Confronting denial of ERISA long-term disability benefits

ERISA claims are settled in Federal bench trials, and offer attorney fees to prevailing parties

By Lee S. Harris

Employees who file disability claims with their employer often don't have any clear understanding of their rights under the Employee Retirement Income Security Act (ERISA). Most private employers' (as opposed to government or church employers') disability benefits as well as health and pension benefits are governed by ERISA. ERISA, which is a federal law, has its own set of rules and deadlines which are very different from those encountered in a typical plaintiff trial practice. Claims are filed with the "Plan" which is generally administered by the Plan's insurer or if the Plan is self-funded by a claims adjusting company. If a claim is denied, the first review is a pre-lawsuit administrative appeal to a different department of the Plan. If the appeal is denied, then the employee may file suit.

Most ERISA lawsuits proceed in Federal court. ERISA plaintiffs are not entitled to jury trials. Instead, ERISA lawsuits are resolved in bench trials based upon the administrative record and are similar to summary judgment motions. The facts contained in the administrative record are gathered during the claim review process and the administrative appeal before the lawsuit is filed. ERISA does away with claims for emotional distress and punitive damages. It, however, allows courts to award attorney fees to the prevailing party. Courts generally award fees to plaintiff employees. It is unusual for fee awards to be granted against employees. "[t]he reason for awarding fees to defendants is to discourage frivolous suits . . . it is important not to punish plaintiffs whose actions fail even though they seemed reasonable at the outset." (*Marquardt v. North America Car Corp.* (7th Circuit, 1981) 652 F.2d 715, 720.) The Court further observed that consideration of the "five Hummell factors" will seldom warrant an award of fees or costs against an ERISA plaintiff. (See *Id.* at 719-20; see also *Arizona State Carpenters Pension Trust Fund v. Citibank* (9th Cir. 1997) 125 F.3d 715, 718. *Mogck v. Unum Life Ins. Co. of America* (S.D. Cal. 2003) 289 F.Supp.2d 1181

Reasonable claims procedure

The ERISA Disability Plan must provide a reasonable claims procedure as required by ERISA regulations and case law. (29 C.F.R. § 2560.503-1(b); *Grossmuller v. Auto Workers* (3d Cir. 1983) 715 F. 2d 853). In addition to the written claims procedure, ERISA Disability Plans frequently make time-consuming requests for an employee's medical records and supporting reports and documents. An ERISA Disability Plan may also fail to provide the employee with timely information regarding their claim. The ERISA statutes govern employees' remedies if proper procedures are not followed. These remedies can involve a lawsuit in Federal Court. The rules are complex and arise from the law of equity.

Filing a claim

The employee should contact his or her HR-department, obtain the claim forms and promptly file their claim. The employee should also request written notification of the status of his or her claim and request the award of their retroactive benefits from the date such benefits became due. What the employee thinks of as "disability insurance" is in reality the "Plan" which is administered by the "Plan Administrator." Frequently the "Plan" delegates the duties to an insurance company that drafted the Plan. In some cases the employer may have a self-insured Plan which delegates the administration to a private claims-adjusting firm. In either case the employee should cooperate with the Plan administrator and provide requested medical record release forms and other documents. It is often helpful if the employee provides supplemental medical information such as letters of explanation from doctors or therapists.

Disabled employees should also pursue State or Federal disability benefits including Social Security Disability benefits. Findings of disability by others can also be helpful in the decision-making process used by ERISA Long-Term Disability providers.

Denial time limits

Within 90 days after an employee has filed a claim for benefits, the Plan must tell the employee whether or not she will receive the benefits. Also, if because of special circumstances the Plan needs more time to examine the request, it must tell the employee within the 90 days that additional time is needed, why it is needed and the date by which the Plan expects to render a final decision. If the claim is denied, the Plan administrator must notify the employee in writing and explain in detail why it was denied. If the employee receives no answer at all in 90 days – or 180 days when an extension of time was needed – the claim is considered a denial and the employee can use the Plan's rules for appealing the denial.

Obtain file if claim denied

If an ERISA long-term disability claim is denied, the employee should immediately request the Plan administrator to send, at no charge, a complete copy of the entire claims file, including any and all documents upon which the Plan relied upon in making any determination with respect to the long-term disability benefit claim. ERISA provides 30 days from the request to provide the documents and assesses a fine of $110 per day beyond that for failure to comply.

Pre-existing condition exclusion applicable or not?

Denials that occur quickly after submission may not include a full analysis of the disability claim. One basis for early denial may be a purported pre-existing condition that excludes coverage. The terms of the Plan should be reviewed carefully. They may be confusing and require coordinated reading of several separate definitions. Accordingly, the provision may not be enforceable. (*Saltarelli v. Bob Baker Group Medical Trust* (9th Cir. 1994) 35 F.3d 382 (rejecting exclusion where found only in the midst of the "Definitions" chapter, and requiring a coordinated reading of three separate definitions); see also *McClure v. Life Ins. Co. of North America* (9th Cir. 1996) 84 F.3d 1129; *Henry v. Home Ins. Co.* (C.D. Cal 1995) 907 F.Supp. 1392 (other citations omitted).)

The recent U.S. Supreme Court case *Cigna Corp. v. Amara* (2011) 131 S.Ct. 1866 held that relying on the rules of equity, Plan provisions can be modified or interpreted to conform to representations that were made to Plan members. Application of a pre-existing condition exclusion or other Plan provisions could be changed by the use of these rules. It is therefore important to check to see if any representations regarding Plan terms were made in addition to those in the actual Plan documents. Confirming correspondence and documents that contradict the basis for rejection of the claim can be especially helpful.

Right to a full and fair review [administrative appeal] of denial

The ERISA Plan is required to, but may not have, provided the Employee with a reasonable procedure to administratively appeal the denial of the claim. (29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(g).) ERISA requires that: "every employee benefit plan shall *** afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." (29 USC §1133(2); 29 CFR 2560.503-1 (h) and (i).) The "full and fair review" must be construed to protect the plan participant from arbitrary or unprincipled decision-making. (*Weaver v. Phoenix Home Life Mut. Ins. Co.* (4th Cir. 1993) 90 F.2d 154, 157.) The relevant provisions of C.F.R. include:

> 29 CFR 2560.503-1 (h):
> (h) Appeal of adverse benefit determinations. (2) (iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
> 29 CFR 2560.503-1 (j):
> After an administrative review, a "decision on review" is to be issued by the "appropriate named fiduciary." "The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review *** In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant (1) The specific reason or reasons for the adverse determination; (2) Reference to the specific plan provisions on which the benefit determination is based….

As the court noted in *Halpin v. W.W. Grainger, Inc.* (7th Cir., 1992) 962 F.2d 685, 693 in a "decision on review", the Plan is required to "set out in opinion form the rationale supporting (their) decision' . . . Bare conclusions are not a rationale." (See also: *Booton v. Lockheed Medical Benefit Plan* (9th Cir. 1997) 110 F.3d 1461.)

The purpose of the ERISA mandated appeal process is an important one. That process enables a claimant who is denied benefits to have an impartial administrative review, but also make an administrative record for a court review if that later occurs. (*Ellis v. Metro. Life Ins. Co.* (4th Cir. 1997) 126 F.3d 228, 236-37.) Thoroughly documenting an appeal is therefore important beyond simply persuading the Plan to reverse its initial denial. The review by the trial court of an administrative appeal denial, with a few exceptions, is required to be based upon the closed administrative record which includes the records reviewed initially by the Plan as well as any additional records reviewed upon administrative appeal. The administrative appeal therefore often becomes the last best opportunity to supplement the file with supporting documents.

If an ERISA Disability Plan does not respond to an employee's claim, the employee should treat the claim as denied and begin the appeal process. In that case it is also most likely that the Plan failed to notify or provide the employee information regarding the employee's right to an appellate review.

The Employee may expressly invoke this right to appeal to ensure that they do not waive any possible benefits that come with the right to a full, fair and independent review on appeal such as the opportunity to supplement the file with additional helpful information. However, the Employee should also consider proceeding directly with a civil action based on the ERISA Disability Plan's failure to provide appellate review, and based on the futility of any such review.

Standards courts use to review improper denial of benefits

Section 502(a)(1)(B) of ERISA [29 U.S.C. § 1132(a)(1)(B)] establishes a cause of action for participants or beneficiaries

under any welfare Plan to recover benefits due under the terms of the plan, to enforce rights under the terms of the plan, or to clarify rights to future benefits under the terms of the plan. (Section 502(a)(3) of ERISA [29 U.S.C. § 1132(a)(3)]) establishes a cause of action for injunctive or other equitable relief to redress violations of ERISA or to enforce the terms of any employee benefit plan.

If the ERISA Disability Plan has no rational basis for denying the employee's claim, and the employee is clearly entitled to benefits, the ERISA Disability Plan's termination/denial of Employee's benefits may be considered arbitrary, capricious, made in bad faith, not supported by substantial evidence, and/or erroneous on questions of law. (See *Malhiot v. Southern Cal. Retail Clerk's Union* (9th Cir. 1984) 735 F.2d 1133.)

Further evidence and confirmation of this wrongful denial would be the failure to comply with the Plan's and ERISA's notice, claims procedure, and appellate review provisions. The Plan's improper conduct may result in a Court awarding an employee long-term disability benefits. (See *Krohn v. Huron Memorial Hosp.* (6th Cir. 1999) 173 F. 3d 542 (holding Plan liable for LTD benefits where Plan fiduciaries acted negligently); *Schleibaum v. K-Mart Corporation* (7th Cir. 1998) 153 F. 3d 496 (failure to follow benefit claims and appeals procedures can result in liability for benefits).)

The United States Supreme Court has held that a denial of benefits "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." (*Firestone Tire & Rubber Co. v. Bruch* (1989) 489 U.S. 101, 115, ("Firestone Tire").) When a plan unambiguously gives the plan administrator discretion to determine eligibility or construe the Plan's terms, a deferential abuse of discretion standard is applicable. (See *Abatie v. Alta Health & Life Ins. Co.* (9th Cir. 2006) 458 F.3d 955, 963 (en banc).)

Even more recently, the Supreme Court set forth a framework considering whether the dual role of administering and funding an ERISA Plan creates a conflict of interest, and if so, how that conflict should be considered in evaluating whether a Plan administrator has abused its discretion. *Metropolitan Life Ins. Co. v. Glenn* 461 F. 3d 660 (2008). The Court noted that "[i]n 'determining the appropriate standard of review,' a court should be 'guided by principles of trust law' "and that "[i]f '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 factor in determining whether there is an abuse of discretion.'" (*Id.* at 2347-48 (citing *Firestone Tire*, 489 U.S. at 115).)

The Court then discussed how that conflict should be considered in evaluating the insurer's exercise of its discretion. The Court noted that the abuse of discretion standard of review still applied despite the structural conflict of interest but that the conflict was a factor to be considered and weighed when determining how much weight to give the Plan's decision.

> We believe that *Firestone* means what the word "factor" implies, namely, that when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one. This kind of review is no stranger to the judicial system. Not only trust law, but also administrative law, can ask judges to determine lawfulness by taking account of several different, often case-specific, factors, reaching a result by weighing all together. (citations omitted)
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> In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.

(*Id.* at 2352)

In California, the insurance commissioner proposed legislation barring discretionary clauses in Disability Insurance contracts. The legislation that followed was supported in committee hearings by a substantial amount of testimony including by this article's author. The legislation subsequently passed the legislature in 2011 and was signed into law by the governor. It is codified as California Insurance Code section 10110.6 with an effective date of January 1, 2012. The law is designed to eliminate or void discretionary clauses found in new or renewed ERISA-governed life, health, and disability Plans. To the extent that a Plan is considered to be bound by this legislation, any review of a denial by a court would be "de novo".

Final thoughts

Long-term disability claims governed by ERISA rules need to be carefully handled from the outset. Plan administrators, typically major disability insurance companies or claims administrators, are extremely well versed in documenting files. It is important for individual claimants to keep tabs on the progress of their claim and to make sure that helpful information is forwarded to the claim administrator. Even though the Plan and claim administrator are required to act as a fiduciary in the claim review process, the Plan may not comply with this high standard.

In several recent large reviews, various state insurance regulators, including California's, have conducted market conduct examinations of different insurance companies. These exams investigated allegations of improper claims adjusting practices. Most recently, in May 2013, CIGNA through its LINA (Life Insurance Company of North America) entity entered into a regulatory settlement agreement as well as a stipulation and waiver with California's Insurance Department following a market conduct examination.

Claimants who carefully documented and closely follow their claims have the best chance of avoiding harm due to improper claims practices. And, claims that go to litigation are substantially helped when the claimant ensures that the administrative record has been well documented.


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