

Docket No. 09-1606

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

UNITED STATES ex. rel. PATRICK LOUGHREN,

Relator-Appellee,

v.

UNUM GROUP, p/k/a UNUMPROVIDENT CORPORATION, a/k/a UNUM

Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

AMICUS CURIAE BRIEF OF AMERICA'S HEALTH INSURANCE
PLANS, INC. AND AMERICAN BENEFITS COUNCIL IN SUPPORT OF
APPELLANT UNUM AND REVERSAL OF THE JUDGMENT BELOW

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Docket No. 09-1606

United States ex. rel. Patrick Loughren v. UnumProvident Corporation, et al.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, the undersigned counsel certifies that Amici Curiae America's Health Insurance Plans, Inc. and the American Benefits Council are nonprofit corporations, have no stock owned by any other entity, and have no parent companies, subsidiaries, or affiliates.

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IDENTITY AND INTEREST OF THE AMICI CURIAE¹

This brief is being filed by two *amici curiae*, America's Health Insurance Plans, Inc. ("AHIP") and the American Benefits Council ("the Council") (collectively, the "*Amici*"), which maintain a common interest in the result of the instant appeal.

AHIP is a national association of nearly 1,300 health insurance plans and other insurance organizations providing coverage to more than 200 million Americans. AHIP's members offer a broad range of products in the insurance marketplace, including health, disability, long-term care, dental, vision, and supplemental coverage. AHIP's membership includes approximately sixty carriers providing disability income protection (including appellant Unum Group, p/k/a UnumProvident Corporation ("Unum")). AHIP seeks to facilitate, preserve, and increase the availability of affordable benefit coverage related to health care and disability.

AHIP has accumulated substantial knowledge and experience concerning the complementary relationship between the private and public disability benefit systems. This public/private relationship is critical to assuring both the accessibility and affordability of privately funded income protection. AHIP has provided testimony to Congress and the U.S. Department of Labor on employee

¹ All parties have consented to the filing of this brief.

benefit issues. AHIP and certain of its disability insurer members have also worked with (and continue to work with) the Social Security Administration on collaborative projects to help the Government expedite and improve the adjudication of Social Security disability claims.

The Council is a broad-based, nonprofit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members are primarily large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional organizations. Collectively, its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

The *Amici* have a strong interest in this case. Coordination-of-benefits and related offset provisions are used extensively throughout various segments of the insurance industry. As they relate to this case, such provisions allow insurance carriers to offset any Social Security disability benefits obtained by their insureds against the disability benefits otherwise payable under the insurance policies. Similarly, self-insured employee benefit plans often include offset and reimbursement provisions as cost-saving devices which inure to the collective benefit of plan participants. The ability to coordinate private benefits with public

benefits – including encouraging or requiring insureds to exercise their right to seek an independent determination of eligibility for disability benefits from the Social Security Administration pursuant to the agency’s “open-door” policy – keeps disability premiums affordable, thus encouraging employers to sponsor plans that include this important income protection for their employees.

The *Amici* are concerned because the district court’s adoption of the Relator’s unprecedented False Claims Act theory undermines the longstanding, beneficial relationship between the public and private disability benefit systems and improperly infringes on the Social Security Administration’s policy judgments. If the district court’s judgment is upheld, private disability carriers will be faced with an entirely new and onerous “regulatory” regime administered by the courts and juries, rather than the Social Security Administration, and contrary to the agency’s well-considered public policy goals. Ultimately, the *Amici* believe the district court’s decision, in addition to being legally erroneous, will adversely affect the cost, breadth, and availability of private disability benefits provided through insurance carriers, employee benefit plans, and their sponsors.

INTRODUCTION

The Social Security Administration (“SSA”), through extensive published guidance, has insisted that every citizen is entitled to apply for Social Security Disability Insurance (“SSDI”). The SSA has established detailed procedures to direct its trained staff’s complex and inherently subjective determinations of SSDI eligibility – a regulatory structure that the Relator here, Patrick Loughren (“Relator”), is asking the federal courts to circumvent without the benefit of an administrative rulemaking process and without any consideration of the public interest. This Court now has an important opportunity to correct the adverse impact of the district court’s erroneous judgment upon the coordinated system of public and private disability benefits.

Since its enactment in 1863, the civil False Claims Act (“FCA”) has “been used more than any other [statute] in defending the Federal treasury against unscrupulous contractors and grantees.” S. Rep. No. 99-345, at 4 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5269. However, there is no need to “defend[] the Federal treasury” against the entirely lawful, nearly universal coordination-of-benefits practices alleged in this *qui tam* suit. The national treasury is not in any way at risk, and Unum is neither a government contractor nor a grantee in connection with the practices at issue. In fact, under Relator’s unprecedented theory – as adopted by the district court – the alleged “false claims” did not result

in the Government paying out any funds to anyone. To the contrary, according to Relator, the “falsity” of an insured’s “claim” springs *only* in those instances where the Government makes an after-the-fact determination *not* to grant benefits and thus *not* to pay money.²

However, if the district court’s judgment is upheld, the negative consequences to employers currently offering (and those who would like to offer) private long-term disability benefits – and the millions of American workers who rely on such benefits for critical income protection – could be staggering. The *Loughren* suit against Unum (and the analogous *Barrett* suit against CIGNA Corporation, also pending in the District of Massachusetts) seeks nothing less than to dismantle the longstanding, effectively functioning process by which the public disability system and the employer-sponsored private disability system work hand-in-hand to create a safety net for individuals who meet certain statutory and contractual standards.

In its place, Relator, with the imprimatur of the district court, seeks to impose an unprecedented requirement that *private* carriers such as Unum prescreen claimants for *public* benefits, under the Government’s unique and complex

² While it is not the *Amici*’s intent to address each and every reason why the district court’s judgment is legally unsustainable, the *Amici* do feel that it is important to keep this unprecedented FCA backdrop in mind when analyzing the regulatory, public policy, and public interest issues at play under the district court’s ruling.

regulatory standards, ostensibly to assure that claimants have a meritorious basis for applying in the first place. If the carriers fail to do so (or are found by a jury to be “recklessly” wrong in even a small percentage of their determinations), they are exposed to trebled fraud liability and mandatory statutory penalties under the FCA. This new legal risk would inevitably alter the use of offset provisions in their current form, leading to increased disability benefit costs and the shrinkage of benefits received by the disabled employees. For its part, the SSA not only has disavowed that such a “prescreening” requirement exists, it has indicated that such a judicially-imposed mandate would be contrary to the well-established public policy goals of the agency.

As an initial matter, carriers and plan sponsors exposed to this new FCA liability would need to grapple with the judicial reversal of the SSA’s decades-old “open-door” policy and imposition of a new private sector prescreening requirement for public SSDI benefits available under the entirely different, and more stringent, SSA eligibility standards. Even those carriers and plan sponsors who might want to at least attempt to maintain their “coordination-of-benefits” and offset rights under their policies and plans would have to divine a way to effectively implement the SSA’s deliberative processes and substantive standards in relation to their existing claim review systems.

While the *Amici* are wary of venturing a guess at the systemic cost of such an endeavor, one thing is nearly certain: carriers and other plan administrators would need to be under-inclusive in their “positive” determinations of entitlement to SSDI benefits because they would face potential FCA liability for each and every “wrong” prediction they make. At the same time, for the over-inclusive pool of “negative” and “not sure” determinations (which, by the laws of probability and predictive modeling, would include a subset of meritorious applications), they would be compelled to forego their offset rights. In addition, the carriers would presumably have to tell these would-be SSDI applicants that they need *not* seek the eligibility determinations to which they are entitled under the law, thus turning the SSA’s public policy goals on their heads.

Besides the inevitable “chilling effect” on SSDI applications that runs directly counter to the SSA’s policies of encouraging applications, requiring independent SSA eligibility determinations, and maximizing program utilization as a gateway to other federal income assistance, health, and vocational benefits, this under-inclusion effect would *also* mean that carriers would have to price the additional system overhead costs, legal risk, *and* substantial foregone value of the lost offsets into their disability products. This would in turn affect employers’ decisions to offer or eliminate disability benefits in their plans. And, in the end, it

would almost assuredly decrease the availability and affordability of private disability benefits to the workers and their families who sorely need them.

As discussed below, the district court's unwarranted interference in the SSA's policy judgments (in addition to the district court's misconstruction of well-established legal principles under the FCA) will result in far-reaching consequences contrary to the public interest – not to mention contrary to the private disability industry's reasonable and long-held expectations about how carriers may properly implement coordination-of-benefits provisions as they relate to SSDI. If the SSA's policies and procedures for determining SSDI eligibility are to be changed, the appropriate *entity* to modify them is the SSA, and the appropriate *process* for proposing and vetting any changes is administrative notice-and-comment rulemaking. As a matter of law and public policy, the critical issues at stake cannot properly be determined through an FCA *qui tam* lawsuit.

ARGUMENT

I. THE UNPRECEDENTED FALSE CLAIMS ACT THEORY ADOPTED IN THIS CASE IS CONTRARY TO BOTH LONGSTANDING SSA POLICY AND THE BROADER PUBLIC INTEREST.

A. The Ability To Coordinate Benefits Helps Keep Private Long-Term Disability Insurance Accessible And Affordable.

Employer-sponsored long-term disability (“LTD”) insurance provides valuable income protection to approximately forty million Americans, or about thirty percent of workers in private industry.³ In 2006, more than 500,000 individuals received LTD payments from private insurers totaling more than \$7.2 billion.⁴ Those carriers not only help replace lost income, they also offer innovative programs to help workers with disabilities return to the workforce.⁵

³ U.S. Department of Labor, Bureau of Labor Statistics, *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2007*, p. 5, available at <http://www.bls.gov/ncs/ebs/sp/ebsm0006.pdf>; see also U.S. Department of Labor, Bureau of Labor Statistics, *The Employment Situation – July 2009*, p. 4, available at <http://www.bls.gov/news.release/pdf/empisit.pdf>.

⁴ Council for Disability Awareness, *The 2007 CDA Long-Term Disability Claims Review*, available at http://www.disabilitycanhappen.org/news/CDA_LTD_Claims_Survey_2007.asp.

⁵ See, e.g., Unum Life Insurance Company of America, *Long Term Disability Income Protection Insurance Highlights*, NATCA – Policy #111263, p. 3, available at [http://w3.unum.com/enroll/NATCA/pdf/LTD_Highlight_NATCA%20LTD%20Highlight%20updated%20for%202009,%20post%20enrollment%20\(7-21-09\).pdf](http://w3.unum.com/enroll/NATCA/pdf/LTD_Highlight_NATCA%20LTD%20Highlight%20updated%20for%202009,%20post%20enrollment%20(7-21-09).pdf) (describing rehabilitation and return to work provisions of a particular policy).

This allows workers to become self-sufficient again and lessens the financial strain on both the private and public disability benefit systems upon which millions of disabled Americans and their families depend for their economic well-being.

Without private LTD coverage, these workers and their families would be in immediate financial peril if faced with a disability. On average, a thirty-five-year-old worker with a \$25,000 annual income would exhaust his or her savings in just over one month. Even thirty-five-year-olds making \$100,000 annually average just under three months in savings.⁶ Nor does SSDI come close to fully protecting most workers when they become disabled. The average monthly SSDI benefit is \$1,062.10 – well below the federal poverty level for a family of four.⁷ And that is if you can get it: of the almost 2.2 million applicants for SSDI benefits in 2007, only 34% were approved.⁸ Moreover, even if ultimately approved, it can take

⁶ America's Health Insurance Plans, *An Employer's Guide To Disability Income Insurance*, p. 6 (Source: U.S. Census Bureau Survey of Income Program and Participation), available at <http://www.ahip.org/content/default.aspx?bc=41%7C329%7C352>.

⁷ Social Security Administration, Office of Retirement and Disability Policy, *Monthly Statistical Snapshot, July 2009*, available at http://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/.

⁸ Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program, 2008*, Table 59, available at http://www.socialsecurity.gov/policy/docs/statcomps/di_asr/2008/sect04.pdf.

upwards of two years or more to receive benefits.⁹ Thus, private LTD coverage provides an essential safety net for those workers fortunate enough to have it. If private LTD coverage became more expensive and thus less available as an employee benefit, the consequences could be catastrophic for many American families.¹⁰

As do Unum's policies, essentially all private LTD policies contain "coordination-of-benefits" provisions.¹¹ A coordination-of-benefits provision

⁹ See *Disability Backlogs and Related Service Delivery Issues: Hearing Before the Subcomms. on Social Security and Income Security and Family Support*, 111th Cong., at 10 (2009) (Statement of SSA Commissioner Michael J. Astrue), hereinafter "Astrue Testimony," available at http://www.ssa.gov/legislation/testimony_032409.htm.

¹⁰ Similarly, if employer-sponsors of self-insured disability plans became exposed to new forms of FCA liability in connection with requiring plan participants to seek offsetting SSDI benefits (or because the market for excess insurance coverage became more expensive or restrictive as a result of this new exposure), such employers would naturally be discouraged from providing LTD as an employee benefit.

¹¹ As the U.S. General Accounting Office (now the Government Accountability Office) stated:

Almost all private long-term disability insurance benefits are coordinated with [SSDI] benefits; that is, private benefits are reduced dollar for dollar by the amount of [SSDI] benefits. The rationale for reducing private benefits is to provide an incentive to return to work by paying only the targeted partial replacement of earnings. Also, reducing private benefits dollar for dollar against [SSDI] benefits can lower disability insurance premiums. As a result, it is common for private plans to require claimants to apply for [SSDI] benefits.

generally permits the LTD carrier to offset any available SSDI benefits against the benefit amount otherwise payable under the LTD policy (often 60% of the insured employee's salary). If the insured obtains offsetting SSDI benefits, the insured's after-tax disability benefit amount from all sources will generally be higher because SSDI benefits, unlike employer-sponsored group LTD benefits, are either tax-free or partially taxable (depending on income level).¹² Thus, it is almost always financially advantageous for insureds to seek SSDI benefits, even though such benefits are offset under their LTD policies.¹³

Moreover, as the Supreme Judicial Court of Massachusetts has observed, "coordination-of-benefits clauses serve the public purpose of avoiding duplicate recoveries for the same injuries. *These clauses enable insurance companies to charge lower premiums.*" *Cody v. Connecticut Gen. Life Ins. Co.*, 387 Mass. 142,

U.S. Gen. Accounting Office, *SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs*, GAO/HEHS-96-133 (July 1996), at 22.

¹² Milliman, Inc., *The Impact Of Disability* (May 2009), p. 13, available at <http://www.ahip.org/content/default.aspx?docid=27012>.

¹³ Less than one-third of current SSDI beneficiaries pay any taxes on those benefits. See Social Security Administration, *Questions?*, available at http://ssa-custhelp.ssa.gov/cgi-bin/ssa.cfg/php/enduser/std_adp.php?p_faaid=493. In contrast, LTD benefits are to be included in the employee's gross income where the employer pays all of the premium for the coverage. See 26 U.S.C. § 105; 26 C.F.R. § 1.105-1. Where both the employer and employee contribute to the premium, a proportionate percentage of the benefit payments is treated as taxable income. *Id.*

151, 439 N.E.2d 234, 239 (Mass. 1982) (citations omitted; emphasis added). *See also* Actuarial Standards Board, *Actuarial Standard of Practice No. 5, Incurred Health and Disability Claims*, pp. 3, 6 (actuaries should consider coordination-of-benefits provisions when, *inter alia*, determining rates).¹⁴ Similarly, the clauses facilitate productive return-to-work efforts, which would be compromised if disabled workers earned more in disability than in active work. *See Richardson v. Belcher*, 404 U.S. 78, 82-83 (1971) (observing Congress's concerns that overlapping workers' compensation and SSDI payments would disincentivize workers from returning to the job). *See also supra* note 11.

In connection with the implementation of the coordination-of-benefits provisions in private LTD policies, AHIP's disability insurer members help workers exercise their rights under the Social Security program, routinely providing assistance in the application process to beneficiaries who may be eligible for SSDI benefits. By encouraging and assisting insureds to pursue SSDI benefits, disability insurers help insureds gain access to additional benefits for which they may be eligible, such as benefits for spouses and/or dependents, access to vocational assistance, and eligibility for Medicare benefits after a qualifying period of twenty-four months.

¹⁴ Available at http://www.actuarialstandardsboard.org/pdf/asops/asop005_076.pdf.

Notably, as set forth in detail in Unum’s brief, a similar coordination-of-benefits approach is taken by the Federal Employee Retirement System (“FERS”), 5 U.S.C. § 8401 *et seq.*, which requires disabled beneficiaries to apply for SSDI benefits as a condition of receiving FERS disability benefits. *See* 5 C.F.R. § 844.201(b)(1). Many state workers’ compensation systems, as well as their public employee retirement systems, also impose such a requirement. *See, e.g.*, 29 Del. Code Ann. tit. 29, § 5253(c)(4); Kan. Stat. Ann. § 4927(1)(B). Like the disability definitions during the initial policy period in private disability policies, these governmental employee benefit programs generally have more liberal “own occupation”-type disability definitions. *See, e.g.*, 29 Del. Code Ann. tit. 29, § 5253(b)(1). Despite this, the government programs do not prescreen the SSDI applicants they direct to the SSA for eligibility determinations under the SSA’s more stringent, multi-level “any occupation” standard.

Thus, both private insurers and government-administered plans almost universally encourage or require, in some form, that claimants apply for SSDI so that it can be definitively determined, by regulation-specified processes, whether an individual is entitled to offsetting federal disability benefits. This integrated design and operation of the public and private disability benefit systems is the

cornerstone to assuring both the accessibility and affordability of privately-funded income protection.¹⁵

Under the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. § 1001 *et seq.*, employers have the freedom to establish benefit plans (or not), as well as broad discretion to define the benefits they choose to provide. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). The ability to coordinate private group LTD benefits with SSDI benefits keeps LTD premiums affordable, thus incentivizing employers to sponsor plans that include this critical employee benefit. Indeed, one study concluded that such coordination lowers the cost of private LTD insurance by 40%-45%.¹⁶ If the ability to offset SSDI benefits is altered if not effectively eliminated because of the private carriers’ need to protect themselves from the unprecedented FCA exposure advanced by the district court’s

¹⁵ One should not lose sight of the fact that the insureds who the carriers request apply for SSDI are those who the carriers have already determined are entitled to LTD benefits under their policies and, thus, at a minimum, have been found to be unable to perform their own jobs for an extended period. By directing such disabled insureds to the SSA without further “prescreening” under the SSA’s unique, unpredictable, and inherently subjective standards, one obtains “perfect” coordination of benefits: all disabled insureds who should get SSDI (according to SSA) get it, and those who should not (according to SSA) do not.

¹⁶ Milliman, Inc., *Impact of Disability Insurance Policy Mandates Proposed by the California Department of Insurance* (Nov. 14, 2005), p. 15, available at <http://ddbchicago.com/archives/Milliman%20DOI%20requests%20cost%20report.pdf>.

holding, the price of LTD coverage will necessarily go up, and the availability of this essential income protection in the workplace will in turn go down.

B. Carriers' Coordination-Of-Benefits And Offset Practices Are Well-Known To The SSA And Are Consistent With The SSA's Policies And Practices.

The SSA's regulations and extensive guidelines governing the SSDI application and review process reflect the SSA's longstanding "open-door" policy, which welcomes any financially eligible individual to seek a determination of eligibility for SSDI benefits. *See* Social Security Administration, *Program Operations Manual System* ("POMS") DI 22501.003(A) ("*Every individual who meets the necessary nondisability requirements of Title II ... is entitled to a substantive determination about whether he/she is under a disability.*") (emphasis added).¹⁷ *See also* 7/22/08 30(b)(6) Deposition of Social Security Administration (per Associate Commissioner, Office of Disability Programs, Glenn Sklar) in *United States ex rel. Barrett v. CIGNA Corp.*, No. 03-12382-MLW (D. Mass.) ("SSA Dep.") (excerpts attached hereto as Addendum A), 43:1-4 ("We typically don't ask why somebody is showing up at our door. *We have, quote, unquote, an open-door policy, all comers are welcome.*") (emphasis added).

¹⁷ Available at <https://secure.ssa.gov/apps10/poms.nsf/lnx>. The POMS is "a primary source of information used by Social Security employees to process claims for Social Security benefits." POMS, Preface.

In administering their coordination-of-benefits provisions, private LTD carriers have for decades operated pursuant to the SSA's "open-door" policy, including the understanding that the SSA has no expectation that anyone is "prescreening" SSDI applications before they are submitted to the SSA.¹⁸ In fact, according to a release issued by Senator Charles Grassley's office, the SSA explained to the staff of the Senate Finance Committee that the basis for the Government's decision not to intervene in the *Loughren* lawsuit now before this

¹⁸ Likewise, the manner in which the private disability carriers implement their coordination-of-benefits provisions is no secret to the SSA, which has never objected to the practice. As Mr. Sklar testified:

In terms of public/private, I suspect that the private disability insurers have contractual provisions requiring their insured to apply for Social Security disability insurance benefits. Thereafter, they want to make sure that those individuals actually apply, and if they do receive benefits, they certainly want to learn about what those benefit amounts were and, thereafter, offset those benefit amounts.

* * * * *

My assumption is it's really general industry practice to do an offset, and if you do not do an offset, you probably would be at a competitive disadvantage since others were doing offsets...

* * * * *

SSA has had general knowledge of the [private LTD insurers' coordination-of-benefits] practice for many years ... and that knowledge went to the highest levels of the agency.

SSA Dep. at 15:6-15; 17:17-21; 25:21-26:2.

Court “was that the SSA disability program has an ‘open-door policy’ and does not prescreen applications. They added that SSA is required to consider all applications and conduct a substantive determination, even those that might seem improbable.” Letter from Charles E. Grassley, U.S. Sen., to Michael J. Astrue, Comm’r, Soc. Sec. Admin. (Mar. 24, 2009).¹⁹

The SSA has been unequivocal in its public pronouncements that it (*the SSA*) – *not* SSDI applicants, *not* insurance companies, *not* even treating doctors – decides whether an applicant is “disabled” or “unable to work” for purposes of obtaining SSDI benefits. *See, e.g., Social Security Handbook* (“Handbook”), § 604.1 (“We make **independent** disability determinations. Our determination is based on all of the facts in your individual case.”) (emphasis in original); § 604.2 (A decision made by another *governmental or non-governmental* agency that you are or are not disabled *does not mean* that you have met the disability requirements of the Social Security Act. A decision made by another agency that you are or are not disabled *is not binding* on SSA.”) (emphasis added); § 618. (“We consider all the medical and vocational evidence in your file *to determine whether you have the ability to work.*”) (emphasis added).²⁰ *See also Disability Benefits, SSA*

¹⁹ Available at http://grassley.senate.gov/news/Article.cfm?customel_data_PageID_1502=19961.

²⁰ Available at http://www.ssa.gov/OP_Home/handbook/ssa-hbk.htm. The Handbook “includes the provisions of the Social Security Act (the Act),

Publication No. 05-10029 (Nov. 2008) at 10 (“Your doctors are not asked to decide if you are disabled...The state agency staff may need more medical information before they can decide if you are disabled...We use a five-step process to decide if you are disabled...”).²¹ The SSA does not pay any benefits unless and until it alone makes a favorable disability determination. Thus, contrary to one of the essential premises of Relator’s lawsuit, the SSA does not and cannot rely on an applicant’s subjective statements regarding these technically complex determinations that are exclusively within the domain of the SSA.²²

Even before its latest statements to the Senate Finance Committee staff, the SSA has been equally clear that there is no requirement or expectation that private disability carriers (or anyone else) “prescreen” potential SSDI applicants under the SSA’s unique standards (or any standard). As Associate Commissioner Sklar testified:

I’m trying to think in my own mind how we could put out guidance on screening of claims. It’s not somewhere where we’ve previously gone, and I’m literally thinking

regulations issued under the Act, and precedential case decisions,” in a “readable, easy to understand resource for the very complex Social Security programs and services.” Handbook, Preface.

²¹ Available at <http://www.socialsecurity.gov/pubs/10029.html>.

²² And it should be re-emphasized that there is no allegation or evidence in the *Loughren* lawsuit that the SSDI applicants misrepresented or omitted (or that Unum encouraged or told such applicants to misrepresent or omit) any factual information in connection with their SSDI applications.

out loud right now whether it's somewhere we should go in the future or not, but the reality is we haven't and there is currently no published policy out there that requires, certainly requires private disability insurer to, quote, unquote, prescreen an application before a claimant comes and files. I'm not aware of any such thing.

SSA Dep. at 105:13-24.

If the SSA does not require that it be done, does not offer guidance on how it should be done, and has never even thought through whether it should or could realistically be done, it is difficult to conceive how the courts through conducting jury trials may properly impose such a substantial new requirement – under the guise of the FCA – on the private disability industry without any consideration of the costs, the benefits (if any), or the overall public interest. *See Encarnacion ex rel. George v. Astrue*, 568 F.3d 72, 80 (2d Cir. 2009) (“The SSA has substantial expertise and is charged with administering a complex statute. The agency’s considerable efforts to refine the disability-determination process ... and align it with congressional purposes has led to a body of experience and informed judgment to which courts and litigants may properly resort for guidance.” (internal quotation marks omitted)); *cf. United States ex rel. Windsor v. Dyncorp, Inc.*, 895 F. Supp. 844, 852 (E.D. Va. 1995) (“To permit Windsor’s claim to go to a jury would result in bypassing the carefully crafted administrative scheme for resolving Davis-Bacon Act classification disputes. Contrary to this scheme, a jury, not the

agency, would ... determine the appropriate classification for any given task by reference to the Department of Labor's complex classification standards.”).

C. The District Court's Effective Reversal Of Existing SSA Policy – Without The Benefit Of A Public Rulemaking Process *And* Despite The Substantial Risk Of Increasing The Cost Of Private Disability Coverage And Ultimately Harming Those Who Most Need Income Protection – Is Inconsistent With Separation-Of-Powers Principles.

It is impossible to precisely quantify the potentially harmful effects of the district court's judgment if it is upheld. But the effects would reach far beyond Unum and its insureds, and, because most large disability carriers (and many self-insured employer plans) operate on a national level, the effects would likely reach beyond the geographic confines of the First Circuit. Suffice it to say that the disability insurance industry and its predominantly employer-based, group-benefit-plan-sponsor customers would have to fundamentally rethink *how* they do business and *whether* to offer benefits because of this entirely unforeseen exposure.²³

Beyond requiring carriers and plan sponsors to alter their long-accepted coordination-of-benefits practices to deal with the judicial reversal of the SSA's decades-old “open-door” policy and the judicial imposition of a new private sector

²³ The potential breadth of application of the district court's erroneous reading of the FCA within the insurance and employee benefit arenas is mind-boggling. Arguably, any insurer or plan administrator seeking to enforce a coordination-of-benefits or reimbursement provision in *any* type of insurance policy or employee benefit plan that implicates public benefits (*e.g.*, Medicare) could be at the mercy of opportunistic *qui tam* plaintiffs.

prescreening requirement under the SSA's unique SSDI eligibility standards (and the attendant adverse effects on disability benefit costs and availability to the ultimate detriment of workers), the district court's disregard for the SSA's clearly articulated policy judgments effectively violates separation-of-powers principles. *See Encarnacion*, 568 F.3d at 80 (noting that courts should generally defer to SSA's interpretations regarding disability determinations); *Todd v. Norman*, 840 F.2d 608, 612 (8th Cir. 1988) ("Perhaps appreciating the complexity of the Social Security Act, Congress gave the Secretary broad authority to prescribe standards in applying its provisions. This conferral of authority recognizes that the Secretary is uniquely qualified to interpret provisions of the Social Security Act and also insulates his administrative interpretations from a judicial override...").

The SSA has plenary regulatory authority over the administration of SSDI benefits pursuant to Congressional mandate. 42 U.S.C. § 405. However, in its unprecedented application of the FCA, the district court has substituted its own policy judgments for those of the SSA. What is worse, this judicial policymaking has been effectuated without the requisite due process and opportunity for input afforded all interested parties, and the public at large, through a notice-and-comment rulemaking. *See National Labor Rel. Bd. v. Wyman-Gordon Company*, 394 U.S. 759, 764 (1969) (notice-and-comment rulemaking "were designed to assure fairness and mature consideration of rules of general application"); *National*

Assoc. of Home Health Agencies v. Schweiker, 690 F.2d 932, 949 (D.C. Cir. 1982) (stating that purposes of notice-and-comment rulemaking are “to reintroduce public participation and fairness ... and to assure that the agency will have before it the facts and information relevant to a particular administrative problem”) (internal quotation marks and footnotes omitted). The critical issues of public importance at stake here deserve nothing less; they should not be determined in the context of a *qui tam* lawsuit where Relator’s driving interest is personal monetary gain.

II. THE ADVERSE PUBLIC POLICY IMPLICATIONS AND THE FUNDAMENTAL LEGAL DEFICIENCIES INHERENT IN RELATOR’S THEORY OF FCA LIABILITY ARE UNIQUELY ALIGNED IN THIS CASE.

“[T]he FCA was enacted in 1863 with the principal goal of ‘stopping the massive frauds perpetrated by large [private] contractors during the Civil War.’” *Vermont Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765, 781 (2000) (quoting *United States v. Bornstein*, 423 U.S. 303, 309 (1976)); *see also* *United States v. Rivera*, 55 F.3d 703, 709 (1st Cir. 1995) (observing similarly). “In 1986, *qui tam* underwent a ... surge of popularity after Congress’s decision to amend the FCA in order to promote such lawsuits in the face of an ever-growing federal deficit and fears that defense contractors were once again defrauding the government.” *Riley v. St. Luke’s Episcopal Hosp.*, 252 F.3d 749, 752 (5th Cir. 2001). As such, historically, “[t]he archetypal *qui tam* FCA action is filed by an

insider at a private company who discovers his employer has overcharged under a government contract.” *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996).

Although the application of the FCA has expanded over the years beyond the archetypal case, never has a court endorsed application of the FCA in a case like this, where FCA liability is exclusively premised on situations where the Government affirmatively decides, with undisputed knowledge of all material facts, *not* to pay any funds in response to a “claim,” and the alleged “falsity” of that claim can only be determined in hindsight – based solely on events occurring *after* the claim is presented. The claims endorsed here do not further the goals of the FCA and its amendments, and, if upheld, they would reflect an imposition of FCA liability that is inconsistent with historic interpretations of the statute. Thus, the district court should have held that, in numerous respects, Relator’s FCA claims fail as a matter of law.²⁴

²⁴ In this section of the brief, the *Amici* do not intend to catalog all of the legal deficiencies inherent in the Relator’s claims, nor do the *Amici* intend to supplant the legal arguments presented by Unum, which are adopted herein by reference. Rather, the *Amici* intend to provide their perspective on certain fundamental elements of an FCA claim which, as a matter of law, are not satisfied in this case. Moreover, as discussed herein, these legal deficiencies coincide with the public policy considerations weighing against affirmance of the district court’s judgment.

A. Even If The SSDI Applications Were Deemed “Claims,” They Were Not “False” At The Time They Were Presented.

The FCA establishes liability for anyone who “knowingly presents, or causes to be presented, to an officer or employee of the United States Government ... a false or fraudulent claim for payment or approval” or “knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government.” 31 U.S.C. § 3729(a)(1), (2). Moreover, the claim or statement must be false *at the time it is presented*. See, e.g., *United States ex rel. Quinn v. Omnicare Inc.*, 382 F.3d 432, 439 (3d Cir. 2004) (“Quinn contends, however, that, in order to impose FCA liability, it is not necessary that the claim have been false when it was originally submitted. We reject this argument.”)

On the undisputed record here, Relator cannot establish that any “claim” was objectively false at the time it was presented (regardless of whether such claim was “caused to be” presented or made by Unum, or not). Instead, Relator appears to assert a “springing” false claim – one that is dependent upon subsequent events. In this case, the subsequent event would be the SSA’s finding that the applicant is not eligible for benefits based on the agency’s determination that the applicant is not “disabled” in accordance with the provisions of the Social Security Act and its implementing regulations. To recognize such a “springing” claim – which is not provably false at the time it is presented – would push beyond the current outer

bounds of FCA liability. *Cf. id.* (valid claim is not rendered a false claim by the occurrence of a subsequent fortuitous event); *United States v. Bottini*, 19 F. Supp. 2d 632, 640 (W.D. La. 1997) (“This court has found no judicial interpretation of 31 U.S.C. § 3729 lending support to the government’s theory that a claim which was valid at the time presented becomes fraudulent and within the purview of the statute where the claimant fails to comply with some regulation and by reason of such failure becomes ineligible to qualify for continuing benefits.”). *See also Murray v. ABT Assocs.*, 18 F.3d 1376, 1379 (7th Cir. 1999) (holding, in the common law context, that only statements which are materially false when made can be fraudulent); *Denny v. Barber*, 576 F.2d 465, 470 (2d Cir. 1978) (stating, in common law context, that there can be no “fraud by hindsight”).

Because, by the very nature of his claim and theory, Relator cannot prove that any statement allegedly attributable to Unum was false at the time it was made or presented, the claim fails as a matter of law. This result is in harmony with the SSA’s stated policies that all comers are welcome to apply and that the SSA alone will make an independent determination of eligibility based upon a complex, subjective, and regulation-governed analysis of a full evidentiary record.²⁵

²⁵ It should be noted that existing federal criminal and civil fraud statutes have acted, and would continue to act, as a sufficient deterrent against the making of false statements or the submission of false records in connection with SSDI applications. *See* 18 U.S.C. § 1001 (criminalizing false statements to federal agencies); 42 U.S.C. § 408(a)(2) (criminalizing false statements in applications for

B. In Any Event, The Alleged “False Claims” Could Not, As A Matter Of Law, Have Been Material To The Government’s Eligibility Determinations.

To prevail on an FCA claim, the plaintiff must also demonstrate materiality. *See, e.g., United States v. Bourseau*, 531 F.3d 1159, 1170 (9th Cir. 2008) (citing cases requiring materiality); *United States v. President and Fellows of Harvard College*, 323 F. Supp. 2d 151, 181-82 (D. Mass. 2004) (materiality considered element of FCA claim). “The accepted definition of materiality for civil FCA claims, as for other federal statutes, equates materiality with ‘ha[ving] a natural tendency to influence, or [being] capable of influencing, the decision of the decisionmaking body to which it was addressed.’” *United States v. Southland Mgmt. Corp.*, 326 F.3d 669, 679 (5th Cir. 2003) (quoting *Kungys v. United States*, 485 U.S. 759, 770 (1988)). *See also Massachusetts v. Mylan Laboratories*, 608 F. Supp. 2d 127, 152-53 (D. Mass. 2008) (applying same materiality standard to claim under Massachusetts False Claims Act, based on federal FCA caselaw).

Similarly, to be actionable, the alleged false statement must have “the practical purpose and effect, and pose[] the attendant risk, of inducing wrongful payment.” *Rivera*, 55 F.3d at 710. *See also United States ex rel. Burlbaw v. Orenduff*, 400 F. Supp. 2d 1276, 1289 (D.N.M. 2005) (“It cannot be an actionable

disability benefits); 42 U.S.C. § 1320a-8 (imposing civil liability for damages and penalties for false or misleading statements of material fact in connection with SSDI benefit determinations).

violation of the FCA for an individual to provide truthful information to the government, in order to allow the government to determine whether or not that information establishes eligibility for a certain program.”), *aff'd*, 548 F.3d 931 (10th Cir. 2008).

At issue here are requests for a determination of eligibility to participate in a federal benefits program (*i.e.*, SSDI) based upon a searching evidentiary inquiry by the SSA. The submission of an SSDI application is the initial step in an often lengthy and inherently adversarial benefit determination process. It generally takes three to four months for the SSA to issue an initial determination of eligibility. *See Astrue Testimony*, at 8. If the SSA issues an initial determination denying benefits, the applicant has the right to pursue four distinct levels of appeal: a request for reconsideration; a hearing before an administrative law judge; review by the SSA Appeals Council; and review in a federal district court. *See Heckler v. Day*, 467 U.S. 104, 106-07 (1984) (describing appeal procedure and citing applicable statutes and regulations). Thus, the Government is not induced to disburse funds (wrongfully or not) merely by virtue of the submission of an SSDI application (or any subjective statements the applicant may be asked to make about her perceived eligibility for benefits).

Moreover, by virtue of the SSA’s own published regulatory guidelines (as well as a lack of any contrary evidence), Relator cannot prove that any “false

statement” Unum allegedly caused to be made had any capability to influence (or did in fact influence) any decisionmakers at the SSA. In other words, any applicant statement about her subjective belief that she was “disabled” or “unable to work” as of a certain date is immaterial to the SSA’s independent disability determination. *See supra* Part I.B, pp. 16-21.²⁶

The SSA guidelines not only reflect the fact that the agency makes an *independent* determination, they also confirm that the agency undertakes an *exhaustive and searching evidentiary inquiry* when evaluating an application for benefits. For example, when an application is filed, an SSA field office is

- responsible for verifying non-medical eligibility requirements, which may include age, employment, marital status, or Social Security coverage information.²⁷ The field office then sends the case to a DDS [Disability Determination Service] for evaluation of disability.
- The DDSs, which are fully funded by the Federal Government, are State agencies responsible for developing medical evidence and rendering the initial determination on whether or not a claimant is disabled or blind under the law.
- Usually, the DDS tries to obtain evidence from the claimant’s own medical sources first. If that evidence is

²⁶ In fact, the SSA’s process is so independent that “[a] decision made by another governmental or non-governmental agency that [an applicant is or is] not disabled does not mean that [the applicant] ha[s] met the disability requirements of the Social Security Act. A decision made by another agency that [an applicant is or is] not disabled is not binding on SSA.” Handbook, § 604.2.

²⁷ Non-medical eligibility requirements are not at issue in this case.

unavailable or insufficient to make a determination, the DDS will arrange for a consultative examination (CE) to obtain the additional information needed. The claimant's treating source is the preferred source for the CE, but the DDS may obtain the CE from an independent source. After completing its development of the evidence, trained staff at the DDS makes the initial disability determination.

Social Security Administration, *Disability Evaluation Under Social Security*, SSA Publication No. 64-039 (Sept. 2008) (also known as the “Blue Book”).²⁸

The medical evidence – all of which is examined and considered in the disability determination process – includes the applicant’s medical history, clinical findings, laboratory findings, treatment prescribed with response, diagnosis, prognosis, and a physician’s statement about capabilities. Handbook, § 615. In addition to the medical evidence, the SSA considers the combined effect of the applicant’s impairment, age, education, and work experience on her ability to work. *Id.*, § 609.1.

Given the independence and thoroughness of the SSA’s disability determination procedures, the mere fact that an application is submitted, or that the applicant is prompted to state her subjective belief about whether she is “disabled” or became “unable to work” as of a certain date, does not and cannot have any capability to influence the SSA’s disability determinations. The fact that, despite

²⁸ Available at <http://www.ssa.gov/disability/professionals/bluebook/>.

containing such statements, only a minority of SSDI applications are initially approved confirms this point. The SSA decides whether its complex eligibility criteria are met after a rigorous independent review; it does not rely on the mere representations of applicants regarding their own eligibility in making that determination. The SSA, Unum, and the entire private disability industry understand that. The district court should have reached that conclusion as a matter of law. Consistent with the SSA's explicit and long-stated regulations and policy guidance, the purported "false statements" upon which Relator's case are based cannot be material under the FCA.

CONCLUSION

For the foregoing reasons, *amici curiae* America's Health Insurance Plans, Inc. and the American Benefits Council respectfully request that this Court reverse the district court's judgment.

Dated: September 10, 2009

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CERTIFICATE OF COMPLIANCE

The undersigned counsel hereby certifies that the foregoing brief complies with Rule 29(d) and Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure. The portions of the brief that count towards the word limit contain 6,996 words as calculated by the word processing system on which such brief was prepared. This brief also complies with the typeface requirements of Rule 32(a)(5) of the Federal Rules of Appellate Procedure and the type style requirements of Rule 32(a)(6) of the Federal Rules of Appellate Procedure because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2002/XP in 14-point font, Times New Roman.

Dated: September 10, 2009

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Amicus Curiae Brief of America's Health Insurance Plans, Inc. and American Benefits Council was served on this 10th day of September, 2009, by overnight delivery, on the following:

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