Summary Overview of Short-Term-Disability Benefits, Long-Term-Disability Benefits and Co-Ordination with Other Benefits and Settlements Under the Employee Retirement Security Act of 1974

Massachusetts Employment Lawyers Association
March 22, 2017

By Jonathan M. Feigenbaum
www.erisaattorneys.com

I. Introduction to Short-Term-Disability Benefits and Long-Term Disability Benefits.

A. The Broad Reach of ERISA.

In the early 1960s, the Studebaker automobile manufacturing company went bankrupt. Because Studebaker had failed to adequately fund its defined benefit pension plan, when the company went bankrupt the pension plan also collapsed, leaving many Studebaker retirees destitute, and its employees without their jobs or some their pensions. For the next decade, Congress drafted and redrafted legislation to address this problem. On Labor Day 1974, ERISA was signed into law. Originally drafted with pension plans in mind, over time ERISA has come to govern much more. Part of the concept behind ERISA was to create a uniform law for employee benefits and pensions nationwide. This was thought to protect employees and to make it more reasonable for employers that operated in many states. Rather than dealing with 50 different state laws, employers would be governed by one Federal law.

Many employers and unions offer short-term disability (STD) and long-term disability (LTD) benefits for employees who are injured or sick and must stop working. Only California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico provide for statutory short term disability coverage.

Private sector and public sector employers often offered STD and LTD benefits paid for by insurance premiums, or self-funded by employers. Both STD and LTD benefits will replace a portion of an employee's pre-disability income; typically, 60% or 66 and 2/3% of the employee's earnings. Some provide lesser coverage, a few provide more. When a union or private employer (but not a government employer or church plan, i.e., Archdiocese) provides benefits such as STD, LTD, health, life, etc. (all employee welfare benefits), the law controlling those benefits is the Employee Retirement Security Act of 1974 ("ERISA).

Why do employers love ERISA? Federal Court jurisdiction, discretion to the defendant fiduciary's decision (even if wrong so long as it is reasonable), generally no discovery, requirement of pre-suit exhaustion, trial on a paper record, generally no witnesses, no damages, no punitive damages, no compensatory damages, equitable relief only, interest often at federal rates, and often the result is a "remand" or a "do-over" for the plan. ERISA creates virtually no incentive for insurers to pay disability benefits to disabled employees as there exists almost no penalty to them for doing so.

ERISA's sweeping unfairness as applied in practice is mind boggling. A law that was created to protect employees has been turned upside down, and now, often has the opposite effect. An attorney

must have an understanding of the remedies that are not available under ERISA, as well as the unusual procedural aspects of ERISA, to ensure their client's well-being.

Congress passed ERISA, after a decade long study, and negotiation to protect the "interest of participants in employee benefit plans . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). The language of the ERISA statute draws heavily from trust law as well as contract law. Congress instructed the Federal Courts to develop a common law of ERISA, using both trust and contract principals. The Department of Labor also has authority to issue regulations governing the processing of ERISA claims.

In a number of seminal ERISA decisions, the Supreme Court has repeatedly referred to the purpose behind ERISA, protection of employees, and then has proceeded to gut the rights of employees and other beneficiaries. In a recent major ERISA decision, Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004), the Supreme Court sided with the HMO industry, rather than patients and their doctors, by concluding that ERISA pre-empted state laws aimed at righting wrongs perpetrated by HMOs.

An "employee benefit plan" is defined as including an "employee welfare benefit plan" and an "employee pension benefit plan." ERISA § 3(3), 29 U.S.C. § 1002(3). An "employee welfare benefit plan" is any "plan, fund or program" which is "established or maintained" by an "employer" or an "employee organization" (union, etc.) or both for the purpose of providing, either directly or through the purchase of insurance, benefits such as medical, dental, disability, vacation, apprenticeship, etc. ERISA § 3(1), 29 U.S.C. § 1002(1). By regulation, severance pay arrangements may also constitute welfare benefit plans (rather than pension benefit plans). ERISA § 3(2)(b)(i), 29 U.S.C. § 1002(2)(b)(i).

ERISA contains one of the broadest preemption clauses ever enacted by Congress. The application of which has been repeatedly referred to by the Supreme Court, a "'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private employee benefit system," Mertens v. Hewitt Associates, 508 U.S. 248, 251, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993), effects almost all aspects of the employer-employee relationship in the private sector. Its sweep effects the payment of disability benefits to injured workers, whether in the form of a single payment, or periodic payments.

ERISA's pre-emption clause provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan …" ERISA § 514(a), 29 U.S.C. § 1144(a). "State laws" are not merely state statutes, but "[all laws, decisions, rules, regulations or other State action having the effect of law. . . ." ERISA §514(c)(1), 29 U.S.C. §1144(c)(1). This provision evinces a congressional intent to allow states to continue their historic role regulating insurance despite ERISA's broadly preemptive effect.

The ERISA "saving clause" then provides that some state laws are not preempted: "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

For a state law to survive preemption by ERISA, the state law must be one that regulates insurance. As opposed to a state laws of general application that have some bearing on insurers. Kentucky Association of Health Plans, Inc. v. Miller, 538 U.S. 329, 123 S.Ct. 1471 (2003), citing ERISA, § 514(b)(2)(A), 29 U.S.C.A. § 1144(b)(2)(A). In order for a state law to survive ERISA

preemption as a law regulating insurance, "it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. . . Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured." Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. at 342 (2003). The risk pooling analysis is relatively easy to meet.

At the same time as to what ERISA gobbles up, ERISA also leaves alone. The "deemer clause" provides for purposes of the savings clause, an ERISA plan may not be deemed to be an insurance company or to be engaged in the business of insurance. ERISA § 514(b)(2)(B). The deemer clause bars states from regulating forbids state insurance regulation of uninsured or self-funded plans.

B. Overview of STD Plans and LTD Plans.

STD policies or plans are called "short-term" disability policies or plans, because the coverage is often for 3 months or 6 months, but sometimes as along as 1 year. The definition of "disability" under an STD plan typically requires that a person only be unable to perform his or her own occupation; thus, if a person is hurt on the job, and has a workers' compensation claim for the time that person cannot perform his or her own occupation, the injured worker may also be eligible for STD benefits. Many STD disability policies exclude injuries or sicknesses that are work related. More about collecting STD benefits and workers' compensation benefits may be found below.

Not all insurance provided to employees fall under ERISA. The Secretary of Labor regulation found at 29 C.F.R. §2510.3-1(j), clarifies that certain insurance policies that are made available at work are not ERISA benefits. This is often referred to as the "safe harbor" provisions of ERISA. See, e.g. Anderson v. Unum Provident Corporation, 369 F.3d 1257, 1262 (11th Cir. 2004); compare *Gross v. Sun Life Assur. Co. of Canada*, 734 F.3d 1, 11 (1st Cir. 2013) (holding a package of benefits offered by an employer was a unitary plan, all benefits fell under ERISA). The regulations explain that the definition of a "welfare plan," shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

> (1) No contributions are made by an employer or employee organization;
> (2) Participation the program is completely voluntary for employees or members;
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoff

In practice this means that some STD benefit plans can escape ERISA. The unfairly treated employee may have recourse under a state Wage Act statute, or for a breach of contract claim.

LTD benefits under an LTD Plan may replace a portion of a person's income if the person is disabled and unable to work; however, LTD benefits, by definition, last longer. LTD benefits are of two types: either pure income replacement, or occupationally governed. Typically, LTD benefits do not start until the person has been disabled through an elimination period that is often six months, but can be as short as three months or as long as twelve. Usually LTD benefits follow a period of STD benefits. LTD benefits usually provide benefits up to age 65, or, in some policies, up to the "normal

retirement age" under the Social Security Act. Most often the definition of disability changes after 24-months from the employee's "own occupation" to "any occupation," which is based on the employee's education, training and experience. This definition is not nearly as narrow as the Social Security Administration definition of disability, which focuses on an inability to earn an income from "any gainful employment."

II. Introduction to the Coordination of Benefits Problem

Under a typical ERISA governed LTD plan, workers' compensation, Social Security Disability Income ("SSDI") (both primary and dependent), pension and often severance benefits as well as, on occasions, veteran's and salary continuation benefits, are usually treated as "offsets" or "other income" and used as a means to reduce benefit payments otherwise payable under the insurance policy or plan. Third party settlements may also be considered an offset. The injured person's attorney must review at the outset the specific policy language in the disability insurance plan or policy and devise a permissible method for assuring that the client's interest are appropriately protected. Of particular concern to employment lawyers are plans that treat payments from employers, such as discrimination settlements or severance payments as "offsets."

It is essential to review the actual policy language in the insurance policy or the plan. Reliance on the Summary Plan Description ("SPD") or Certificate Booklet is ill advised. The Plan documents tend to exclusively govern although inconsistencies with the SPD sometimes (depends on the Circuit) will ultimately control.

The problem faced by the injured person is easily understood by actual example. The following is policy language contained in a typical long term disability policy written by the world's largest disability insurer:

MONTHLY BENEFIT

To figure the amount of monthly benefit:
1. Multiply the Insured's basic monthly earnings by the benefit percentage shown in the policy specifications.
2. Take the lesser of the amount:
a. determined in step (1) above; or
b, of the maximum monthly benefit shown in the policy specifications; and
3. Deduct other income benefits, shown below, from this amount.

But, if the insured is earning more than 20% of his Indexed pre-disability earnings in his regular occupation or another occupation, the following formula will be used to figure the monthly benefit.

(A divided by B) x C

A = The insured's "indexed pre-disability earnings" minus the insured's monthly earnings received while he is disabled.
B = The insured's "indexed pre-disability earnings".
C = The benefit as figured above.

The benefit payable will never be less than the minimum monthly benefit shown in the policy specifications.

OTHER INCOME BENEFITS

Other income benefits means those benefits as follows.

1. The amount for which the insured is eligible under:

a. Workers' or Workmen's Compensation Law;
b. occupational disease law; or
c. any other act or law of like intent.

2. The amount of any disability income benefits for which the insured is eligible under any compulsory benefit act or law.

3. Payment from your *employer* as part of a termination or severance agreement.

Number 3 is not in the world's largest disability insurance plan, but appears in a top ten insurance company's typical LTD Benefits insurance policy.

For purposes of illustration, assume that John Doe earns $96,000.00 per year, or $8,000.00 per month. Let's make John Doe a salaried truck driver. He is injured in a car crash. He is out of work. He incurs $50,000 in medical bills that are covered by his worker's compensation carrier. John Doe's wife is so upset, she needs and seeks counseling. She incurs $15,000 in mental health care bills. John Doe's employer's health plan pays the counseling costs.

Assume that Mr. Doe's disability plan pays to him 60% of his base monthly earnings - $8,000.00 * .60 = $4,800.00 per month. Now assume that Mr. Doe receives workers' compensation payments of $1,000 per week. Under the above scenario, Mr. Doe's "offsets" will gobble up most of his monthly disability payment $1,000 x 4.3 = $4,300, leaving him with an LTD payment of $500 per month. Most plans pay a $100 minimum. If Mr. Doe qualifies and receives SSDI payments, his payment under the long term disability plan will be further eroded, leaving him with the monthly minimum benefit.

What happens if Mr. Doe and Mrs. Doe bring a tort suit against the negligent driver? If there is a recovery, who gets paid? Can the LTD Plan recover? What about the health plan? Both?

There is no general rule that applies, other than insurance policies or plans that contain language permitting off sets against workers' compensation payments or other income will be allowed. Attempts to attack the offsets as being in conflict with other state or Federal laws have been unsuccessful. The actual offset will be controlled by Plan language. See Nesom v. Brown and Root, U.S.A., Inc., 987 F.2d 1188 (5th Cir 1993) (Nothing in the policy ousts federal law or defers to a state court's determination of the amount of disability benefits owed.). There are fair and square ways to allocate, for example, for scarring as opposed to income and other legal grounds that may diminish the amount of money an LTD plan may recover.

What if the employer engages in a prohibited employment practice? What if the employee and employer agree to settle their differences? Is that payment by the employer to the employee, another offset?

Would a reasonable employer pay premiums to an insurer if that employer really understood how long term disability benefits are calculated and paid? Would an employee make a partial payment toward the premium? Is the insurance reasonably priced? Would an employee purchase an individual disability policy instead? Most employees and probably many HR departments do not really consider the minimal amount of coverage group long term disability insurance provides when off sets are deducted.

III. The Standard of Review of ERISA Claims

Probably the most litigated issue in all ERISA claims is the standard of review in Court. A denial of benefits challenged under 29 U.S.C. § 1132(a) (1) (B) is reviewed *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case an abuse of discretion standard is applied. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 103 L.Ed.2d 80, 109 S. Ct. 948 (1989). For example, the First Circuit has "steadfastly applied Firestone to mandate de novo review of benefits determinations unless 'a benefits plan ... clearly grant[s] discretionary authority to the administrator,' " Terry v. Bayer Corp., 145 F.3d 28, 37 (1st Cir.1998) (quoting Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 583 (1st Cir.1993). If plan administrators are granted such authority, an "arbitrary and capricious" standard of review will apply. *See* Recupero v. New England Tel. & Tel. Co., 118 F.3d 820, 827 (1st Cir.1997). *See*, Dana M. Muir, *Fiduciary Status as an Employer's Shield: The Perversity of ERISA Fiduciary Law*, 2 U. Pa. J. Lab. & Emp. L. 391 (2000). The standard of review correlates directly with a person's chance of success in overturning an unfair insurance decision. If the review is *de novo*, rather than deferential, the odds of prevailing grow.

The nonprofit Families USA advocates expansion of the NAIC's Model to Prohibit Discretionary Clauses to disability insurance contracts.... "The discretionary clauses create an uneven playing field for consumers who want to file legal challenges against an insurer's decision, according to Sonya Schwartz, an attorney and health policy analyst for Families USA. These clauses give legal deference to the insurer's decision unless the claimant can prove that the insurer's decision was unreasonable or irrational (the "arbitrary and capricious" standard), which is a "very difficult standard to meet," Ms. Schwartz noted. Claimants are much less successful in cases where the arbitrary and capricious standard was applied (only 28% were successful) than they were in cases involving "de novo" review (68% were successful). According to Ms. Schwartz, "Prohibiting discretionary clauses in disability insurance contracts insures that courts will apply the same standard of review as they do in other contract cases so that consumers will get a fair, impartial review of their claim."

A number of state insurance regulators, including some of the largest insurance markets, California and Texas, have banned by regulation the use of "discretionary clauses." Massachusetts has not, although a bill has been introduced.

The reasoning for banning such clauses is based on a recommendation of the National Association of Insurance Commissioners that voted unanimously in 2002 to outlaw such language in insurance policies. In California, the Insurance Commissioner found the use of the clause in the nature of offering a fraudulent insurance policy.

What does this all mean? If the Plan contains language that grants it discretion to interpret the Plan, then a Court will only overturn its decision so long as it is not "arbitrary or capricious." That means, in most Circuits that the Plan's interpretation of language will be upheld so long as it is reasonably based. That's it.

The Court might disagree with the interpretation, but so long as it is reasonable it will not be overturned. In cases where the plan delegates such authority to the administrator, "the district court must uphold the administrator's decision unless it is 'arbitrary, capricious, or an abuse of discretion." D & H Therapy Assoc., LLC v. Boston Mut. Life Ins. Co., 640 F.3d 27, 34 (1st Cir.2011)). "In these cases, "where review is based only on the administrative record before the plan administrator and is an ultimate conclusion as to disability to be drawn from the facts, summary judgment is simply a vehicle for deciding the issue." Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 517 (1st Cir.2005)).

IV. ERISA Plans and Beneficiaries May Only Obtain Equitable and Never Legal Relief

Most claims for relief arise under section 502(a) (1) (B) of ERISA, or 29 USC 1132(a) (1) (B). Other relief, which is rare falls under section 502(a) (3) or 29 USC 1132(a) (3). The Supreme Court is willing to go all out and find that relief under ERISA is never legal, but always equitable.

ERISA fiduciaries have a duty to act prudently and with loyalty toward participants in the plan. 29 U.S.C. § 1104(a) (1) (A) & (B). When fiduciaries (typically an insurer) breach that duty, Section 502(a) (3) entitles plan participants (employees) to sue them to redress the breach. 29 U.S.C. § 1132(a) (3); Varity v. Howe, 516 U.S. 489 (1996). The Supreme Court has described Section 502(a) (3) as a "catchall" clause that provides a "safety net" to redress injuries that ERISA does not remedy under other provisions. Id. at 512. Section 502(a) (3), however, expressly limits recovery to "appropriate equitable relief." The Supreme Court, through a series of cases, has unequivocally concluded that this excludes "legal" relief. Great-West Life & Annuity Ins. Co. v. Knudson, 122 S. Ct. 708, 713 (2002).

Janette Knudson was seriously injured in a car accident. Her health insurer provided by through her husband's employer paid $411,157.11 in medical benefits. She sued Hyundai for defects in the car that caused the accident. She settled her tort claim for $650,000 -- $13,828 was designated to reimburse the insurer Great West medical expenses. The insurer rejected that amount claiming that it was entitled to $411,157.11 of the $650,000 settlement, the full amount of medical bills paid. That settlement included $256,745.30 to a Special Needs Trust to pay for Ms. Knudson's future medical care plus money to reimburse California Medicaid and to pay attorney's fees and costs. A series of litigation in both state and federal courts arose. The case made its way from the Ninth Circuit to the Supreme Court.

The question presented to the Supreme Court was whether §502(a) (3) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 891, 29 U.S.C. § 1132(a) (3) (1994 ed.), authorizes this action by Great West to enforce a reimbursement provision the ERISA governed health insurance plan. Finding this claim to be premised upon a "contractual obligation," the Court today concluded that the action was not equitable because suits for specific performance of a past-due financial obligation typically were not available in equity. The Court reasoned that the "restitution" claim did not seek to restore money in the "possession" of the defendant that is directly traceable to a property interest of the plaintiff, and as such amounted to a claim for restitution allowed at law but not at equity. The Supreme Court ruled that, as section 503 "by its terms, only allows for equitable relief," the provision excludes "the imposition of personal liability . . . for a contractual obligation to pay money."

Curiously the ERISA statute does not define "equitable relief." However, in Great-West, the Supreme Court clarified that to determine if the requested relief is "equitable" under Section 502(a)(3), courts should look to standard texts on remedies and trusts as well as how such relief was

characterized when the bench was divided between equity courts and law courts. 122 S. Ct. at 712, 714 & 716 (considering character of restitution "in the days of the divided bench.") The Court explained that to qualify as equitable under Section 502(a)(3), the relief must be the type "typically available in equity." Id. at 712 (quoting Mertens, 508 U.S. at 252). Thus, the plaintiff must not only show that the relief would have been granted in equity in the days of the divided bench, the days in which some courts sat only in equity, but others in law, but that the relief was *typically*, as opposed to occasionally, available in equity. Id. at 715 (fact that damages such as those against non-fiduciaries were "occasionally awarded in equity cases" does not render them equitable relief). (emphasis omitted). The end result is one of the rare instances under ERISA, where the statute seems to help rather than hurt the injured individual. The obstacle to a plan recovering under its subrogation and reimbursement provisions arises under ERISA itself but became especially problematic after Knudson.

In Montanile v. Board of Trustees of Nat. Elevator Industry Health Benefit Plan, 136 S.Ct. 651 (2016) the Supreme Court again held that relief under ERISA is equitable and not legal. In particular, the Supreme Court held, when an ERISA-plan participant wholly dissipates a third-party settlement on non-traceable items, the plan fiduciary may not bring suit to attach the participant's separate assets under Section 502(a)(3) of ERISA, which authorizes plan fiduciaries to file suit "to obtain… appropriate equitable relief," because the plan is not seeking equitable relief under the circumstances of seeking to recover such general funds.

Robert Montanile was injured in a car accident, and his ERISA group healthcare plan paid his medical expenses, totaling $121,044. Under the plan's terms, acceptance of benefits constituted an agreement that any amounts recovered from another party will be applied to reimburse the plan in full for benefits advanced by it. He secured a $500,000 settlement for his injuries. After payments to his attorneys, $240,000 remained of the settlement, most of which those attorneys held in a client trust account. The health plan sought reimbursement of the medical expenses it had paid.

Negotiations broke-down. One of Montanile's attorneys informed the health plan that he would distribute the remaining settlement funds to Montanile unless the health plan objected within 14 days. The health plan did not respond within that time, and so the attorney gave Montanile the remainder of the funds.

Given that ERISA generally preempts state claims related to ERISA benefit plans, the plan's only recourse was a suit for "appropriate equitable relief" under Section 502(a)(3). Six months after the reimbursement negotiations with Montanile broke down, the plan filed suit against him, seeking to enforce its equitable lien and to enjoin him from dissipating any such funds. Montanile argued that because he had already spent al-most all of the settlement, no identifiable fund existed against which to enforce the lien. The health plan prevailed in the District Court and Eleventh Circuit. The lower courts, rejected Montanile's argument. They held that even if Montanile had completely spent the settlement proceeds, the plan was entitled to recover out of Montanile's general assets. The Supreme Court reversed.

By an 8-1 vote (with Justice Alito agreeing with the result but not all the Court's reasoning and Justice Ginsburg dissenting), the Supreme Court reversed the Eleventh Circuit and held that the plan's right to "appropriate equitable relief" did not permit a judgment against Montanile's general assets, but only against funds related to the settlement. Under Sereboff, whether the remedy a plaintiff seeks is legal or equitable depends on the basis for the plaintiff's claim and the nature of the underlying remedies sought, which are determined by looking at "standard treatises on equity," which establish the "basic contours" of what equitable relief was typically available before the merger of law and equity courts.

The Court held that the equitable lien by agreement could be enforced to the extent Montanile had purchased "traceable assets" with the settlement or commingled the settlement proceeds with a different fund. The lien would survive in these circumstances and commingling would allow the plan to recover the amount of the lien from the entire commingled fund. This appears to mean that if Montanile had deposited the settlement proceeds in his bank account or used the funds to buy "traceable assets," the plan could enforce its lien against what was left in the bank account or against assets purchased with the settlement funds. If Montanile had spent the proceeds on food, travel, medicines, the health plan was out of luck.

VI. What an Attorney Should do to Assist the Injured Client

1. Request the Summary Plan Description, the Plan and all related documents from the Plan Administrator, Employer and Insurance Company. Write a letter to the Plan Administrator **and** the insurer asking for the identical documents. 29 U.S.C. § 1124.

2. Read everything and think about it very carefully. How would an insurer or Plan argue that it is entitled to the money? Some insurers are reasonable in all aspects of reimbursement and off sets. If you are dealing with such an insurer, make a deal.

3. Is the language ambiguous? Is the Plan language subject to *de novo* or the deferential standard of review? What arguments might succeed if you are forced to litigate? There is no such thing as an ERISA lien. There are equitable liens by agreement.

4. Be creative within the confines of the law. Look at how a single payment might be divided. Payment for attorneys' fees; payment for medical bills, past and future; payment for disability, total and partial; payment for disfigurement; payment for interest; payment over time; payment in a lump sum; payment to family members; payments to be off set against future payments; payments to coincide with life expectancy

5. The ultimate nightmare for your client is that s/he makes a substantial payment to the insurer, and then the insurer reviews the claim in two months and concludes that your client is "no longer disabled" under the terms of the Plan. This happens with some frequency in connection with Social Security Award "overpayments." Try to negotiate a repayment agreement that spans over time.

6. What do you do if the LTD Plan, and Health Plan both claim reimbursement rights from the same funds?

7. Some states, such as New York have anti-subrogation and anti-reimbursement laws. What if your client works in Massachusetts for a New York Bank, i.e., Citi, whose health plan is sited in New York?

8. Think about Montanile. If you client spends the award or commingles the funds, what can the insurer or Plan do to recover those monies? What is the lawyer's obligation to the client to disburse? What about the third-party who claims rights to the funds?

9. When drafting severance or settlement agreements, be aware of the specific offset language in the policy.

10. Carveout claims for employee welfare benefits from settlement or severance agreements with employers. This includes STD, LTD, life, health, COBRA, accidental death and disability, pension, etc. Employer welfare benefits, unlike pension benefits, are not vested benefits under ERISA. These claims need to be specifically carved out to protect your client's rights.