

TESTIMONY OF KAREN L. HANDORF

**Hearing on “IMPROVING RETIREMENT SECURITY AND ACCESS TO
MENTAL HEALTH BENEFITS”**

U.S. House of Representatives Committee on Education & Labor

Subcommittee on Health, Employment, Labor, and Pensions

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Chairperson DeSaulnier, Ranking Member Allen, and members of the Subcommittee. Thank you for the opportunity to testify at today’s hearing on “Improving Retirement Security and Access to Mental Health Benefits.”

I am a Senior Counsel in the Employee Benefits and ERISA Practice Group at the law firm of Berger Montague P.C., in its Washington, D.C. office. I have spent almost 40 years representing participants and beneficiaries of employee benefit plans in litigation brought under the Employee Retirement Income Security Act (ERISA) in the district courts and on appeal. I began my ERISA career in 1982 as a trial attorney with the Office of the Solicitor, Plan Benefits Security Division, U.S. Department of Labor (PBSD), which provides legal advice and litigation support to the Employee Benefits Security Administration (EBSA). During my 25-year career at PBSD, I conducted and supervised ERISA fiduciary litigation in the district and appellate courts, supervised ERISA civil penalty enforcement actions, and supervised the amicus brief writing program through which the Department of Labor (DOL) expressed its views on novel and difficult ERISA issues in private litigation. During the last six years of my career at DOL, I served as the Deputy Associate Solicitor of PBSD. Since leaving DOL in 2007, I have represented participants and beneficiaries of employer sponsored welfare and pension plans in class action litigation brought against fiduciaries alleged to have violated ERISA. The current focus of my work at Berger Montague is ERISA-covered health plans.¹

I applaud Congress for its recent legislation strengthening ERISA’s protections by giving DOL additional tools to enforce The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) (MHPAEA), as well as requiring disclosure of health plan broker and consultant

¹ I am grateful for the assistance of my Berger Montague colleague Senior Counsel Julie Selesnick in preparing this testimony.

compensation, prohibiting gag clauses and enacting the No Surprises Act. I also applaud DOL's work and substantial expenditure of resources to bring health plans into MHPAEA compliance as described in the 2022 MHPAEA Report to Congress submitted by the Departments of Labor, Health and Human Services, and Treasury (the Departments), titled *Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage* (2022 Report).

My testimony today will first focus on EBSA's MHPAEA enforcement activity and the Departments' recommendations for strengthening MHPAEA's consumer protections. I will then discuss amendments that should be made to ERISA to remove barriers to effective private enforcement of participants' ERISA rights, including rights to mental health parity.

The Need for More DOL Enforcement Authority and Resources

I was disheartened, but not surprised, by the level of MHPAEA non-compliance reported by the Departments in the 2022 Report. EBSA issued 156 letters to plans and issuers requesting comparative analyses for 216 unique non-quantitative treatment limitations (NQTLs) across 86 investigations and none of the responses contained sufficient analyses for review upon receipt. 2022 Report at 4, 8.

Although plans were required to have their analyses ready for EBSA review as of February 10, 2021, 40 percent of those receiving letters requested extensions with a significant number stating that their analysis was not complete and some stating that they had not even started the analysis. *Id.* at 14. DOL reports that when it did have sufficient information to allow a comparative review of 48 NQTLs corresponding to 30 plans and issuers, none of the comparative analyses were compliant. *Id.* at 15. When EBSA issued letters detailing the insufficiencies and gave plans and issuers an opportunity to supplement their analyses, many of the supplementations did not cure the insufficiencies or revealed new insufficiencies. *Id.* at 18.

The level of noncompliance by plans and issuers targeted by EBSA indicates widespread non-compliance among plans and issuers in general. The 2022 Report notes that many plans were unable to provide comparative analyses of their NQTLs because plan sponsors erroneously assumed their service providers had already prepared such an analysis or would prepare one for them. 2022 Report at 14. EBSA discovered, however, that the plans' service providers had not prepared

an analysis and were also not complying with MHPAEA while administering the plans. *Id.*

The lack of compliance with MHPAEA is most likely symptomatic of a much greater problem. Most employers sponsoring self-insured plans adopt a prototype plan and sign an administrative service agreement, sometimes called an administrative service only agreement (ASO) with one of the large insurance carriers – Blue Cross, UnitedHealth, Cigna, Aetna, Humana (BUCAHs) – and assume that they have no more responsibility for the plan until contract renewal. Their choices among network plans are limited because the market in a particular area is usually dominated by one carrier. Often, the broker directing them to one of the BUCAHs is operating under significant conflicts of interest because the broker receives compensation by the carrier it recommends. Employers think that they are getting access to lower cost networks when, in fact, the evidence shows that in many cases it would be cheaper for an employee to pay for the care out of pocket than use insurance.²

The BUCAHs, acting as third-party administrators (TPAs), have no incentive to cut costs because they are not paying the tab; the employer and employees are. Employers who attempt to audit claims payments are met with resistance and limitations on the number and type of claims that can be audited. TPAs are further disincentivized to ensure that only valid claims are paid because their contracts allow them to collect a percentage of what they recover if they fix their own mistakes in paying the claim in the first instance. And in some instances, TPAs who are also insurers self-deal by recouping overpayments made from fully-insured plans to providers by taking money legitimately owed to those same providers from self-funded plans.³

It is well-established that employers are fiduciaries when they hire service providers and have a duty to monitor them on an ongoing basis.⁴ Congress gave employers much-needed tools to assist them in this important task when it passed the broker and consultant fee disclosure requirements and prohibited gag clauses under Division BB of the Consolidated Appropriations Act of 2021 (CAA). Based on my discussions with experts and service providers in the employee benefits

² See, e.g. How New Data On Hospital “Discounted Cash Prices” Might Lead To Patient Savings, Health Affairs Blog, November 8, 2021, DOI: 10.1377/hblog20211103.716124

³ See, e.g. *Lutz Surgical Partners v. Aetna, Inc.*, Case No. 3:15-cv-02595 (BRM) (TJB) (D.N.J. Jun. 21, 2021).

⁴ See *Tibble v. Edison Int’l*, 135 S. Ct. 1823 (2015).

field, many employers are not aware of their responsibilities under these provisions (just as they were not aware of their responsibilities under MHPAEA) and very few are prepared to comply with them. Shockingly, many employers are not even aware that they have fiduciary duties with respect to their health plans even though health plan fiduciaries have been subject to ERISA's fiduciary rules since the statute was passed more than 40 years ago.

While many employers have been asleep at the wheel, the cost of employer-sponsored healthcare has sky-rocketed. According to a recent survey, the average employee premium for family coverage has increased 22% over the last five years and 47% over the last ten years. During this same period, workers' wages increased only 5% and inflation increased 1.9%.⁵ A recent Gallup poll showed that nearly 100 million Americans consider their health care system "expensive" and "broken," and 65% of those surveyed believe that employers have the most power to bring down health care costs, with 65% saying that they have a lot of power and 25% saying they have some.⁶

Enhance EBSA's Ability to Enforce MHPAEA

If Congress is committed to enforcement of MHPAEA and an employer-sponsored healthcare system that actually delivers the benefits promised for a price workers can afford, it must give EBSA tools to leverage its limited resources (additional financial resources would also be extremely helpful). As the 2022 Report notes, DOL is responsible for overseeing over two million group health plans covering 136.5 million individuals. This is in addition to its responsibility for overseeing other types of welfare plans and more than 700,000 retirement plans holding more than \$10 trillion in assets.⁷ EBSA is a relatively small agency with fewer than 1,000 employees overall and only 364 investigators as of FYE 2020.⁸ With so few

⁵ Employer Health Benefits 2021 Annual Survey at 6, Kaiser Family Foundation, November 10, 2021; <https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/>, accessed February 25, 2022.

⁶ Have Americans reached a breaking point with our health care system? Scott Woolridge, Benefits Pro, Dec. 21, 2021; <https://tinyurl.com/ywt3tumx>, accessed February 25, 2022.

⁷ EBSA Restores Over \$2.4 Billion to Employee Benefit Plans, Participants and Beneficiaries, Fact sheet; U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC, 20210, Updated as of October 14, 2021; <https://tinyurl.com/2p8srwdh>, accessed February 25, 2022.

⁸ Employee Benefits Security Administration: Enforcement Efforts to Protect Participants' Rights in Employer-Sponsored Retirement and Health Benefit Plans, May 27, 2021; U.S. Government

resources, EBSA has done a remarkable job of enforcing a very complex statute covering such a wide range of plans and impacting the national economy in such a significant way.

One way that EBSA can leverage its resources more efficiently is if Congress passes legislation based on the 2022 Report's recommendations. First, EBSA should be given the authority to assess civil monetary penalties for parity violations. Under the current statutory scheme, there are no strong financial incentives for an employer to comply with MHPAEA before being investigated by EBSA because the only penalty for noncompliance is for the employer to do what it should have done in the first place – bring the plan into compliance and pay the required benefits. The threat of substantial civil monetary penalties would serve as a strong deterrent to non-compliance and incentivize employers to take their fiduciary duties seriously or risk financial consequences.

Second, ERISA should be amended to give DOL the authority to directly pursue parity violations by issuers and issuers serving as TPAs. Section 502(b)(3) of ERISA, 29 U.S.C. § 1132(b)(3), prohibits the Secretary of Labor from enforcing mental health parity provisions against health insurance issuers offering health insurance coverage in connection with a group health plan. More than one-third (36%) of ERISA participants and beneficiaries are covered by fully insured plans.⁹ Moreover, most employers with self-insured plans purchase prototype plans from these same major insurers. Those same employers rely on the insurers to administer their plans including making final and binding coverage determination in mental health cases. Because the insurers generally apply the same utilization review criteria across their entire commercial book of business, they are incentivized to reduce benefit costs and deny coverage in both insured and self-insured plans, resulting in systemic violations.¹⁰

Accountability Office, GAO-21-376; <https://www.gao.gov/products/gao-21-376>, accessed February 23, 2022.

⁹ Employer Health Benefits 2021 Annual Survey at 9, Kaiser Family Foundation, November 10, 2021; <https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/>, accessed February 25, 2022.

¹⁰ See, e.g., *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019) (finding that United Behavioral Health's single set of guidelines for making coverage determinations meant its decisions for self-insured plans were infected by its conflicts of interest with respect to the fully insured plans it provided).

Enabling DOL to directly pursue issuers and TPAs would leverage DOL's resources to enforce MHPAEA significantly. Because of the significant control issuers have over all aspects of employer-sponsored healthcare, I would urge Congress to extend that authority beyond MHPAEA to enforcement of all ERISA provisions relating to employer-sponsored healthcare plans.

Third, Congress should amend ERISA to clarify that participants and beneficiaries of ERISA-covered plans are entitled to be made whole when their claims are denied and additionally give the Secretary of Labor authority to seek such relief on their behalf. While the Supreme Court in *Cigna Corp. v. Amara*¹¹ laid the groundwork for an argument that participants are entitled to be made whole and courts have granted such relief, it is not explicit in the statute and is subject to judicial interpretation. This would not only redress the harm caused by parity violations, but it would also incentivize compliance. Plan fiduciaries are more likely to comply with MHPAEA and provide the required benefits if they know that they will be liable for the harm caused to participants if they do not do so. Moreover, the threat of a lawsuit by DOL on behalf of large numbers of injured participants for make-whole relief is much more likely to result in compliance.

Finally, Congress should significantly alter the existing standards of MHPAEA. The admirable goals of MHPAEA cannot be met by the above measures alone. The attempt to make comparable mental health and medical coverage, plan by plan, is inherently unwieldy and unenforceable. Congress should, at a minimum, consider DOL's recommendation that MHPAEA be amended to ensure that mental health and substance use disorder benefits are defined in an objective and uniform manner pursuant to external benchmarks based on nationally recognized standards.

Amend ERISA to Strengthen Participants' Rights to Protect their Interests

Even if Congress could increase EBSA's resources exponentially, private enforcement of ERISA's protections for participants and beneficiaries in health plans as well as pension plans must be strengthened. One of the primary purposes of ERISA is to protect the interests of plan participants and beneficiaries "by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and

¹¹ *Cigna Corp. v. Amara*, 563 U.S. 421 (2011).

ready access to the Federal courts.” 29 U.S.C. § 1001(b).¹² ERISA, as interpreted, has fallen far short of that purpose.

It would be impossible to provide enough funding for the DOL to oversee and enforce ERISA on behalf of two million group health plans covering 136.5 million individuals, 700,000+ retirement plans holding more than \$10 trillion in assets, and the many other benefit plans DOL is charged with regulating (*i.e.*, dental plans, vision plans, wellness plans, short-term disability plans, long-term disability plans, severance plans). For this reason, it is imperative that Congress strengthen the rights of participants and beneficiaries to protect their own interests in their ERISA-covered employee benefit plans. While the statute was enacted explicitly for this purpose, the following issues have all served to weaken the rights of participants and beneficiaries and have made it more difficult for them to protect their own interests, placing an even greater burden on DOL to enforce ERISA.

Discretionary Clauses.

Since the Supreme Court’s decision in *Firestone Tire & Rubber Co. v. Bruch*,¹³ the vast majority of employee benefit plans grant insurance companies and others deciding benefit claims broad discretion to determine eligibility for benefits and to interpret the terms of the plan. These clauses change the default *de novo* review standard that courts would otherwise apply in reviewing benefit denials to a standard that is extremely deferential to the plan fiduciaries (referred to as either the abuse of discretion standard or the arbitrary and capricious standard). In practice, this deferential standard of review makes it extremely difficult for plan participants and beneficiaries, particularly those challenging healthcare or disability denials, to obtain promised benefits even if the court determines that it would decide the matter differently under a *de novo* standard of review. The deferential standard of review also severely limits the scope of discovery in a suit challenging a benefit denial. All of this unfairly disadvantages sick, retired, and disabled individuals challenging benefit denials.

¹² See S. Rep. No. 127, 93d Cong. 1st Sess. 35 (1973) (ERISA's enforcement provisions are “designed specifically to provide both the Secretary and participants and beneficiaries with broad remedies for redressing or preventing violations of [ERISA]. *** The intent of the Committee is to provide the full range of legal and equitable remedies available in both state and federal courts and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law or recovery of benefits due to participants.”).

¹³ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 1010 (1989).

Indeed, many states have banned such clauses in insurance policies issued in their states. According to the National Association of Insurance Commissioners (NAIC), as of the spring of 2020, 26 states have enacted laws prohibiting these clauses in at least some kinds of insurance policies.¹⁴ Some of these bans are based on a model rule adopted by the NAIC. The NAIC and these states have generally cited the misleading nature of discretionary clauses and the fact that they undermine promises of coverage. While courts have nearly always upheld these bans, such bans are only applicable to insured plans, and not to self-funded plans, because of ERISA's broad preemption provision.

The same reasons that support the adoption of the model rule drafted by the NAIC and the adoption of bans on discretionary clauses by so many states also support adoption of a federal ban in ERISA. A federal ban enacted through ERISA will also serve to ensure uniformity among plans in different states and between insured and self-funded plans. Finally, such a ban is in keeping with ERISA's statutory goal to protect plan participants and beneficiaries and ensure that they receive the benefits they have been promised.

Arbitration Clauses.

Plan sponsors are increasingly including provisions in their employee benefit plans requiring participants to arbitrate benefit and fiduciary breach claims instead of bringing suit in federal court as permitted under ERISA. Some courts have upheld plan arbitration provisions that also prohibit class action lawsuits and/or severely limit a participant's ability to obtain relief to the plan as a whole.¹⁵ Other courts have held the opposite.¹⁶ Some plan fiduciaries assert that participants have agreed to these arbitration provisions by continuing to work and participate in the plan, even when they have not received a copy of the plan document and the arbitration provisions are not included in the summary plan description. Some arbitration

¹⁴ Prohibition on the Use of Discretionary Clauses Model Act, Jennifer Neuerburg; ST-42-2, NAIC Model Laws, Regulations, Guidelines and Other Resources—Spring 2020; <https://tinyurl.com/4tpmu4sw> accessed February 24, 2022.

¹⁵ See, e.g., *Dorman v. Charles Schwab Corp.*, 780 F. App'x 510 (9th Cir. 2019); *Holmes v. Baptist Health South Florida, Inc.*, No. 21-22986-Civ-Scola, 2022 WL 180638 (S.D. Fla. Jan. 1, 2020); *Coleman v. Brozen*, Case No. 4:19-cv-705, 2020 U.S. Dist. LEXIS 79367, at *9 (E.D. Tex. May 6, 2020)..

¹⁶ See, e.g., *Smith v. Board of Directors of Triad Manufacturing, Inc.*, 13 F.4th 613 (7th Cir. 2021); *Cedeno v. Argent Trust Company*, No. 20-cv-9987 (JGK), 2021 WL 5087898 (S.D.N.Y. Nov. 2, 2021); *Hensiek v. Bd. of Dirs. of Casino Queen Holding Co.*, No. 3:20-cv-377-DWD, 2021 WL 267655 (S.D. Ill. Jan. 25, 2021); *Hawkins v. Cintas Corp.*, No. 1:19-cv-1062, 2021 U.S. Dist. LEXIS 14766, 2021 WL 274431 (S.D. Oh. Jan. 27, 2021).

provisions include confidentiality clauses that make it impossible for participants to inform others of fiduciary breaches.¹⁷

Plan fiduciaries are also asserting that participants are required to arbitrate benefit and fiduciary breach claims based on employment agreements.¹⁸ Participants are often unaware that by agreeing to arbitrate employment claims, they are also agreeing to arbitrate plan claims. These provisions erect barriers in conflict with ERISA's stated purpose of "providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1002(b). They also potentially make plan fiduciaries subject to conflicting arbitration decisions, even when the behavior in question impacts all plan participants equally, violating ERISA's goal of consistent and uniform application of fiduciary standards among plan participants.

In addition, some plans purport to prohibit participants and beneficiaries from bringing actions against the plan or against plan fiduciaries as class actions or as representatives of the plan. The cost of pursuing an individual participant's claim may outweigh the value of the individual claim. Thus, these restrictions may defeat the ability of participants and beneficiaries who have a small claim from obtaining redress even if the violation at issue is systemic and many other participants or beneficiaries would have similar claims that could be addressed on a class or representative basis.

Representational Standing.

ERISA was enacted to protect the interests of participants and beneficiaries in employee benefit plans by subjecting those who administer plans to stringent fiduciary standards and by giving participants and beneficiaries ready access to the federal courts to protect those interests. ERISA section 502(a)(2), 29 U.S.C. 1132(a)(2), expressly gives plan participants and beneficiaries a cause of action for fiduciary breaches that impact a plan and provides for appropriate relief to the plan for those breaches under section 409 of the Act, 29 U.S.C. 1109.

In *Thole v. U.S. Bank*,¹⁹ the Supreme Court ruled that a plan participant lacks standing under Article III of the Constitution to assert a fiduciary breach claim

¹⁷ See, e.g., *California Commerce Club, Inc.*, 369 NLRB No. 106 (June 19, 2020) (The National Labor Relations Board (NLRB) held that confidentiality language in an arbitration agreement an employer required its employees to sign as a condition of employment was a lawful action).

¹⁸ See, e.g., *Cooper v. Ruane Cunniff & Goldfarb, Inc.*, 990 F.3d 173 (2d Cir. 2021); *Williams v. Imhoff*, 203 F.3d 758 (10th Cir. 2000).

¹⁹ 140 S. Ct. 1615 (2020).

involving a defined benefit pension plan where the participant continues to receive vested benefits. The effect of this decision is to deprive participants and beneficiaries of the right to hold plan fiduciaries accountable for losses to the plan from fiduciary breaches or to obtain other equitable relief to protect the plan unless the plan does not have enough assets to pay benefits. While an injury to a participant's plan will, other things being equal, increase the risk that the plan's participants and beneficiaries will ultimately fail to receive their full promised benefits, the court failed to view this risk as a sufficient injury to confer standing under Article III.

Thole has been applied to deny Article III standing to health plan participants seeking to correct fiduciary breaches. Even though plan participants contribute to the cost of their own benefits through premium deductions, deductibles and co-payments, courts have held that they do not have Article III standing to challenge fiduciary breaches in the management of their health plans that increase costs unless they have been denied a benefit because of the wrongdoing.²⁰

Anti-Assignment Provisions.

Some plans prohibit participants or beneficiaries from assigning their claims for health care benefits. Giving effect to these anti-assignment provisions, some courts have refused to honor assignments by plan participants or beneficiaries to their medical providers.²¹ The medical provider, however, normally has greater knowledge and resources to pursue claims that may relieve the participant of a payment obligation if successful. Indeed, it is very often the case during the claims process that the plan's TPA (often an insurance company) deals with the medical provider rather than the participant, whose treatment or illness may hinder the participant's ability to deal with the claim and who, in any event, likely cannot explain the clinically appropriate reasons for the medical necessity of the treatment. Medical providers nearly always obtain assignments from their patients but have no way to know if the plan has a provision that purports to prohibit such assignments. This inability to know if an assignment will be honored, and the very real risk that it will not, adds to the medical provider's risk of non-payment and may lead some providers to refuse to treat even insured patients unless they pre-pay for their treatment, which many people cannot afford to do. For these reasons,

²⁰ See, e.g., *Scott v. UnitedHealth Group, Inc.*, 540 F. Supp. 3d 857 (D. Minn. 2021); *Winsor v. Sequoia Benefits & Ins. Services, Inc.*, No. 21-cv-00227-JSC, 2021 WL 5053087 (N.D. Cal. Nov. 2, 2021).

²¹ See, e.g., *Davidowitz v. Delta Dental Plan of Calif., Inc.*, 946 F.2d 1476, 1481 (9th Cir. 1991).

it is simply more equitable and efficient to allow a medical provider to pursue the claim if the patient assigns the claim to that provider.

Attorney's Fees for Participants and Beneficiaries that Prevail in Actions for Benefits.

In many disputes over benefits or payments from a plan, the participant or beneficiary must retain legal counsel and other experts to analyze difficult legal, medical and contractual issues and to protect their rights during the plan's internal claims process. Indeed, because claimants generally are forbidden from supplementing the plan's claims procedure file with additional pertinent evidence during the lawsuit, it is very important that the record in the claims file contain complete information, which is hard for a plan participant to analyze without legal counsel.

The current language of ERISA section 502(g)(1), 29 USC 1132(g)(1), states that in any action brought "by a participant, beneficiary, or a fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." Courts have read this provision as not authorizing the award of attorney's fees for that portion of the attorney's work and costs incurred in the pre-judicial claims process (the administrative phase), even if a participant achieves some success on the merits of his benefits claim in the court action.²² This makes it more difficult for claimants to retain legal counsel, particularly in cases with relatively small claims, and results in unfair claims denials. Section 502(g)(1) should be amended to require courts to consider attorney's fees and costs incurred during the administrative phase of the claims process, as well as those incurred in the court action, when deciding on an award of attorney's fees and costs. It should also be amended to enable courts to award fees incurred for consultants and other experts during the administrative phase.

In addition, some courts do not allow a prevailing party's expert witness fees incurred in the court action to be included as a cost under section 502(g).²³ Section 502(g) should be amended to make clear that such expenses are includible when a court awards costs of action filed in the claims dispute.

²² See, e.g., *Cann v. Carpenters' Pension Trust for N. Calif.*, 989 F.2d 313, 317 (9th Cir. 1993); *Anderson v. Procter & Gamble Co.*, 220 F.3d 449 (6th Cir. 2000).

²³ See, e.g., *Agredano v. Mut. of Omaha Companies*, 75 F.3d 541, 542 (9th Cir. 1996) (affirming district court order denying plaintiff's request for expert witness fees, in which it stated that "[t]here is no right to expert witness fees under ERISA"); *Holland v. Valhi, Inc.*, 22 F.3d 968, 979-80 (10th Cir. 1994) (holding that section 502(g)(1) does not authorize courts to shift expert witness fees except to the extent allowed by 28 U.S.C. §§ 1920 and 1821).

Venue.

Currently, section 502(e)(2) of ERISA, 29 USC 1132(e)(2), allows suits to enforce ERISA's protections in federal court to be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found. Some employee benefit plans, however, require that participants and beneficiaries agree to bring any such suits in a particular federal district, such as where the plan is administered. Courts have upheld these plan provisions.²⁴ In effect, this may limit participants and beneficiaries to bringing ERISA claims in courts that are hundreds or even thousands of miles from where they live or work, which is likely to be prohibitively inconvenient and expensive for the participant or beneficiary. These plan provisions frustrate the statutory protections and discourage participants and beneficiaries from enforcing their rights under ERISA.

Statute of Limitations for Benefit Claims.

ERISA contains a statute of limitations for suits to enforce ERISA's fiduciary requirements but does not contain a statute of limitations for suits to recover benefits or for other relief pursuant section 502(a)(1)(B), 29 USC 1132(a)(1)(B). Courts generally apply whatever time limits the plan provides, or in the absence of a plan provision that has been disclosed to the claimant in the final adverse determination, courts look to statutes of limitations applicable to similar claims under state law in the district where the suit is brought.²⁵ These courts do not always agree about the analogous state law and the statutory periods can vary greatly even with respect to the same kind of state-law claim. In addition, courts disagree about when claims accrue. ERISA should be amended to provide for a uniform statute of limitations for denial of benefits claims that also defines when a claim accrues.

Effect of Fraud or Concealment on the Statute of Limitations.

Section 413 of ERISA, 29 USC 1113, sets out the statute of limitations for legal actions under Title I of the Act. Cases must be brought within 6 years after the violation occurs, or within 3 years after the plaintiff had actual knowledge of the violation, whichever is earlier. However, in cases where the fiduciary breaches are

²⁴ See, e.g., *Smith v. Aegon Cos. Pension Plan*, 769 F.3d 922 (6th Cir. 2014); *In re Mathias*, 867 F.3d 727 (7th Cir. 2017).

²⁵ See, e.g., *Patterson v. Chrysler Grp., LLC*, 845 F.3d 756, 762–63 (6th Cir. 2017); *Castaldi v. River Ave. Contracting Corp.*, No. 14-CV-5435, 2015 WL 3929691, at *8 (S.D.N.Y. June 22, 2015) *Syed v. Hercules Inc.*, 214 F.3d 155, 166 (3d Cir. 2000); *Lang v. Aetna Life Ins. Co.*, 196 F.3d 1102, 1104 (10th Cir. 1999).

fraudulent or where they have been concealed, the action may be brought within 6 years after the discovery of the fiduciary breaches. Courts have consistently read the “fraud or concealment” language of section 413 to mean only fraud, thereby effectively reading out the term “concealment” as a separate basis for invoking the 6-year period.²⁶ The proposed amendment would return section 413 to its original plain meaning by treating concealment as a separate and distinct basis for the longer limitation period.

Exculpatory Provisions.

Plan fiduciaries sometimes agree to contractual provisions in service provider agreements that require the plan to hold harmless or reimburse the TPA or other plan service provider if they have been found liable for illegal conduct. These provisions are essentially contracts of adhesion and result in ERISA plan fiduciaries spending plan assets meant to pay for plan benefits on reimbursing the illegal conduct of their service providers. Those acting on behalf of employee benefit plans often lack the bargaining power or will to restrict these provisions which should be made illegal.

Exhaustion of Fiduciary Breach Claims.

The majority of courts have held that participants and beneficiaries who are alleging that plan fiduciaries have violated ERISA fiduciary duties may file suit in court without having to exhaust internal plan procedures such as those that are designed to resolve benefit claims.²⁷ Some courts, however, including the Seventh and Eleventh Circuits, have required plan participants or beneficiaries that wish to sue plan fiduciaries for breaching their fiduciary duties under ERISA to first exhaust any plan procedures to allow plan fiduciaries to consider whether to correct or defend the asserted violations.²⁸ This sets up an unfair and unnecessary obstacle to court access for workers who wish to protect their employee benefit plans from mismanagement or other wrongdoing by plan fiduciaries.

²⁶ *Radiology Ctr., S.C. v. Stifel, Nicolaus & Co.*, 919 F.2d 1216, 1220 (7th Cir. 1990); *Larson v. Northrop Corp.*, 21 F.3d 1164, 1172-73 (D.C. Cir. 1994); *Schaefer v. Arkansas Medical Soc’y*, 853 F.2d 1487, 1491 (8th Cir. 1988).

²⁷ *See, e.g., Zipf v. AT&T Co.*, 799 F.2d 889 (3d Cir. 1986); *Smith v. Syndor*, 184 F.3d 356 (4th Cir. 1999); *Chailland v. Brown & Root, Inc.*, 45 F.3d 947 (5th Cir. 1995); *Hitchcock v. Cumberland Univ.*, 851 F.3d 552 (6th Cir. 2017); *Horan v. Kaiser Steel Ret. Plan*, 947 F.2d 1412 (9th Cir. 1991); *Held v. Hanover Leasing Corp.*, 912 F.2d 1197 (10th Cir. 1990); *Stephens v. PBGC*, 755 F.3d 959 (D.C. Cir. 2014).

²⁸ *See, e.g., Lindemann v. Mobil Oil Corp.*, 79 F.3d 647 (7th Cir. 1996); *Lanfear v. Home Depot, Inc.*, 536 F.3d 1217 (11th Cir. 2008).

Disclosure of Documents.

ERISA has long required plans to disclose certain documents to their participants and beneficiaries, upon request. Section 104(b) of the Act, 29 U.S.C. § 1024(b), requires plans to provide certain specific types of documents as well as “other instruments under which the plan is established or operated.” Participants and beneficiaries have cited this provision in requesting copies of asset valuation reports and actuarial reports used to determine benefit amounts in certain plans as well as audit reports of plan accounting practices required by the Act. Courts, however, have interpreted this language as not requiring plans to disclose such reports.²⁹ Amending ERISA to clarify that all of the documents discussed in this paragraph, and any contracts entered into with covered service providers for which plan assets are used to pay (such as ASO contracts between TPAs and plans), are required to be produced in response to a request made pursuant to section 104(b), would allow Plaintiffs to better research the issues affecting their claim prior to litigation. Not only will this increase transparency and help participants and beneficiaries protect their employee benefits, but it will also discourage the filing of class action lawsuits when the documentary evidence does not support a violation. Plaintiffs lacking the necessary documents often file the complaint on “information and belief” only to later find out that documents to which the plaintiff did not have access defeated or changed the nature of their claims.

Conclusion

Congress passed ERISA to protect the interests of participants and beneficiaries of employee benefit plans because it believed it was in the public interest to have such plans. The financial stress placed on workers who contribute their hard-earned dollars toward out-of-control healthcare costs is a major cause of the mental health crisis facing our nation. Every dollar spent by an employer on an inefficient healthcare system is a dollar not spent on employee wages or other business priorities. Every dollar spent by an employee on increased premiums, deductibles and co-payments is a dollar not spent on other necessities of life. Congress can move toward fixing our broken healthcare system and solving the mental health crisis by giving EBSA the resources it needs and by removing the barriers placed on private enforcement.

²⁹ See, e.g., *CWA/ITU Negotiated Pension Plan Bd. Of Trs. v. Weinstein*, 107 F.3d 139 (2d Cir. 1997) (actuarial reports not disclosable); *Faircloth v. Lundy Packing Co.*, 91 F.3d 648 (4th Cir. 1996) (stock valuation reports not disclosable); *Shaver v. Operating Eng’rs Local 428 Pension Trust Fund*, 332 F.3d 1198 (9th Cir. 2003) (financial records used on forms submitted to DOL and IRS not disclosable).

