STRATEGIES FOR DISABILITY ERISA CLAIMS

Teresa S. Renaker and Julie Wilensky
Lewis, Feinberg, Lee, Renaker & Jackson, P.C.
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I. Determine If There Is an ERISA Claim.

- The Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 *et seq.*) governs employer-sponsored benefit plans, both self-funded and insured plans.
- ERISA's coverage is set forth in § 4, 29 U.S.C. § 1003. ERISA does not cover individual policies not sponsored by an employer, and church or governmental plans.

II. General Tips.

- The ERISA claims and administrative appeals process is mandatory – if you miss deadlines or fail to exhaust your administrative remedies, you will lose your right to pursue your claims in litigation.
- The administrative record is extremely important – make sure all the evidence you need to support the claim is in the administrative record, as it is difficult to add any additional evidence in litigation.

III. Prepare the Original Claim for Benefits.

- Request a copy of plan document and summary plan description
  - ERISA § 104, 29 U.S.C. § 1054(b)
- Request medical records from medical providers to demonstrate disability.
- Obtain job description to determine physical/mental requirements of position.

- ***Timing for Decision*:**
  - Deadlines in 29 C.F.R. § 2560.503-1(f)(3)
    - The Plan Administrator must provide notice of a claim denial within 45 days of the receiving the claim. The Plan Administrator may get two separate 30-day extension (for a total of 105 days), if it provides written notice of the extension before the original 45-day period and 30-day extension period expires.

IV. If the Claim Is Denied or Ongoing Benefits are Terminated, Request Review of the Adverse Benefit Determination.

- The discussion below generally applies to appeals of disability claims denied on the ground that the claimant is not disabled.
- ***Review the Claim Denial Letter.***
  - ERISA § 503 and 29 C.F.R. § 2560.503-1(g) require that a claim denial letter include:
    - Specific reason(s) for the claim denial;
    - A description of additional material necessary to perfect the claim and an explanation of why the material is necessary;

        - Description of the plan's review procedures and time limits; and
        - Identification of any internal rule, guideline, or protocol relied on in denying the claim.
    - What is the plan thinking when it writes the denial letter?
        - What plan provision(s) is the plan relying on?
        - What facts did the Plan Administrator consider?
        - What medical evidence is there?
        - Surveillance of the claimant?
        - Any contrary evidence indicating that the claimant is disabled? If so, did the Plan Administrator consider such evidence when making its decision?
        - What is the job description of the claimant/education, training, and experience of the claimant?
        - Any concerns about a structural conflict of interest or misrepresentations by the Plan Administrator?
        - Internal or external review process?
    - What should you be thinking about when reviewing the denial letter?
        - The plan terms identified in support of the denial
        - The evidence relied on denying the claim
            - Internal/external medical reviews
            - Surveillance
        - The evidence ignored in denying the claim
            - Opinions of treating physicians
            - Subjective complaints
        - Claimant's job description (under an own occupation standard of disability) or education, training, and experience (under an any occupation standard of disability)
        - Social Security Disability Insurance (SSDI) approval
- ***Gather Evidence from the Plan.***
    - Request all governing plan documents if you have not done so.
        - ERISA § 104.
    - Request the Claim File from the Plan Administrator.
        - ERISA § 503; 29 U.S.C. § 1133
        - Make a general request for all documents, records, and other information relevant to the claimant's claim for benefits. 29 C.F.R. § 2560.503-1(h)(2)(iii)
        - Supplement your general request with specific, enumerated requests as appropriate, such as a request for surveillance, as well as correspondence with attorneys or other service providers consulted by the insurer in the course of making a decision on the claim
    - What do plans do when they receive a document request?
        - What documents, records, or other information are "relevant?
        - 29 C.F.R. § 2560.503-1(m)(8)
            - If it was relied upon in making the benefit determination;
            - Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such

            document, record, or other information was relied upon in making the benefit determination;
            - Demonstrates compliance with the administrative processes and safeguards required under ERISA;
            - Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination
    - Considerations in Analyzing the Claim File
        - What if the plan has obtained a medical review?
            - Carefully read the medical reviewer's report
            - Did the medical reviewer speak with the treating physician?
            - What records did the plan provide to the medical reviewer?
            - What records did the plan fail to provide?
            - Did the medical reviewer consider the claimant's job description?
        - What if the plan requests an independent medical exam?
            - Can occur before or after the appeal is submitted
        - What if the claim file includes surveillance?
            - Make sure you receive copies of all surveillance video and reports in the claim file
            - Observe time stamps or other indications of the passage of time in video
            - Review reports for indications of length of observations
            - If surveillance is misleading, consider preparing a video of your own to counter it
- ***Gather Evidence from Outside the Plan.***
    - Request updated medical records from medical providers.
        - If the plan obtained a medical review, try to obtain the treating physician's response to the medical reviewer's report
    - Research medical articles describing the claimant's disability
    - Don't forget about the disabling side effects of prescribed medications
    - If appropriate based on the reasons for denial, obtain additional evidence of disability, such as a neuropsychological evaluation or functional capacity evaluation.
    - If appropriate based on the reasons for denial, obtain documentation of the claimant's work requirements and qualifications, such as a vocational analysis.
    - Consider whether declarations from the claimant and/or friends and family help demonstrate the level of disability
- ***File the Appeal.***
    - Document all evidence submitted in support of the appeal
    - Summarize the medical evidence in a readable way
    - Describe why the medical evidence demonstrates the claimant can no longer perform his/her job duties
        - Link directly to job duties from job description
        - Potential for future physical harm
        - Inability to perform job duties with reasonable consistency

        - Interaction of multiple conditions
        - Side effects of prescribed medications
    - Identify procedural irregularities in the initial claim review and denial
        - In disability claims: failure to consider all evidence or accurate job description; problems with surveillance reports
        - Problems with medical reviewer reports
        - *MetLife v. Glenn*, 554 U.S. 105 (2009)
    - Request that the plan provide any new evidence developed during its review of the appeal, and reserve the right to supplement to address new evidence
    - The plan participant is not required to exhaust issues. *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620 (9th Cir. 2008).
- ***Timing to File:***
    - The plan document will establish the period in which a claimant may file an appeal. It must be at least 180 days.
        - 29 C.F.R. § 2560.503-1(h)(3)(i), (h)(4)
- ***Timing for Decision on the Appeal:***
    - The Plan Administrator must provide notice of an appeal determination within 45 days of receiving the appeal.
    - The Plan Administrator may get one 45-day extension (for a total of 90 days), if it provides written notice of the extension before the original 45-day period expires and complies with certain other requirements
    - 29 C.F.R. § 2560.503-1(i)(3)

V. <u>If the Appeal Is Denied, Evaluation for a Second Appeal.</u>

- Request the claim file again. ERISA § 503; 29 U.S.C. § 1133
- Review the plan document to determine if a second-level claim appeal is allowed.
- Review the appeal denial letter. There may be an opportunity for another appeal if the Plan Administrator provided a new justification in appeal or relied on new evidence, such as a reviewing physician, in the appeal.
    - *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003)
- Consider strategic goals – second appeals are always optional for disability claims.

VI. <u>If the Appeal Is Denied, Evaluate for Litigation.</u>

- Individual claims for benefits are litigated under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).
- ***Evaluating the Claim:***
    - Request the claim file again.
        - ERISA § 503; 29 U.S.C. § 1133
    - Have you exhausted the plan's claim and appeal procedures to the extent required by law?
        - *Madden v. ITT LTD Plan for Salaried Employees*, 914 F.2d 1279 (9th Cir. 1990)
        - *White v. Jacobs Eng'g Group LTD Benefit Plan*, 896 F.2d 344 (9th Cir. 1989)
    - What benefit is your client entitled to, should their claim be granted?

        - ERISA allows only claims to recover benefits under the plan. ERISA does not allow punitive or compensatory damages.
            - *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985)
        - Most plans have offset provisions to subtract other income benefits received by the claimant, such as Social Security Disability Insurance or workers' compensation.
    - Does the plan establish a contractual statute of limitations? If not, generally use the statute of limitations for breach of written contract – 4 years in California.
        - *Felton v. Unisource Corp.*, 940 F.2d 503 (9th Cir. 1991)
        - *Schendel v. Pipe Trades Dist. Council No. 36*, 880 F. Supp. 710, 714 (N.D. Cal. 1995)
    - What is the future of the claim, should the claimant be successful?
        - Is there a 24-month mental health illness limitation that may limit the claimant's recovery?
        - Does the definition of "disability" change at any point, such as from an inability to perform one's own occupation to an inability to perform any occupation?
- ***Standard of Review and Discovery***
    - Does the plan have "discretionary language" – language that gives the Plan Administrator the discretion to interpret the terms of the plan document?
        - This will affect the court's standard of review of an appeal denial. If no discretionary language, the court reviews the Plan Administrator's decision de novo.
        - *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)
        - *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006)
        - Discretion-granting provisions in insurance policies are prohibited in California, Cal. Ins. Code § 10110.6, and 17 other states.
    - Is there a conflict of interest that could affect the standard of review?
        - *MetLife Insurance Co. v. Glenn*, 554 U.S. 105 (2008)
        - *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006)
    - Do you need discovery?
        - If the standard of review is abuse of discretion, and there is a conflict of interest (*i.e.*, almost any insured plan), discovery may be available on the scope and impact of the conflict.
            - *Stephan v. Unum Life Ins. Co. of Am.*, 697 F.3d 917 (9th Cir. 2012)
            - Types of discovery sought and (sometimes) granted: information on insurer's (and doctors') financial incentives and compensation, claims handling information (*e.g.*, claims manual), information on claims approved vs. denied.
    - After submission of the appeal, is everything in the claim file that you will need to litigate the claim?
        - It is difficult to add information to the claim file in litigation.
            - *Alford v. DCH Found. Group Long-Term Disability Plan*, 311 F.3d 955 (9th Cir. 2002)

            - *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003)
        - But, if the court allows discovery, or if the Plan Administrator came up with a new reason for denying the claim after the appeal, the court may let in additional evidence.
            - *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. 2006)

VII. **<u>Special Issues in Long-Term Disability Cases</u>**

- Cognitive impairment
    - E.g., problems with memory, concentration, attention, or information processing
    - Neuropsychological evaluation is often useful for objective evidence
    - There is a lot of literature on cognitive deficits and long-term HIV infection which can be included with a request for review.
- Pain and fatigue/subjective evidence of disability
    - Courts have recognized that pain itself can be disabling
        - *Minton v. Deloitte & Touche USA LLP Plan*, 631 F. Supp. 2d 1213, 1219 (N.D. Cal. 2009)
    - If the plan does not require the claimant to provide objective evidence, the insurer can't deny the claim solely on the ground that the claimant's evidence is subjective.
        - *Maronde v. Sumco USA Group Long-Term Disability Plan,* 322 F. Supp. 2d 1132, 1139 (D. Or. 2004)
    - Requiring objective evidence of a purely subjective problem, like pain, may be an abuse of discretion.
        - *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 872 (9th Cir. 2008)
        - *Salomaa v. Honda LTD Plan*, 642 F.3d 666 (9th Cir. 2011)
    - Helpful evidence to buttress a claim based on pain or fatigue: functional capacity evaluation (depending on evaluator), declarations from friends, family, and/or former co-workers.
    - Insurer must also consider side-effects of medication in evaluating whether claimant is disabled.
        - *Frei v. Hartford Life Insurance Company*, 2006 WL 563051 at *11 (N.D. Cal. March 7, 2006)
- Participant worked while disabled
- Mental illness limitations
- Offsets
- Social Security disability benefits
- Medicare eligibility
- COBRA extension
- Recurrent disability
- Partial disability