The Law Offices of
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ERISA | Health | Life | Disability | Insurance

# INTRODUCTION TO ERISA WELFARE BENEFIT CLAIMS

## Introduction

A former client calls and tells you that s/he suffered a severe injury or illness and s/he cannot work. S/he said that s/he applied for and was granted disability income benefits under the United States Social Security Act.

The client notified the employer and the insurance company that provides long term disability benefits. The client applied for long term disability benefits that either s/he and/or the employer paid premiums to the insurer. S/he expected that the insurance company would keep its promise, would investigate the claim promptly, and fairly, and would pay the benefits that the client deserves. The client said that the application was denied and now has been granted an opportunity to appeal back to the insurer. The client cannot understand how the insurance company could deny benefits while the Social Security Administration granted benefits.

Faced with the need for disability insurance, you read your client's disability insurance policy or plan for the first time. The document seems simple, but yet at the same time ambiguous. The language of disability insurance is often unclear and open to broad interpretation. There is startling lack of uniformity of particular definitions within disability insurance policies, and core provisions can vary substantially. The harsh reality is that you have stumbled into a complex and frequently disputed area of the law.

On September 2, 1974 (Labor Day) Congress enacted the Employee Retirement Income Security Act (ERISA). Although the statute uses the word retirement in its title, ERISA governs both retirement benefits (pensions) and employee welfare benefit plan. Those are benefits that private sector employers provide to employees; government employees and those employed by churches are not subject to ERISA. Typical ERISA governed employee welfare benefit plans, include, disability insurance; health insurance or health plans, including those provided through Health Maintenance Organizations (HMO); sometimes severance plans and other type of employee benefits. Retirement benefits are regulated under separate provisions of ERISA that are more protective of employees than those pertaining to welfare benefit plans.

ERISA is not an area to experiment in or to "learn on the fly." If you are new to ERISA, or even if you are experienced, it is wise to confer with other attorneys who

consistently practice in this area. The pitfalls facing an ERISA claimant are never ending. For the most part, the chances of achieving a successful result are determined long before suit is ever filed. The pre-suit application for benefits or appeal of a claim denial will shape the ensuing litigation and will most likely be determinative of the end result.

Once suit is filed, it is unlikely that there will ever be a real "trial." Most ERISA welfare litigation claims are decided on cross motions based on materials contained in the insurance company's claim file. It is rare that there is ever live witness testimony. Worse yet, obtaining discovery is difficult, and persuading the Court to consider the discovery can be an uphill battle too.

After more than 30 years, , ERISA welfare benefits litigation has become a dangerous landscape, with pitfalls and mine fields full of traps for the unwary. For example, ERISA preempts almost all disputes over benefits that are provided by private employers. ERISA limits the remedy of a claim in a benefits case to the benefits that should have been paid under the plan, plus maybe attorneys' fees, but precludes other state law remedies, such as claims for bad faith failure to pay an insurance claim, or fraud and precludes punitive damages or other state law remedies.

**History Leading to the Enactment 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. 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. As a result, ERISA tends to control the outcome of almost all employee benefit claims. Of significance is that government employees are exempt from ERISA and remain protected under state laws.

**The Broad Sweep of Federal Preemption under ERISA.**

The Employee Retirement Income Security Act of 1974 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 welfare benefits are those employee benefits, such as disability insurance, health insurance, life insurance etc., as opposed to pension benefits which are governed under different provisions of ERISA. When Congress enacted ERISA in 1974, its focus was on abuse and mismanagement of pension funds:

> It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, 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. ERISA Sec. 2., 29 U.S.C. ' 1001(b)

Since 1974, ERISA has been greatly expanded, both legislatively B Consolidated Omnibus Budget Act of 1985 ("COBRA"); Health Insurance Portability and Accountability of 1996 ("HIPAA") – and by Supreme Court decision. With the enactment of ERISA, state laws have been trampled.

Insurance regulation had been the province the states. Insurers liked this. The insurance industry sought to avoid federal regulation, and has been protected by the McCarran-Ferguson Act since 1945. The McCarran-Ferguson Act was adopted in 1945 after extended controversy over the jurisdiction of state and federal governments in regulating the business of insurance. The principal objective of the Act was to establish the primacy of the states in regulating the industry. The purpose clause of the Act states that the continued regulation and taxation of the business of insurance by states are in the public's best interests.

Insurers also have a limited exemption from antitrust laws. This may be ending. The charge is being lead by Senator Trent Lott of Mississippi who has had problems post-Katrina in obtaining payment from his home owner's insurer after suffering a catastrophic loss to his home on the Gulf of Mexico. In various public filings, he has indicated that he will file legislations removing anti-trust protections granted to insurers.

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 the most recent major ERISA benefits 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.

> Congress enacted ERISA to "protect ... the interests of participants in employee benefit plans and their beneficiaries" by setting out substantive regulatory requirements for employee benefit plans and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U. S. C. '1001(b). The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions, see ERISA '514, 29 U. S. C. '1144, which are intended to ensure that employee benefit plan regulation would be "exclusively a federal concern." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U. S. 504, 523 (1981). Aetna Health, Inc. v. Davila, 542 U.S. 200, 208 (2004).

The genesis of this line of decisions evolved from Pilot Life Ins. Co. v. Dedeaux,, 481 U.S. 41 (1987). In that decision, the Supreme Court held that ERISA pre-empted virtually all state law claims, including Abad faith@ insurance claim arising under state law. In Dedeaux, the Court first reiterated the need to protect employees' and participants' rights. The holding of the Court, however, provided insurers with free reign to engage in behavior that would not be tolerated under state tort laws:

> [T]he detailed provisions of '502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in '502(a) of the statute as finally enacted ... provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.' "Dedeaux, 481 U.S. at 54.

Justice O=Connor writing for the Court relied on an expansive reading of Section 514 that specifies ERISA shall, except as otherwise provided, Asupersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.@ The decision was reached despite the Asaving clause@ found in ERISA. That clause, exempts from preemption Aany law of any State which regulates insurance, banking, or securities." That language, an integral part of ERISA, was enacted to leave insurance regulation to the states.

In Dedeaux, the Supreme Court could have limited its decision, but chose not to. It concluded that Congress had intended Section 502(a) to provide the exclusive remedy for Aplan participants and beneficiaries asserting improper processing of a claim for benefits and that varying state causes of action for claims within the scope of Section 502(a) would pose an obstacle to the purposes and objectives of Congress.@ The Court concluded that Congress had intended to Adisplace entirely any state cause of action@ and make any ERISA suit Apurely a creature of federal law.@

It is the fall-out from Dedeaux that makes ERISA the best friend of insurance companies. Without the risk of Abad faith@ or exemplary or consequential damages, or even having to face a jury trial, an insurer's downside risk to engaging in bad conduct is very minimal. It may be ordered to pay back benefits, plaintiff=s counsel fees, interest and its own counsel fees. No other damages are permitted.

**The Misuse of Administrative Law under ERISA.**

Plaintiff's efforts to obtain full relief have been further hampered by the erroneous importation of administrative law into ERISA welfare benefits litigation. Too many Courts have been willing to analogize ERISA law with administrative law. The unfairness in adopting the administrative law paradigm without the underlying benefits of fact finding neutral; a right to present evidence; and cross examine witnesses, hampers a client's efforts to achieve a fair and winning result. In the typical ERISA welfare benefits claim, the insurer serves as fact finder, judge and benefit payer of the judgment, if any. The Seventh Circuit Court of Appeals and Eleventh Circuit Court of Appeals both warned against this:

> What may have misled courts in some cases is the analogy between judicial review of an ERISA plan administrator's decision to deny disability benefits and judicial review of the denial of such benefits by the Social Security Administration.... Judicial review of the latter sort of denial is of course deferential, and it is natural to suppose that it should be deferential in the former case as well. But the analogy is imperfect, quite apart from its having been implicitly rejected by the Supreme Court in *Bruch* when it determined that the default standard of review in ERISA cases is plenary review, and quite apart from the fact that the social security statute specifies deferential ("substantial evidence") review. 42 U.S.C. § 405(g). The Social Security Administration is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by plan administrators. Herzberger v. Standard Ins. Co., 205 F.3d 327, 332(7th Cir. 2000).

The warning of the Circuit Courts has gone unheeded, and seems to have been forgotten by that very same court. See Semien v. Life Ins. Co. of America, 436 F.3d 805, 815(7th Cir. 2006) (Establishing an astonishingly high bar to obtain any discovery.).

A plaintiff=s likelihood for seeking reasonable relief has been hampered by the "suspension" of the Federal Rules of Civil Procedure ("FRCP"). Although the FRCP have not been literally suspended, defendants have engaged in a masterful campaign with a surprising rate of success convincing the federal judiciary that FRCP do not apply, and therefore, plaintiffs are not entitled to seek any discovery. Sandoval v. Aetna Life & Casualty Ins. Co., 967 F.2d 377, 380 (10th Cir. 1992) (Court may consider only the evidence and argument before administrator at time it made its decision; plaintiff cannot introduce new evidence or arguments at trial). That often means, no depositions, no interrogatories, no admission, etc.

In an early 2006 decision, the Seventh Circuit Court of Appeals concluded that discovery was to be allowed only when: "Ya claimant must identify a specific conflict of interest or instance of misconduct. Second, a claimant must make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination.@ To make matters worse, that Court went further, and without Congressional basis or federal common law precedent, concluded that ERISA benefit claims are subject to the most minimal judicial review. Semien v. Life Ins. Co. of America, 436 F.3d 805, 815 (7th Cir. 2006):

> Congress has not provided Article III courts with the statutory authority, nor the judicial resources, to engage in a full review of the motivations behind every plan administrator's discretionary decisions. To engage in such a review would usurp plan administrators' discretionary authority and move toward a costly system in which Article III courts conduct wholesale reevaluations of ERISA claims. Imposing onerous discovery before an ERISA claim can be resolved would undermine one of the primary goals of the ERISA program: providing "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously." *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990) (internal citation omitted). While claimants who believe they are the victims of arbitrary and capricious benefits decisions should feel free to seek relief in federal court, trial judges must exercise their discretion and limit discovery to those cases in which it appears likely that the plan administrator committed misconduct or acted with bias. Id. at 815.

Nothing in ERISA states that regular litigation rules do not apply. However, over time, and dramatically in this case, the Federal Judiciary has sought to limit an employee's opportunity to seek relief and to engage in normal pre-trial discovery.

Additionally, when reviewing the limited record, most claims are reviewed by the Court under a standard of review that is deferential to the decision made by the insurance company. The insurer is permitted to stand in the shoes of a fiduciary, and its profit making role, for the most part is ignored. Unlike a true fiduciary that must bear the burden of proof in showing that its decision was not tainted by self interest, the ERISA insurance fiduciary does not.

**ERISA Procedures Pre-litigation**

Get 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. Also include in this letter a detailed request for documents set forth in the DOL regulations, such as claims guidelines, claims manuals, etc. Most Courts have failed to enforce these regulations, but not all. Levy v. INA, 2006 WL 3316849, (S.D.N.Y, Nov. 14, 2006); 29 C.F.R. ' 2560.503-1(i)(5)

If the Plan Administrator is not identified on any documents, the statutory default Plan Administrator is the Plan Sponsor who is most often the employer. The letter should be sent by certified mail return receipt requested. By writing simultaneously to both, the Plan Administrator cannot point to the insurer, and the insurer to the Plan Administrator advising the plaintiff to seek the documents from the other party. Do not take NO for an answer. Keeping writing and requesting the documents. Do it every thirty days. If the documents are not produced, and you file suit, seek statutory penalties of $110 per day.

At the current time, only the First Circuit and Eleventh Circuit are willing to award penalties against any party other than the Plan Administrator. The focus should be on which party controls the documents, not the label of the party. See Law v. Ernst & Young, 956 F.2d 364 (1st Cir. 1992) (ATo hold that an entity not named as administrator in the plan documents may not be held liable under ' 1132(c), even though it actually controls the dissemination of plan information, would cut off the remedy Congress intended to create.@) ; Rosen v. TRW, Inc., 979 F.2d 191, 193-94 (11th Cir. 1992) (AWe agree with the reasoning of the First Circuit and we hold that if a company is administrating the plan, then it can be held liable for ERISA violations, regardless of the provisions of the plan document@). Although the First and Eleventh Circuit stand alone, the Fifth Circuit more than fifteen years ago indicated a willingness, under certain circumstances, to award penalties against a party other than the Plan Administrator. Fisher v. Metropolitan Life Ins. Co., 895 F.2d 1073 (5th Cir. 1990). Most Circuits, however, will not; only a named Aplan administrator@ may be found liable. See, e.g. Caffey v. UNUM Life Ins. Co., 302 F.3d 576, 585 (6th Cir. 2002) (Refusing to award penalties against insurer).

Before filing a law suit, a claimant must exhaust the available remedies under the plan, so long as the plan's procedures are reasonable. Following ERISA's enactment in 1974, the Secretary of Labor issued a set of regulations describing reasonable claims procedures. 29 C.F.R § 2560.503-1, as published at 42 Fed. Reg. 27426 (May 27, 1977). The regulations were recently overhauled, and "new" claims regulations were published. 65 Fed. Reg. 70265 (Nov. 21, 2000), with minor amendments published at 66 Fed.Reg. 35887 (July 9, 2001). In regards to claims for disability benefits, the "old" regulations apply to claims filed prior to January 1, 2002, and the "new" regulations apply to claims filed after that date; the regulations have a later effective date for health care claims.

The claims regulations require that every plan shall establish and maintain reasonable claims procedures. 29 C.F.R. § 2560.503-1. At a minimum, a reasonable

claims procedure must be described in the summary plan description, and must not be administered in a manner that unduly inhibits or hampers the filing or processing of claims. Pursuant to a "written request," plan procedures must allow claimants to "review pertinent documents" and "submit issues and comments in writing."

The claims regulations also establish maximum time limits for an administrator to consider a claim and minimum time for a claimant to appeal.

*Under 29 CFR 2560.503-1, to be reasonable, claims procedures that apply to disability claims under the new DOL claims regulations (claims filed after January 1, 2002) require:*

The plan must provide reasonable claims procedures.

After the initial claim is filed, the plan/claim administrator must make a decision within 45 days, which may be extended 30 days then by another 30 days. If denied, the time to file an appeal must be reasonable, but not less than 180 days. Once appealed the insurer is suppose to render a decision within 45 days, which may be extended another 45 days under special circumstances.

*Under 29 CFR 2560.503-1, to be reasonable, claims procedures that apply to disability claims under the old DOL claims regulations (for claims filed before January 1, 2002) require:*

An initial decision must be made within 90 days after the application, which can be extended by 90 days. The time to file an appeal must be reasonable and related to the nature of the benefit but not less than 60 days. The decision on appeal must be made within 60 days, which can be extended another 60 days.

If a claimant does not appeal within the time limits, his claim may be denied for failure to exhaust administrative remedies. If the administrator does not make a decision within the required time limit, the claim may be deemed denied.

**ERISA Litigation – The Standard of Review**

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.

As the party advocating a deferential standard of review, or interchangeably referred to as an "arbitrary and capricious" standard of review, the Plan Fiduciary bears the burden of demonstrating that its adverse determination is entitled to such deference. Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 251-52 (2d Cir.1999). "Despite the holding of *Firestone Tire,* plan sponsors have been unaccountably loath to amend their plans to make the delegation of discretionary authority unambiguously explicit. The result is a plenitude of litigation contesting the standard of review to be applied in individual cases, with claimants advancing inventive, if at times impervious, arguments for applying the friendlier *de novo* standard." Giannone v. MetLife, 311 F.Supp.2d 168, 174 (D. Mass. 2004). "If a plan wishes to insulate its decision to deny benefits from plenary review, the surest way to do so…is by including language that either mimics or is functionally equivalent to the "safe harbor" language we have suggested: 'Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them'." Diaz v. Prudential Ins. Co. of America, 424 F.3d 635, 637 (7th Cir. 2005).

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."
http://www.benico.com/News/News%20Updates/6-21-04.htm

A number of state insurance regulators, including two of the largest insurance markets, California and New York, have banned by regulation the use of "discretionary clauses." Although the pre-emption clause in ERISA is broad, the statute has a specific savings clause that leaves insurance regulations to the states.

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. Leonard v. Southwestern Bell Corporation Disability Income Plan, 408 F.3d 528 (8th Cir. 2005).

**Other issues:**

Disability benefits are often reduced by an offset for other benefits, such as social security benefits, worker's compensation benefits or other benefits paid on account of disability; read the plan documents carefully. If your client is paid disability benefits under an ERISA plan, and later is awarded social security or worker's compensation benefits, the insurance company may claim an overpayment. Your client may or may not have to repay the "overpayed" benefits, but you need to be familiar with ERISA law to address this.

Your client may have other benefits available at work that are payable based on a finding of disability under the company LTD plan or the benefits may require a separate application (a waiver of life insurance premiums is common). Be sure you ask the employer/plan administrator whether such other benefits are available and what should be done to apply for them.

**Mistakes to avoid:**

1. Do not assume you can add more evidence later; submit all favorable evidence before filing suit to ensure it will be before the court.
2. Watch the insurance company's or plan administrator's deadlines.
3. Do not file suit until you have exhausted all your remedies.
4. Do not assume your client's treating doctor's conclusory opinion or a worker's compensation rating is enough to establish disability; you must establish restrictions and limitations to support that your client cannot work.
5. Ensure you submit vocational evidence such as proof your client cannot do his own job as it is described in his job description or the Dictionary of Occupational Titles. If your client needs to show he is totally disabled, submit the opinion of a vocational expert that his restrictions would preclude work under the definition of disability in the plan.
6. Screen your cases carefully--the standard of review gives a huge advantage to the insurance company.
7. Do not ignore the plan's contractual statute of limitations; it may be shorter than the regular statute of limitations, but a court will likely uphold it.
8. Be thoroughly familiar with how ERISA has been interpreted in your Circuit. Justice is meted out very differently in each Circuit. Don't expect that this Federal statute is interpreted the same in every Circuit.

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