When the evidence does not show that the symptoms of fibromyalgia or a similar disease prevent the claimant from completing the actions of a normal workday or even the actions of a modified normal workday to accommodate a sedentary level of activity, a court will not typically overturn an insurer's denial of a claim.

Commonly, when a covered employee makes a claim for disability under ERISA, he simultaneously makes a claim for disability under the Social Security Act, and many private long-term disability plans encourage claimants to also file for Social Security benefits.¹⁷⁶ Under the Social Security Act, there is a "treating physician rule" that requires administrative law judges to accord "special weight . . . [to the] opinions of the claimant's treating physician."¹⁷⁷ The Ninth Circuit attempted to attach this rule to review of ERISA plans, but the Supreme Court overturned this determination in *Black & Decker Disability Plan v. Nord*.¹⁷⁸ The Supreme Court refused to bring the "treating physician rule" over to ERISA claims because "[n]othing in the Act itself . . . suggests that plan administrators must accord special deference to the opinions of treating physicians" and ERISA does not "impose a heightened burden of explanation on administrators when they reject a treating physician's opinion."¹⁷⁹ Therefore, treating physicians are given less deference under ERISA claims than those for Social Security, though many involve the same disability. It falls upon the Secretary of Labor to adopt a treating physician rule for ERISA claims.¹⁸⁰ Justice Ginsburg's opinion in *Black & Decker*, writing for a unanimous Court, suggests that the Court would be deferential to, and likely uphold, such adoption of the rule by the Secretary of Labor.

175. *Id.*

176. *See Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 109 (2008) ("MetLife . . . directed Glenn to a law firm that would assist her in applying for federal Social Security disability benefits . . .").

177. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 825 (2003) (citing 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2) (2002)).

178. *Id.*

179. *Id.* at 831.

180. *See id.*

When a claimant is denied, he must exhaust his administrative remedies, then may appeal the decision to the appropriate district court, and then on to the appropriate appellate court.¹⁸¹ When appealing a denial of disability benefits, the district court is generally limited to reviewing the administrative record.¹⁸² This limited scope is not how most district court cases are resolved—consistent with the normal application of the Federal Rules of Civil Procedure in a civil action.¹⁸³ There is no discovery, and the district court does not hear new evidence in an appeal for denial of disability benefits:

[J]udicial review is confined to the administrative record before the ERISA plan administrator, and, thus, the district court sits more as an appellate tribunal than as a trial court, in that it does not take evidence, but, rather, evaluates the reasonableness of an administrative determination in light of the record compiled before the plan fiduciary.¹⁸⁴

This review of the “administrative record” is analogous to the type of review found in administrative proceedings.¹⁸⁵ In an administrative proceeding, adjudicatory power lies with an administrative law judge or a publicly appointed official.¹⁸⁶ For example, in a claim for Social Security benefits, “[t]he Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under [the Social Security Act].”¹⁸⁷ In an ERISA benefits proceeding, adjudicatory power lies “in the hands of plan administrators,

181. *See supra* Section I.A.

182. *See* DeBofsky, *supra* note 16, at 204.

183. *See id.*

184. Wooster, *supra* note 69, § 8.

185. *See* Roy F. Harmon III, *The Debate over Deference in the ERISA Setting – Judicial Review of Decisions by Conflicted Fiduciaries*, 54 S.D. L. REV. 1, 1 (2009). Harmon argues that the Supreme Court’s decision in *MetLife* further aligns administrative law principles with administrative proceedings:

Though framed in terms of trust law, the standard of review applied in most ERISA cases is essentially the same as that applied when federal courts review administrative agency actions. In both contexts, the standard of review can afford broad discretion to decision-makers and suppress inquiries, and thereby disputes, regarding matters outside the administrative record.

Id.

186. *See* 28 C.F.R. § 68.28 (2019).

187. 42 U.S.C. § 405(b) (2012).

who may frequently have a vested interest in the proceedings.”¹⁸⁸ Though claimants are still allowed a civil action, claimant advocates argue that “[w]ith a judicial process that denies claimants a full opportunity to challenge the basis for adverse claim decisions, the civil action authorized by section 502 of ERISA is often rendered meaningless.”¹⁸⁹

B. Language of the Insurance Plan

Courts have looked to the language of the insurance plan to determine if a denial of benefits is arbitrary or capricious. In an opinion that was later vacated due to a settlement, the United States District Court for Kansas analyzed the requirements of a policy’s “self-report clause” in relation to a claim for disability based on a diagnosis of fibromyalgia.¹⁹⁰ Though vacated, the opinion provides relevant analysis of the interaction of fibromyalgia claims with plan terms that require objective evidence or limit availability of benefits for self-reported symptoms. The district court sought to determine whether the plan administrator’s denial of the claim for benefits due to fibromyalgia was arbitrary and capricious due to the application of the plan’s self-reported symptoms limitation.¹⁹¹

The applicable provision of the plan “limit[ed] disability payments to a period of 24 months for ‘[d]isabilities, due to sickness or injury, which are primarily based on self-reported symptoms.’”¹⁹² The plan defined self-reported symptoms as “the manifestations of your condition which you tell your doctor, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine.”¹⁹³ The court maintained that to limit benefits on the question of “whether Ms. Welch’s fibromyalgia itself was *diagnosed* primarily on self-reported symptoms . . . [the insurer] would have acted arbitrarily and capriciously.”¹⁹⁴ But since UNUM, the plan administrator, “based its denial on whether Ms. Welch’s

188. Harmon, *supra* note 185, at 3.

189. DeBofsky, *supra* note 16, at 214.

190. Welch v. UNUM Life Ins. Co. of Am., No. 00-1439-DWB, 2007 WL 4374219, at *1 (D. Kan. Dec. 13, 2007), *vacated by* Welch v. UNUM Life Ins. Co. of Am., 649 F. Supp. 2d 1220 (D. Kan. 2009).

191. *Id.* (quoting Welch v. UNUM Life Ins. Co. of Am., 382 F.3d 1078, 1082 (10th Cir. 2004)).

192. *Id.* at *3 (quoting the language of the policy).

193. *Id.* (quoting the language of the policy). The plan also listed examples of self-reported symptoms that included “headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.” *Id.* (quoting the language of the policy).

194. *Id.* at *5.

claimed *disability* was based on self-reported symptoms that could not be verified by tests or procedures,” the court found the provision enforceable.¹⁹⁵

In distinguishing the case at bar, the district court noted that “cases where courts have concluded that it was an abuse of discretion to require objective evidence of fibromyalgia (or other similar diseases such as chronic fatigue syndrome) have generally involved factual situations where the plan itself contained no self-report provision.”¹⁹⁶ Conversely, the court found that UNUM had incorrectly applied the self-report clause to Welch’s fibromyalgia symptoms.¹⁹⁷ The court reasoned that UNUM improperly “disregard[ed] the caveat that even self-reported symptoms such as pain may fall outside of the plan definition where there are tests, procedures or *clinical examinations* standardly accepted in the practice of medicine that would verify the severity of the patient’s reported pain.”¹⁹⁸ The availability of clinical examinations and other verification procedures took the claimant’s fibromyalgia outside of this self-report provision.

In *Meraou v. Williams Co. Long Term Disability Plan*, the court affirmed an insurer’s denial of benefits because the claimant “fail[ed] to show that the Committee’s decision, based on her failure to submit recent, comprehensive medical evidence sufficient to establish the disabling nature of her fibromyalgia, was arbitrary and capricious.”¹⁹⁹ The plan in question provided that “‘*Total Disability*’ means . . . the inability of [the] Participant, based upon *conclusive medical evidence*, to engage in any gainful occupation for which he or she is reasonably fitted by education, training or experience, as determined by the Plan Administrator.”²⁰⁰ The court found that the claimant “fail[ed] to show that it was unreasonable for the Committee to interpret this definition to require recent, *objective* evidence of the existence of a condition.”²⁰¹

Even in cases where the courts have sided with the claimant, the opinions have noted that plan administrators could protect themselves with plan language that excluded coverage for subjective-proof diseases such as

195. *Id.* at *5, *7.

196. *Id.* at *6.

197. *Id.* at *10.

198. *Id.*

199. *Meraou v. Williams Co. Long Term Disability Plan*, 221 F. App’x 696, 706 (10th Cir. 2007).

200. *Id.* at 698 (quoting the language of the plan) (second emphasis added).

201. *Id.* at 704.

fibromyalgia or chronic fatigue syndrome.²⁰² Though courts have espoused the ability of plan administrators to contract around these diseases, Congress could rectify the corresponding detriment to claimants.²⁰³

In evaluating the restrictions and requirements in disability plans, courts typically distinguish the evidence that supports the diagnosis and the evidence that supports the disability. When a plan calls for objective evidence of a *diagnosis*, the court may find the requirement unreasonable, especially when confronted with a disease such as fibromyalgia that has no objective basis for diagnosis. When the plan calls for objective evidence of *disability*, this inquiry may require the claimant to provide objective evidence of the limitations that the fibromyalgia or similar disease impose upon the claimant. Even with evidence of disability, a plan administrator may still deny a claimant based on lack of objective diagnosis. In that case, the denial is against public policy because the claimant cannot obtain such evidence.

C. Subjective Proof in Other Arenas

In contrast to adjudications involving disability denials under ERISA, subjective evidence is frequently used and credited in other judicial proceedings. Moreover, this type of evidence can be outcome determinative in other areas of the law.

A jury determining an amount of damages takes into account the subjective evidence of the plaintiff.²⁰⁴ A jury instruction of: “Do not take into account plaintiff’s subjective evidence as to the amount of pain and suffering he or she endured as a result of the injury,” would be absurd. A jury cannot separate subjective evidence and pain and suffering, for they are inherently intertwined.

In tort law, damages for “pain and suffering” have been a longstanding component of litigation.²⁰⁵ In Oklahoma, for a jury award for future pain and suffering based on subjective reports, “there must be evidence by expert witnesses that plaintiff, with reasonable certainty, will experience

202. See *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 678 (9th Cir. 2011) (“The plan has no exception to coverage for chronic fatigue syndrome, so CIGNA has taken on the risk of false claims for this difficult to diagnose condition.”).

203. See *infra* Section IV.C.

204. See Steven Plitt & John K. Wittwer, *Colossus Under Attack: The Legal Efficacy of Computerized Evaluation of Bodily Injury Claims*, 29 INS. LITIG. REP. 321, 321 (2007).

205. *Id.*

such pain and suffering and that the injury is permanent.”²⁰⁶ When “the injury is ‘objective, and it is plainly apparent from the nature of the injury . . . the jury may infer that fact from proof of that injury alone.’”²⁰⁷ For example, for future pain and suffering damages due to an injury that is reliant on subjective evidence, the plaintiff would have to show future pain and suffering with expert evidence:

Where the injury is subjective, and of such a nature that laymen cannot, with reasonable certainty, know whether or not there will be future pain and suffering, then, in order to warrant an instruction on that point, and to authorize a jury to return a verdict for future pain and suffering, there must be offered evidence by expert witnesses, learned in human anatomy, who can testify, either from a personal examination or knowledge of the history of the case, or from a hypothetical question based on the facts, that the plaintiff, with reasonable certainty, may be expected to experience future pain and suffering, as a result of the injury proven.²⁰⁸

In claims for pain and suffering, rewards have included recovery for hardships such as insomnia and mental suffering.²⁰⁹ These elements, especially insomnia, are also symptoms of some diseases that result in disability claims, such as fibromyalgia.²¹⁰

Because of the inherently personal aspects of awards for “pain and suffering,” attempts to develop a formula or otherwise quantify an amount for a jury have failed.²¹¹ In *Loth v. Truck-A-Way Corp.*, an expert informed the jury that, based upon his calculations, “the baseline value of an average person’s remaining 44-year life expectancy is \$2.3 million.”²¹² He then told them “that after adjusting the baseline value to account for the plaintiff’s expected lifespan, the jury could calculate the plaintiff’s hedonic damages by multiplying the percentage of the plaintiff’s disability by the adjusted

206. *Edwards v. Chandler*, 1957 OK 45, ¶ 5, 308 P.2d 295, 297.

207. *Id.*

208. *Reed v. Scott*, 1991 OK 113, ¶ 9, 820 P.2d 445, 449 (quoting *Shawnee-Tecumseh Traction Co. v. Griggs*, 1915 OK 576, ¶ 4, 151 P. 230, 231).

209. STUART M. SPEISER ET AL., 2 AM. LAW OF TORTS § 8:19 (Monique C.M. Leahy, ed. 2019).

210. *Morgan v. UNUM Life Ins. Co. of Am.*, 346 F.3d 1173, 1175 (8th Cir. 2003).

211. *Loth v. Truck-A-Way Corp.*, 70 Cal. Rptr. 2d 571, 573 (Ct. App. 1998).

212. *Id.*

baseline figure.”²¹³ The court noted that “[t]here is ‘[n]o definite standard or method of calculation . . . prescribed by law by which to fix reasonable compensation for pain and suffering.’”²¹⁴

Hedonic damages, or loss of enjoyment of life, is not a separate damages award in all states.²¹⁵ In Oklahoma, hedonic damages “ha[ve] not yet gained favor as a separate element of damages,” but “Oklahoma does allow for a broad sweep of evidence to be entertained in determining future pain and suffering.”²¹⁶ The law does not require a claimant to objectively show a pecuniary value for pain and suffering, because in many cases, it is impossible.²¹⁷ As the Oklahoma Supreme Court questioned, “Is a person injured in an accident to be deprived of compensation for the pain and suffering endured because he cannot offer evidence of what the pain and suffering were worth from a pecuniary standpoint?”²¹⁸

This rationale should cross over into claims for disability. Is a person who makes a claim for disability due to subjective disease to be deprived of benefits because he cannot offer objective medical proof of his disability? Typically, claimants who are vying for disability coverage have information in the administrative record from their treating physician supporting the claim that they are disabled.²¹⁹ Though an administrator does not have to honor a personal doctor’s belief that the claimant is disabled and should be entitled to benefits,²²⁰ in a personal injury claim this evidence would allow the jury to award damages for future pain and suffering.²²¹

IV. Legislative and Judicial Solutions

The problems inherent in current ERISA jurisprudence are not unknown to Congress. In 2010, the Senate Finance Committee held a hearing in which they reviewed practitioners’, doctors’, and judges’ views on the current state of ERISA and the discrepancies between the legislative intent

213. *Id.*

214. *Id.* at 575–76 (quoting Cal. Civil Jury Instruction 14.13 (8th ed. 1994)).

215. See VICKI LAWRENCE MACDOUGALL, OKLAHOMA PRODUCT LIABILITY LAW § 12:13 (2017) (vol. 8 in Thomson Reuters’ “Oklahoma Practice Series”).

216. *Id.*

217. *Town of Sentinel v. Boggs*, 1936 OK 620, ¶ 9, 61 P.2d 654, 656–57 (per curiam).

218. *Id.*

219. See *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 826 (2003).

220. *Id.* at 825.

221. *Reed v. Scott*, 1991 OK 113, ¶¶ 9–11, 820 P.2d 445, 449.

behind that act and the current experience of policy-holders.²²² In calling the hearing to order, the Senate Finance Committee Chairman acknowledged the “loopholes in the law” that permit insurance company “abuses.”²²³ The Chairman enumerated these loopholes as ERISA preemption resulting in evidentiary restrictions²²⁴ and the allowance of discretionary clauses.²²⁵ One testimonial described current ERISA jurisprudence: “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.”²²⁶

Though pain determinations produce difficulty for both plan administrators and reviewing courts, the Social Security Administration (“SSA”) has solicited public input on its administrative consideration of pain in disability claims.²²⁷ The SSA aims to “remain[] aligned with contemporary medicine and health care delivery practices.”²²⁸ This determination to keep abreast of medical and scientific advances to provide a fairer disability claims process should be imported into ERISA. If plan administrators were required to evaluate subjective pain diseases in a way current with medical and scientific practices that emphasize the availability of clinical examinations, then unfair denials and judicial review would not be as common or complicated. However, as the SSA’s call for notes and comments is still so recent, any implementation of the SSA’s findings is unlikely to occur soon.²²⁹

While a scientific solution for pain evaluation may be on the horizon, there is no telling how long such a solution will take to find and implement in disability claims and administrator evaluations. For now, having a

222. *Do Private Long-Term Disability Policies Provide the Protection They Promise?: Hearing Before the S. Comm. on Fin.*, 111th Cong. (2010) [hereinafter *Hearing*].

223. *Id.* at 2 (statement of Sen. Max Baucus, Chairman, S. Comm. on Fin.).

224. The Congressman listed the following evidentiary restrictions: “[C]laimants cannot get jury trials, pretrial discovery, or the right to submit evidence to the court.” *Id.* (statement of Sen. Max Baucus, Chairman, S. Comm. on Fin.).

225. *Id.* (statement of Sen. Max Baucus, Chairman, S. Comm. on Fin.).

226. *Id.* at 5 (statement of Mark DeBofsky, Att’y, Daley, DeBofsky, and Bryant, Chi., Ill.).

227. Consideration of Pain in the Disability Determination Process, 83 Fed. Reg. 64493-01 (proposed for comment Dec. 17, 2018).

228. *Id.*

229. The deadline for public comments and supporting data about pain evaluation was due February 15, 2019. *Id.*

judicial safeguard that ensures claimants are not being denied unfairly will ensure that ERISA's primary goal of protecting beneficiaries' interests is given full strength.

A. Heightened "Abuse of Discretion" Standard

A universal standard of review for appeals of ERISA denials would allow for more clarity and consistency among ERISA appeals.²³⁰ Though the Supreme Court in *MetLife* refused to enlist a "talismanic" set of factors to be considered by courts, a "list of nonexclusive factors" would guide lower courts and help ERISA's goal of creating "uniformity in the field of employee benefits."²³¹ One factor that should be included in this list is whether the denial of benefits was based on a lack of objective evidence or tests. Even if there is not a universal list of factors that lower courts must take into account when reviewing denials of benefits, circuits should elucidate that a lessening of deference is warranted where a plan administrator bases the denial upon lack of objective proof of disease. When faced with an appeal for a denial of disability benefits for a claimant with a subjective-proof disease, the reviewing court should heighten the abuse of discretion standard. This solution mirrors that proposed by the Supreme Court in *Firestone* for the conflict of interest the insurer has when acting as both plan administrator and payor of benefits.

When outlining the factors for reviewing courts to consider in analyzing a denial for benefits, the courts should consider the presentation of subjective proof as a factor, sliding the scale against the deferential standard usually implemented by appellate courts.²³² The benefits of a heightened standard of review for claims that are based on subjective evidence include better protection for claimants from discriminatory denials and improved guidance for courts in reviewing claims of this nature. Acknowledging that the medical community cannot objectively prove these diseases, and that plan administrators are taking advantage of that ambiguity will ensure that claimants are not unfairly denied. Though this solution still grants deference to the plan administrator, allowing the fact that a claimant's diagnosis is based on subjective proof to lower that deference makes it more likely that a claimant will get a full and fair review.

One major drawback of heightening the abuse of discretion standard is the potential for judicial confusion regarding the standard of review. With

230. See Stevenson, *supra* note 10, at 134–45.

231. *Id.*

232. See Weber v. GE Grp. Life Assurance Co., 541 F.3d 1002, 1010 (10th Cir. 2008).

the Supreme Court's decision in *Metropolitan Life Insurance v. Glenn*, the Court solidified that the plan administrator's position as both decision-maker and payor of benefits is a conflict of interest.²³³ Further, the decision explicated that the conflict of interest is to be taken into account in ERISA appeals.²³⁴ The circuits implemented this heightened scrutiny, with some using a sliding scale approach and others essentially leaving the abuse of discretion standard the same.²³⁵ Adding one more factor to a non-exhaustive list of considerations may create judicial confusion, as judicial ERISA reviews have no universal template. Though circuit courts are unlikely to reach unanimity in evaluating subjective-proof diseases, elucidating the subjective-proof concern as a specific factor would ensure that claimants with these diseases are not unfairly barred by a judicial framework that does not ensure claimants have a fair chance at overturning a denial.

B. De Novo Review

The Supreme Court has been wary of instituting de novo review for benefit claim denial appeals.²³⁶ Though the Supreme Court has not been willing to expressly adopt a system of de novo review for denials of claim benefits under ERISA, Congress could implement legislation establishing this level of review to better protect claimants.²³⁷ Such an implementation would ensure that claimants are properly heard in court and that claimants receive a full and fair review of the benefit denial. This change would not only aid claimants suffering from subjective-proof diseases, but also protect those who make claims for objectively diagnosed diseases. Instead of an interested plan administrator, the appeal would be decided by an uninterested third party, thus giving the claimant the best chance for a fair decision. De novo review could also encourage expanded discovery, which would allow claimants to present evidence outside of the administrative record for review. Enabling courts to look at more evidence would fully effectuate the allowance of full and fair review under ERISA.

Though appealing to claimants, de novo review of all ERISA claim denials is unlikely because of the immense judicial expense it would

233. 554 U.S. 105, 114 (2008).

234. *Id.* at 117.

235. *See* Stevenson, *supra* note 10, at 114–32.

236. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115–17 (1989).

237. *Glenn*, 554 U.S. at 114 (“Had Congress intended such a system of review, we believe it would not have left to the courts the development of review standards but would have said more on the subject.”).

require.²³⁸ It would also deny the insurer the benefit of the discretions that it bargained for in the insurance contract.²³⁹ The increased litigation expenses would likely be passed through to the employers using the plans, thus decreasing the appeal of providing these benefits for employees. If plan administrators were not allowed this discretion, the added cost for employers might cause them to abandon their plans altogether.²⁴⁰ Though potentially more costly, the legislature drafted ERISA to provide for de novo review, and only subsequent judicial interpretation of that Act has given insurance companies discretion.²⁴¹

Since universal de novo review for ERISA denials is unlikely, whether by Supreme Court ruling or legislative intervention, other, more narrow alternatives would still protect claimants whose diseases have unknown etiology or use subjective proof. Courts should alter the standard of review when plan administrators deny benefits for reasons involving subjective evidence. These decisions should be evaluated de novo, without the deference normally given to plan administrators. Courts could review the factual contentions and independently determine if the claimant is entitled to disability benefits.

Even in cases where the court has overturned a denial of benefits for an abuse of discretion, the weighing of conflicts of interest is a difficult judicial task.²⁴² For example, “unlike weighing potassium bromide and

238. See *Hearing*, *supra* note 222, at 11–12 (“[B]usiness owners would be disinclined to provide voluntary benefits if it becomes overly expensive or it exposes the business to the threat of costly litigation.”) (statement of Paul Graham, Senior Vice President, Ins. Reg., and Chief Actuary, Am. Council of Life Insurers, Wash., D.C.).

239. *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1563 (11th Cir. 1990) (“While de novo review is an attractive avenue for controlling the exercise of discretion contrary to the interests of the beneficiaries, the application of this strict standard would deny Blue Cross the benefit of the bargain it made in the insurance contract.”).

240. *But see Hearing*, *supra* note 222, at 6 (statement of Mark DeBofsky, Att’y, Daley, DeBofsky, and Bryant, Chi., Ill.). DeBofsky argues that the value of providing employee benefit plans “to recruit and retain prized employees” is outweighed by any increased cost. *Id.* (statement of Mark DeBofsky, Att’y, Daley, DeBofsky, and Bryant, Chi., Ill.). He predicts that “it is extremely unlikely that employers would cease sponsoring benefit plans, nor is there a legitimate fear of markedly increased costs.” *Id.* (statement of Mark DeBofsky, Att’y, Daley, DeBofsky, and Bryant, Chi., Ill.).

241. See 29 U.S.C. § 1132(a)(1)(B) (2014); see also *Hearing*, *supra* note 222, at 8 (“The clear language of ERISA recognizes nothing less than a trial on the merits.”) (statement by Hon. William M. Acker, Jr., Senior U.S. Dist. Court Judge, N.D. Ala., Birmingham, Ala.).

242. See *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 675 (9th Cir. 2011).

potassium ferricyanide in a traditional darkroom, [a court's] 'weighing' is done without a scale, without the little brass weights, and without a substance to weigh that has any weighable mass."²⁴³ This difficulty would be ameliorated by adjusting the standard of review when plan administrators deny a claim due to a lack of objective evidence. Instead of wading into the bog of evaluating conflicts of interest, the court could simply review the underlying claim *de novo* and determine if the claimant is entitled to disability benefits.

Currently, judicial review is limited to review of the administrative record because of the discretion granted to plan administrators. This scope limitation means that the claimant is not able to present further evidence to the court to attempt to prove disability or show that the plan administrator wrongfully denied disability benefits. Though *de novo* review does not automatically guarantee the claimant's ability to provide further evidence, an alteration to the current judicial process to allow evidence outside of the administrative record could ensure that the policy goals of ERISA are upheld. If a reviewing court can examine this evidence *de novo* and determine if the claimant is entitled to benefits, then there is the greatest surety of "full and fair" review, which is guaranteed under ERISA. Further, when a plan administrator denies a claim for disability because the claimant brings forth subjective evidence, the courts should consider the denial an automatic abuse of discretion. Courts should require that a plan administrator have more reason to deny a claimant than just the fact that she brings forward only subjective evidence.²⁴⁴

Though the Supreme Court has been reluctant to permit *de novo* review in these types of claims, such an approach would ensure that claimants receive a full and fair review. Because plan administrators act under a conflict of interest, diseases evidenced by subjective proof present an easy and mildly persuasive justification for denying claims. Therefore, courts should pursue heightened standards of review in order to give disadvantaged, pain-filled claimants the protection they need.

243. *Id.*

244. *See id.* at 676 (finding plan administrator's denial was unreasonable because "the plan administrator demanded objective tests to establish the existence of a condition for which there are not objective tests" among other factors).

C. Disallowance of “Self-Report” Clauses in Long-Term Disability Plans

Today, many private LTD plans limit benefits for diseases that rely on subjective-proof or self-reported symptoms.²⁴⁵ For example, a plan may state that plan benefits will be terminated after twenty-four months for diseases “not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine.”²⁴⁶ This plan language is hard to reconcile with the current state of medicine regarding subjective-proof diseases.²⁴⁷ With many very real, very debilitating diseases, there are not objective medical tests available to prove the existence of some conditions. When an LTD plan includes a clause that explicitly denies benefits to a class of claimants with disabling diseases that are unprovable, the plan impedes the basic purpose of ERISA.

Requiring objective proof of the etiology of a disease or discontinuing benefits because a claimant’s complaints are self-reported fails to provide adequate protection. There are medical evaluations that can provide evidence of disability where a disease is not objectively measurable.²⁴⁸ With the availability of these tests to determine whether a disease renders a claimant *disabled*, there is not a need for objective proof of the *disease*. If Congress disallowed the use of self-report provisions, then claimants with subjective-proof diseases would have the same benefits and review process as other more objectively verifiable diseases. If denied, the proper district court could then review the claim without the bias against self-reported symptoms.

Since the Supreme Court has found that trust law largely governs ERISA, plan administrators are acting as fiduciaries.²⁴⁹ As such, they must “discharge [their] duties with respect to a plan solely in the interest of the [plan] participants and beneficiaries.”²⁵⁰ This duty is hard to reconcile with

245. See, e.g., *Weitzenkamp v. UNUM Life Ins. Co. of Am.*, 500 F. App’x 506, 507 (7th Cir. 2013); *Cox v. Allin Corp. Plan*, 70 F. Supp. 3d 1040, 1043 (N.D. Cal. 2014). The plan at issue in *Weitzenkamp* contained a clause that ceased benefits after two years for disabilities “which are primarily based on self-reported symptoms.” *Weitzenkamp*, 500 F. App’x at 507 (quoting language of the plan). The plan defined self-reported symptoms as “those that ‘are not verifiable using tests, procedures or clinical examinations.’” *Id.* (quoting the language of the plan).

246. *Cox*, 70 F. Supp. 3d at 1043 (quoting the language of the plan).

247. See *supra* Part III.

248. See *Liebel v. AETNA Life Ins. Co.*, 595 F. App’x 755, 759–61 (10th Cir. 2014).

249. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110–11 (1989).

250. 29 U.S.C. § 1104(a) (2012).

contract language that denies relief for a certain class of diseases. If Congress required disability plans to cover self-reported symptoms, then an entire class of disability claimants would be better able to obtain the full and fair review that ERISA promises.

Conclusion

Diseases evidenced by subjective proof are inherently impossible to prove objectively, and therefore are difficult to address on judicial review. The standard of review that courts employ in these appeals is that of “abuse of discretion,” which is heightened if there is a conflict of interest, which there often is. This conflict of interest arises because the insurer is both the administrator of the plan and the payor of benefits if the claimant succeeds in their application. Even with a heightened “abuse of discretion” standard, claimants whose diseases are evidenced by subjective proof are not guaranteed a full and fair review of their claims. Plan administrators may simply deny claims and then argue that the denial was justified due to a lack of objective evidence on appeal. While they are not always successful, with today’s judicial scheme, it is more likely than not that the plan administrator’s denial will be upheld.

Increasingly, insurance plan language discriminates against claimants with subjective-proof diseases. “Self-Report” clauses and those that deny any form of relief for these illnesses are against public policy and should be disallowed by federal legislation. To provide that an employee *must* have objective evidence of his disease contradicts modern medicine’s recognition of many debilitating diseases that do not have medical tests for diagnosis. If an employee is provided coverage by his employer or buys long-term disability coverage independently, plan administrators should not deny his claim because his plan has unfairly excluded his disease. These self-report clauses are against public policy and Congress should mandate an exclusion from long-term disability plans covered under ERISA. ERISA’s goal to protect the rights of employees goes against the coverage provided in many of these plans, and these contradictions should not be allowed.

By altering the standard of review or disallowing clauses biased against subjective-proof diseases, a claimant’s right to full and fair review will be ensured. Just because objective tests do not evidence these diseases does not mean they are any less disabling. Ensuring a claimant receives full and fair review guarantees that the employee’s rights are upheld and plan administrators do not unfairly deny their claims.

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