NAVIGATING ERISA: DISABILITY CLAIMS FROM APPLICATION THROUGH THE COURTS

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What is (and what is not) governed by the Employee Retirement and Income Security Act of 1974?

ERISA applies to employee benefit plans. These can include pension benefit plans, 401(k) plans, healthcare, disability insurance, and other employee benefits provided by an employer. The ERISA statute is found at 29 U.S.C. §1001, *et seq.*

29 U.S.C. §1003(a) states that with some exceptions, the ERISA statute applies to any employee benefit plan if it is established or maintained:

A. by any employer engaged in commerce or in any industry or activity affecting commerce; or
B. by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
C. by both.

ERISA excludes the following plans:

A. A governmental plan;
B. A church plan;
C. A plain maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;
D. Plans maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or
E. An access benefit plan that is unfunded.

THE LONG-TERM DISABILITY PLAN: CRITICAL ISSUES TO IDENTIFY BEFORE ADVISING YOUR CLIENT

Who is the Plan Administrator: This is critical to identify whom to send request for plan documents and administrative records. The plan administrator is typically found at the end of the plan document or summary plan description.

What is the Definition of Disability?

A. Unable to perform the insured's own occupation

Is "own occupation" defined as the insured performed it, or as it is generally performed in the national economy?

B. Unable to perform any-occupation

Is there a minimum pay required for the "any occupation" standard? This can be a good source of supporting continued entitlement to benefits.

What is the elimination (or waiting) period for LTD?

Pre-Existing Condition Limitations: These are best handled in the application, if possible.

Who is a Covered Employee, and are there Classes of Covered Employees?

What is the Benefit Amount?

A. Based on commissions/bonuses vs. base salary/hourly rate
B. What is the percentage of pre-disability earnings?
C. Does the policy contain maximum and minimum monthly amounts, and do they apply?

What are the Offsets to the Benefit Amount?

A. Social Security Payments, including disability and retirement;
B. Other disability programs (i.e. OPERS, STRS, SERS);
C. WC benefits;
D. Other retirement benefits;
E. Severance

What is the maximum benefit period?

A. Age 65, full retirement age per Social Security, or a scaled date due to the insured's age at claim?
B. Maximum benefit period for mental health disabilities & other conditions
    1. "Self-reported" conditions, pain conditions, etc.
    2. Watch out for how you deal with this on an application or appeal. Remember, cognitive limitations are not always "mental health" conditions. The LTD plan will lay out the definition of the exclusions. It is advisable to work with a psychologist or psychiatrist to properly classify the impairment to assist your client in maximizing his or her LTD benefits.

THE PRACTICAL REALITIES OF FILING A CLAIM AND APPEALING A DENIAL

Before Filing the Claim

A. Plan an exit from work with your client, if you are so fortunate. This is not "setting up" a claim. The plan can happen in a day or two if necessary.

B. Your client should speak with his or her doctor about supporting a claim for disability. If the doctor says he or she does not support the disability claim, find out why. Sometimes educating the physician on the definition of disability is all that is needed. Sometimes you will find out some critical information and can consult with your client.

C. Does the insured have appropriate care?

D. Can you obtain a copy of the job description from your client or human resources?

Making a Claim for Disability Insurance

A. Typically, the forms that are needed will be the claimant's statement, an attending physician's form, and an employer's statement.

   1. Do not take these forms lightly. The statements on these forms, especially the claimant's statement and the physician's form, could establish the basis of a denial. If possible, an attorney should review the policy and the completed forms to ensure an accurate and strong presentation of the claim.
   2. Read the Plan for Pre-existing condition limitations. A good attorney can avoid disaster and set up a strong claim by identifying issues prior to submitting an application.

B. Obtain medical records and evidence supporting the disability claim.

   1. It is the insured's responsibility (not the insurance company's responsibility) to produce evidence supporting the claim for LTD benefits. Do not rely upon the insurance company to obtain and consider all of the relevant medical records.
   2. *Practice Tip*: If appropriate or mandatory (and oftentimes it is), file an application for Social Security Disability Insurance Benefits at the same time as the LTD application. You can obtain medical records free of charge. Pursuant to R.C. §§3701.741(C)(1)(e), a health care provider or medical records company shall provide one copy of the patient's medical record and one copy of any records regarding treatment performed subsequent to the original request without charge to the patient or his/her attorney if the medical record is necessary to support a claim under the Social Security Act. Once you obtain a free copy of the records to support the SSD claim, you can use them to support the

LTD claim as well, saving your client hundreds of dollars in costs.

Appealing a decision (denial or termination)

A. **180 Day Deadline. Do not miss this deadline.** 29 C.F.R. §§2560.503-1(h)(3)(I), (h)(4).

1. Most of the time, insurance companies will grant you additional time to submit medical evidence, arguments, etc. However, you must be certain to **appeal** the denial and then ask for an extension. *Practice Tip:* Do not file a request for an extension of time to appeal the decision. Instead, file the appeal with a request for additional time to provide evidence and an argument in support of the appeal.

B. Make requests to the Plan Administrator for the following:

1. A complete and unredacted copy of the plan document that governs your client's application, together with any amendments to such plan; and
2. A complete and unredacted copy of the entire administrative record.

* Pursuant to 29 U.S.C. §1132©, the Plan Administrator is responsible for supplying these documents within thirty (30) days of its receipt of the request. If the Plan Administrator fails to do so, there is a penalty of $110 per day until the documents are produced.

C. Include Everything

1. Do not slow-play arguments or hold something back for use in litigation. With only rare exceptions, the Court will only be permitted to decide the case upon the administrative record. 29 U.S.C. §1133.
2. *Practice Tip*: Some LTD plans grant a discretionary second appeal to the insured. It is usually beneficial to take that opportunity to obtain and present evidence and legal argument to rebut the reasoning behind the denial.
3. When does it make sense to hire a vocational expert ("VE")?
    a. If the issue is whether the jobs identified in an "any occ" case meet certain salary thresholds in the LTD plan, hire a VE;
    b. If there is a dispute about the exertional and/or non-exertional requirements of insured's own occupation, hire a VE; and
    c. If you can use the insurance company's own functional capacity finding to prove that your client meets the definition of disability according to the LTD plan, hire a VE.
4. When does it make sense to hire a medical expert and/or obtain an FCE?
    a. This is a tougher question to answer generally. Many times, it may be more valuable to have the appropriate treating physician write a report or conduct testing to contradict the analysis or findings of the insurance company's medical consultants;

b. If the denial/termination references incomplete testing, hire a medical expert to conduct the testing and interpret the results;
c. If there is a dispute about whether a 24-month limitation applies (i.e. for a mental health limitation), it likely will be valuable to hire an expert to explain the source of the cognitive impairment in a non-excluded manner; and
d. If the reason for the denial is a finding that a pre-existing condition causes the disability, it is likely appropriate to hire a medical expert.

D. Surveillance, Social Media, and in-person interviews
1. Surveillance is commonly used by insurance companies to support a termination of benefits. Obtain a copy of the surveillance video, not just of the surveillance repot. Attack the credibility of the written report if it contains exaggerations. Talk about the video with the insured. Get statements from friends, family, neighbors about your client's ability to maintain any activity.
2. Social Media is used by insurance companies to strengthen a decision to deny or terminate claims. Advise clients to make their profiles private, stop posting pictures, stop posting updates, and/or consider deleting/shutting down accounts.
3. Some insurance companies will try to interview the insured, commonly at the insured's home. The insurance company has the right to interview the insured; however, the insured is not required to submit to a surprise interview. Instruct your client to politely (but assertively) reschedule another day and time for the interview, and then to inform the attorney of the scheduled meeting.

E. "Significant change" in the insured's condition.
1. An insurance company's decision to terminate benefits may be arbitrary and capricious where there is no evidence of a significant change in the medical condition (and there is no change in definition of disability).

Social Security's (and OPERS/STRS/SERS's) Impact on the LTD Claim

A. When appropriate, include the Social Security disability decision to help your LTD case. If the SSD case has been awarded at the initial or reconsideration levels, obtain a copy of the CD and submit the medical and vocational analysis that proves (at a minimum) that the insured cannot perform his or her past work. *Note*: sometimes an SSD <u>denial</u> (at step 5) can still support the LTD claim during the own occupation period.

B. Ever since the Social Security Administration did away with the "treating physician rule," the use of the favorable SSD determination in an LTD claim or appeal has become even more valuable.

C. Almost all LTD carriers provide an insured with "free" representation for a

SSD claim. If the insured is over 50 years old, he or she can be harmed by being awarded SSD pursuant to the "Grids" and not appealing. For example, a 57-year old man with a history of medium or heavy semi-skilled work may easily win his SSD claim even if he is limited to light duty work. However, his acquiescence to this decision may give the insurance company leverage to deny his claim under the "any occ" test because rules like the Grids do not apply to LTD claims. An insured should also be careful of amending his onset date for a favorable decision pursuant to the Grids.

The Plan Administrator has 45 days after receipt of the appeal within which to issue its decision. However, the decision-maker may extend this time by 45 days with notice in writing to the insured (or his/her attorney). 29 C.F.R. §2560.503-1(i)(3)(i).

ERISA PROCEDURAL REGULATION CHANGES

81 Fed. Reg. 243, 92316 (Dec. 19, 2016)

The Department of Labor issued significant changes to administration of disability benefits under ERISA. This change went into effect on April 1, 2018, after delays to the original effective date. The following are a few highlights of the changes contained in the regulations.

Conflicts of Interest: "In the case of a plan providing disability benefits, the plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision."

Referencing the U.S. Supreme Court finding in *MetLife v. Glenn*, the DOL's overview to the final rule notes that the rule "requires that decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual must not be made based upon the likelihood that the individual will support he denial of disability benefits. For example, a plan cannot provide bonuses based on the number of denials made by a claims adjudicator. Similarly, a plan cannot contract with a medical expert based on the expert's reputation for outcomes contested cases, rather than based on the expert's professional qualifications."

Denial Notice Information: Denial notices must not contain reasons and criteria relied upon when denying benefits. This includes a detailed explanation for disagreeing with the insured's treating physician or a favorable decision from Social Security.

Provide the claimant with new or additional evidence considered: If the insurance company obtains a report from a consulting physician, it must provide it to the insured and

give the insured an opportunity to respond prior to an adverse decision being made.

Deadline to File a Lawsuit: If the plan has a contractual limitation to bring a lawsuit, the adverse decision notice must include a description of the contractual limitations period and the actual calendar expiration date.

Non-English Notices: Insurance companies must make translation services available to claimants who speak languages other than English.

Failure to Adhere to Processing Rules: "[I]f the plan fails to strictly adhere to all of the requirements of this section with respect to ta claim, the claimant is deemed to have exhausted the administrative remedies available under the plan, [with certain exceptions]." However, *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant "so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant" will not be a reason to conclude that the claimant has exhausted administrative remedies.

ERISA LITIGATION

Exhaust Administrative appeals first.

Where to File

A. In Ohio, ERISA is almost always preempted when you are asserting a right to disability payments under the terms of a plan document.
B. A lawsuit is proper:
    1. Where the Plan is administered;
    2. Where the breach occurred (this can be the plaintiff's residence – where the benefits were to be paid);
    3. Where the insurance company/defendant is located; or
    4. Where the insurance company/defendant may be found.
C. *Practice Tip*: There are a number of reasons why I currently prefer to file in federal court in the N.D. Ohio. First, the judges are, on a whole, more familiar with ERISA law. Second, defense counsel almost always removes to federal court. Third, and possibly the most important for your client, the N.D. of Ohio still offers free magistrate mediation.

Statute of Limitations: This can be stated in the Plan itself; otherwise, look to state law, typically under breach of contract limitations. Note that the new DOL regulations require a

final adverse benefit decision to include the deadline to file in court.

Causes of Action

A. Failure to provide required information (i.e. plan documents). §502(a)(1)(A)
B. To enforce benefit rights. §502(a)(1)(B)
C. Breach of fiduciary duty. §502(a)(2)
D. To enforce plan terms. §502(a)(3)

Note: ERISA does not provide a right to a jury trial. With very limited exceptions, there is no evidentiary hearing or bench trial.

Discovery is generally not permitted except upon certain issues such as bias. However, a claim of bias, without evidence to support the claim, will likely result in your motion to be denied.

Remedies and Damages

A. Back benefits and an order clarifying the insured's right to future benefits.
B. Pre-judgment interest at the Court's discretion. *See*, *Cattrill v. Sparrow, Johnson & Ursillo, Inc.*, 100 F.3d 220 (1st Cir. 1996); *Lutheran Med. Ctr. v. Contractors, Laborers, Teamsters & Eng'rs Health & Welfare Plan*, 25 F.3d 616 (8th Cir. 1994).
C. Attorney Fees are available to either party at the Court's discretion. 29 U.S.C. §1132(g)(1).
   Practice Tip: Sometimes (oftentimes?) this is your best leverage negotiating with the insurance company. Because of the limited remedies available under ERISA (i.e. no treble damages or punitive damages), an insurance company is not fearful of an adverse decision.
D. Punitive damages are not available under ERISA. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

Standard of Review

A. A Court reviews an ERISA denial of benefits *de novo*. In reality, this almost never happens, because...
B. If the Plan grants the decision-maker discretionary authority, then the denial of benefits is reviewed under an arbitrary and capricious standard. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).
C. A conflict of interest (the insurance company is the decision-maker and the payer of benefits) does not change the standard of review, but it does serve as a factor to be considered and possibly to "erode" the standard.

Valuing and Negotiating an ERISA claim

A. Typically, an insurance company is not willing to negotiate reinstatement of benefits.

B. Value the lifetime benefit for the client.
   1. Remember the offsets.
   2. Calculate the present value.
   3. Don't forget the value of associated benefits (life insurance, etc.)
   4. 50% maximum risk? According to some defense counsel, insurance companies value their maximum risk on any LTD case at a maximum of 50% and therefore want to begin with a ceiling of 50% of the present value of lifetime benefits.

C. Settlement Agreement: Read the release and advise the client of what is being released.

   Oftentimes overlooked: If your client might one day return to work, make sure that there is a carve-out for being insured by the same LTD carrier *if* the policy is a part of a potential future employer's benefit package.