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Anatomy of an ERISA-benefit claim

ACCEPTING THE ERISA CASE AFTER CLAIM DENIAL AND DEVELOPING A SOLID RECORD FOR LITIGATION

The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted in response to widespread pension problems and provides minimum standards for voluntarily established benefit plans for employees in the private industry.[1] ERISA governs "employee benefit plans" including pension benefit plans, welfare benefit plans, health plans, disability benefit plans, severance plans, and life and AD&D plans. It does not govern government plans, church plans,[2] or plans maintained solely to comply with workers' compensation, unemployment, or disability laws.

As enacted, the ERISA statute contained a remedial scheme which permitted plan participants or beneficiaries whose benefit claims were denied, to file an action in either federal or state court to recover the disputed benefits.[3] However, the Department of Labor subsequently enacted regulations which "afforded" the claimant a "right" to have the denied claim "reconsidered" by the Plan claims administrator. The "right" to seek reconsideration was subsequently determined by the federal courts as a mandatory obligation prior to initiating litigation. In common terms, there now exists an obligation to "exhaust administrative remedies" prior to initiating litigation following a claim denial. The U.S. Supreme Court has gone so far as to address the existence of a two-tiered remedial scheme, the first being the pre-suit administrative process, followed by the right to litigate after the administrative process has been exhausted.[4]

The exhaustion doctrine became of paramount importance in the handling of a denied benefits claim under ERISA. The Department of Labor (DOL) regulations establish deadlines for the submission of the administrative appeal. If missed, by even a day, the claimant may be denied the right to have her claim reconsidered, and also be denied the right to seek redress in court.

Moreover, the federal courts have uniformly established rules limiting judicial review to the contents of the "administrative record." For that reason, it is critical for a claimant or her representative to take all possible steps to include all available evidence supporting the benefits claim.

Most federal circuit courts have held that all bases for a claim denial must be set forth by the Plan's claim administrator during the administrative process, such that the claimant has the opportunity to respond to the basis for denial. The courts considering the issue will typically not permit new reasons for the claim denial to be raised for the first time during litigation.[5] However, with the increase of *de novo* review of claim denials, defendants may be permitted to make arguments about the facts that they did not make during the administrative process.[6] This is presenting interesting and new challenges to plaintiffs with ERISA denial of benefits claims.

This article will focus on considerations relevant to supporting your client's position during the administrative review process with a particular focus on ERISA-governed disability benefit claims.

Know the claim file (a.k.a. "administrative record")

In order to properly evaluate a benefit claim, you must have the entire claim file, which we will refer to as the "administrative record" (although not administrative in the likeness of the DFEH or EEOC). In addition, you must also have all of the governing Plan documents which set forth the eligibility and other requirements for payment of benefits.

Entities to whom to direct the requests for information

To request both the administrative record and the Plan documents (the latter which should, but may not always, be included in the former), you must be careful to direct your requests to the appropriate entity. The Plan Administrator must provide the controlling plan documents. ERISA, § 104(b)(4), 29 U.S.C. § 1024(b)(4) states,

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.

The named Plan administrator should not be confused with the claims administrator. More often than not the Plan administrator is the employer who sponsors the benefit plan and the claims administrator is the insurance company which funds the benefit and makes eligibility determinations.

If you have any question about who the plan administrator might be, the easiest way to check is at www.freeerisa.com or at https://www.efast.dol.gov/portal/app/disseminate?execution=e1s1. Most

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health and welfare benefit plans are required to file Form 5500 and these forms set forth the Plan's administrator.

However, with respect to the administrative record, the Plan Administrator is typically not the entity which maintains the record because either the insurance company or a third-party administrator ("TPA") makes the benefits decision. In these situations, the requests for the administrative record should also be made to the insurance company or TPA. It is a good practice to send both the request for Plan documents and the administrative record to the Plan administrator and claims administrator simultaneously. Here is an example of a request for Plan documents and the administrative record:

> Pursuant to ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4), Mr. _____ hereby requests all Plan documents for the Plan, including but not limited to a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.
>
> In addition, pursuant to Section 503 of ERISA, 29 U.S.C. § 1133, and applicable Department of Labor regulations, including 29 C.F.R. § 2560.503-1(h)(2)(iii), Mr. _____ requests all documents relevant to his claim for benefits that are in your office's possession or control. Under 29 C.F.R. § 2560.503-1(m)(8), a document, record, or other information is "relevant to a claim for benefits" if it:
>
> (i) Was relied upon in making the benefit determination;
>
> (ii) 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;
>
> (iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or
>
> (iv) In the case of . . . a plan providing disability benefits, 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.

If at all feasible,[7] one should review the Plan documents and administrative record before making a decision to take a case.

Reviewing the governing plan documents

Plan sponsors are required to establish the Plan pursuant to a written instrument that complies with ERISA § 402; 29 U.S.C. § 1102. In addition, Plan sponsors are required to have a Summary Plan Description ("SPD") in compliance with ERISA § 102; 29 U.S. Code § 1022. Especially in light of the U.S. Supreme Court's decision in *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011), which held that disclosures set forth in ERISA-required SPDs could not be enforced as terms of the plan itself, it is important to have the actual Plan document rather than just the summary of its terms. Sometimes provisions in an SPD conflict with the terms of the Plan, and in most circumstances the terms of the Plan will trump disclosures set forth in an SPD. In some cases there may only be an SPD and not a formal plan document. In these circumstances, a court will likely enforce the terms of the SPD as the terms of the Plan.

Statutory document penalties

An ERISA plan administrator has a duty to respond to written requests for information. ERISA § 502(c)(1), 29 U.S.C. § 1132(c)(1) provides for a penalty for any administrator,

> (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

The limit was increased to $110 for violations after July 29, 1997.[8] The reason it is important to request Plan documents from the proper entity is because a court will likely not award penalties against a claims administrator for failing to produce the Plan documents.

Practical considerations of representation

When you are first contacted by the potential client, and you have determined that ERISA applies to her claim, the first area of inquiry must be to determine the procedural posture of the claim. If it has been denied, has the appeal time run without an appeal having been submitted? Has the claimant submitted his or her own appeal? Does the Plan afford a right to file a second appeal, and is there still time to file the second appeal? If you do have time to prepare an appeal for the potential client, do you have enough time to properly appeal?

Each of the foregoing presents its own special considerations and problems. If the time to submit the appeal has already run, there is likely little or nothing you can do to assist the claimant. If the claims administrator refuses to accept a late appeal, the courts are not forgiving in allowing late filed appeals. However, all may not be lost. The DOL regulations require that

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the claimant be advised of her appeal rights. If not properly advised, the claimant cannot be barred from litigation. Also, some courts will only mandate that the administrative remedies be exhausted if the Plan mandates that an appeal be submitted as a prerequisite to bring litigation. It is the rare Plan that does not contain such a requirement, but if it is your only possible way to save your client's case, it is imperative you read the Plan and the SPD to determine your client's rights and obligations.

If your client has not submitted an appeal, and the time to do so is so limited that you don't feel you can properly represent the client's interest, you can seek an extension of time from the claims administrator. Most carriers are very reluctant to deny an attorney the opportunity to assist a claimant who has been previously unrepresented. Doing so brings into question their claimed status as a fiduciary with higher than marketplace obligations.[9] If the insurer/claims administrator refuses to grant an extension, advise the administrator that the claimant is appealing. Make it clear in writing that the claimant is submitting an appeal of the denial and provide as much of an explanation as you can, along with the supportive documentation. Thereafter, gather the additional information as quickly as possible and submit it to the carrier as you obtain it. Many courts will require additional evidence of disability to be considered up until the time the appeal has been formally denied, which is typically not sooner than 45 days after the appeal submission.

If your potential client has already submitted an appeal, and it is still pending, consider withdrawing it (time permitting) while you get the entire administrative record, and determine if you can find additional evidence to support the claimant's position.

If the claimant has submitted an appeal, and it has been denied, the first thing to do is to check to see if the Plan affords a second appeal, and if there is still time to submit more evidence. Time permitting, the ability to submit a second appeal is not materially different than appealing an original denial.

If there is nothing more you can do for the claimant other than file a lawsuit, you need to make sure you are prepared to litigate the case on the record that exists. While there are exceptions, do not anticipate that you will be able to supplement the record with evidence pertaining to the client's claim during litigation.

Considerations for perfecting the disability claim

Once you have evaluated the claim file, there are certain issues that must be considered and addressed on appeal. Because the administrative record is often limited to the evidence that was before the administrator at the time it made the final claims decision, perfecting the claim and appeal is arguably the most important part of any benefits claim.

Disability claim denials can be grouped into three camps: (1) No objective evidence of diagnosis; (2) No objective evidence of disability; and (3) No vocational causation between diagnosis, disability, and the claimant's inability to do her occupation.

Where there is a claimed lack of objective evidence of a diagnosis, one should start with a medical literature search for diagnostic considerations. Then, review the claimant medical history, complaints, examination findings, and diagnostic studies for consistency with the treating physician's diagnosis. One should also consider missed diagnosis or alliterative errors (influence that one radiologist exerts on another after attaching the wrong significance to an abnormality). Although treating physicians are not entitled to any special weight, plan administrators may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician.[10] As such, one should obtain a statement from the treating physician addressing subjective complaints, examination findings (how they correlate with subjective complaints), diagnostic studies, diagnosis, bases for diagnosis, medical literature, and rebuttal of peer review opinion, if any.

With respect to the question of whether there is a lack of objective evidence of disability, the first step is to review the Plan to see if it requires "objective" evidence and how that is defined. Objective evidence may include: (1.) current symptoms; (2.) other medical conditions that might affect or lengthen the recovery period; (3.) existing abnormalities or deficiencies; (4.) results from physical examinations; (5.) observations made by the treatment provider during office visits/therapy sessions; (6.) diagnostic tests and their results (for example, lab results, X-rays and MRIs); (7.) a treatment plan; (8.) any prescribed medications and the response to those medications; (9.) level of functionality (restrictions and limitations); (10.) clinical documentation that supports the rationale that the treatment provider used when determining the level of functionality; and (11.) a description of the impact that the employee's level of functionality has on her ability to perform her job or any other job assigned by the company. Any of this evidence pertaining to your client should be submitted to the administrator.

Lastly, with respect to vocational causation between the diagnosis, disability, and the claimant's inability to do her occupation, that may be addressed by independent evaluations, testing, determinations by other agencies, and vocational assessments.

A claim denial may be supported by the findings of an "independent" medical evaluation ("IME") or a peer review. Typically, in-person evaluations are given more weight than a mere paper review since the Ninth Circuit recognizes that the insurer's decision to conduct a pure paper review raises questions about the thoroughness and accuracy of the benefits determination.[11] Where the record contains a well-reasoned but negative IME, that evaluation may make it difficult to succeed on appeal, and ultimately in court, if it is not properly rebutted. At a minimum, a claimant should seek another IME or other objective testing to substantiate

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her claim. In the Ninth Circuit, it is often a fatal mistake of claims administrators who may only obtain a records review. Courts will often give more credence to a treating physician, not because he is entitled to deference, but because he has actually examined the claimant and can assess subjective symptoms and credibility.[12]

When handling a claim where you have the opportunity to supplement the record, obtaining an IME from a qualified specialist may go a long way towards convincing the court that the denial of the benefit claim was either arbitrary or capricious, or against the weight of the evidence. This may be particularly true where your client has a potential cognitive deficit. Thorough testing by a qualified and respected neuropsychologist may carry the day if the matter proceeds to litigation.

There are times when you may review a file and determine that the denial is predicated on the opinion of a physician whose reports have been the subject of consistent criticism by the courts. If conducting an appeal, it might be in your client's interest to demand that a review be performed by a reviewer without the same level of perceived inherent bias. On the other hand, if you foresee the matter being litigated, you might want to remain silent as to the subjectivity of the utilized reviewer, and attack his credibility at the time of trial.

Similarly, there are a number of claims handling regulations which are intended to mandate that the claimant receive a full and fair review of her claim. The same individual employed by the claims administrator may not be involved in both the original claim and the appeal, the appeal may not be assigned to a subordinate of the person who issued the original claim denial, and it is a requirement that the claims administrator utilize a physician of at least equal expertise as that of the treating physician. In the handing of the claim, some or all of these regulations may have been violated. While some attorneys believe it is incumbent upon them to bring them to the attention of the claims administrator during the appeal process, others believe it is in their client's best interest to say nothing, and attack the fairness of the appeal during litigation.

The impact of Social Security Disability benefits

Federal courts have recognized that a determination that an individual is eligible for Social Security Disability Insurance ("SSDI") benefits is relevant evidence that merits consideration in ERISA disability cases.[13]

An approved SSDI claim tends to strengthen the claim for disability benefits under the ERISA plan. For clients whose claim for SSDI benefits have been approved, helpful information may be obtained from the SSA file, including Activities of Daily Living forms completed by the claimant, supporting statements of friends, and Residual Functional Capacity evaluations by SSA doctors and treating doctors.

Because an award of SSDI benefits is an offset to the benefits paid by the carrier, it will often assist the claimant in making an SSDI claim, or even go so far as to retain a Social Security vendor to represent the interests of the insured. If successful, it then becomes difficult for the carrier to immediately turn around and deny benefits. Courts have frowned upon denials in these circumstances, suggesting that the conduct comes close to constituting judicial estoppel.[14]

Beware sub rosa surveillance

Surveillance of a claimant's activities can be the death knell to her claim if not properly addressed. Often, activities seen on surveillance do not indicate full-time work ability.[15] However, surveillance can suggest that a claimant is not forthcoming about her restrictions or limitations if the filmed activities are grossly inconsistent with her self-report. This goes to the credibility of the claimant and can be important if the disability is based on self-reported symptoms.[16]

One should review the administrative record for the claimant's and/or treating doctor's statements about the surveillance. It is important to carefully review surveillance videos and watch time stamps carefully and compare them with the surveillance report. You should also determine whether there are contradictory statements made by the claimant regarding the surveillance; whether there is any evidence in the record which contradicts or is consistent with the activities seen on surveillance; review peer reports for possibly flawed interpretations of the surveillance; obtain client and other statements to "fill in the gaps" of the surveillance; request that the treating physician or IME review surveillance and render an opinion; and investigate whether surveillance was done lawfully. With enough diligence, damage done by surveillance can be rehabilitated.

Vocational evidence is often crucial

After gathering the relevant evidence, a vocational expert is helpful in showing how a claimant's restrictions and limitations erode the possible occupational base. At the time of a claim denial, the administrative record may contain a vocational assessment, usually based on restrictions and limitations determined by the administrator's own doctor. It is important to analyze the basis of the vocational report as it may be premised on faulty or otherwise unreliable information.

The recent opinion in *Contreras v. United of Omaha Life Ins. Co.*, No. 16 C 3495, 2017 WL 1493701 (N.D. Ill. Apr. 25, 2017) shows that prior work history is not only relevant to determine for what alternative work disability insurance claimants can qualify, but also the likelihood of their ability to meet a particular earning level within a given occupation if they do qualify. Though insurers routinely take a position claimants will earn the median or mean wage for a given occupation, the entry level wage or 10th percentile wage, may be more appropriate if the claimant never did the type of work before. United of Omaha denied Contreras' claim for disability benefits reasoning she was not disabled from any Gainful Occupation under the insurance policy, defined as "an occupation for

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which You are reasonably fitted by training, education or experience, [and] is or can be expected to provide You with Current Earnings at least equal to 85 percent of Basic Monthly Earnings within 12 months of Your return to work." Contreras most recently worked as a hand packer, packing steel lacing, loading a machine with steel lacing for packing, and labeling and palletizing the packages. Before that, she worked as a home health aide, and held several jobs as a retail cashier. The only occupation United of Omaha contended met the policy's requirements as a Gainful Occupation was Order Clerk, a sales and clerical position.

The court explained in order for United of Omaha to prevail, it needed both (1) Contreras to be reasonably fitted for the Order Clerk occupation, and (2) to be able to earn 85 percent of her prior wages within 12 months of starting work as an Order Clerk. Though the parties supplied competing expert vocational reports on the question of Contreras' qualification for work as an Order Clerk, the court declined to make a finding on that question, calling it a "close question." While United of Omaha's expert opined Contreras would earn the median wage as an Order Clerk (which slightly exceeded the policy's required wage), she did not state when that would occur. Contreras' vocational expert, James Radke, explained based on Contreras' work history, if she were able to obtain a job as an Order Clerk, she would begin at an entry-level wage, which was approximately $2,271 per month, though the policy's required wage is $2,808.17 per month. Radke likewise did not opine as to what Contreras' earnings would be within 12 months of beginning work, but the court inferred reasonably that Contreras would not likely yield a 23 percent raise after one year of work. Additionally, the court explained Contreras' prior unskilled work "would be highly unlikely to motivate an employer to pay her at least $2,808.17 per month – approximately double her earnings as a cashier – within her first year working as an Order Clerk."[17]

In sum, it is important to not take a vocational assessment at face value and that any rebuttal report clearly sets forth the basis of its findings.

What do others have to say?

Because in typical denial-of-benefits claims, witnesses are not allowed to testify in court, third-party statements in the record can play an important role in providing corroborating evidence of disability and must be considered by the administrator.[18] Indeed, observations made by persons with first-hand knowledge can be very useful in helping to understand how someone functions in activities of daily living on a daily basis.[19] The best practice is to have the witnesses sign statements under the penalty of perjury. Although administrators must consider this evidence, they often ignore or don't address them. An administrator is highly unlikely to contact the witness to obtain additional information.

In conclusion, the above constitutes only some of many issues an attorney may want to consider in deciding both whether to take a case and the additional information which may be obtained to best support the claims of her client. Given the importance of the claim and appeals process, it is important to devote ample time to making sure the administrative record is as complete as possible. Gathering all of the required evidence may take the entire time until the due date of an appeal so it is important to start the evaluation early and to be aware of possible road bumps.

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Endnotes:

1 29 U.S.C. § 1001, et seq.

2 Recently, the U.S. Supreme Court decided that for the church plan exemption to apply, a benefit plan maintained by a church-affiliated organization need not be originally established by a church. *Stapleton v. Advocate Health Care Network*, 817 F.3d 517 (7th Cir.), cert. granted, 137 S.Ct. 546, 196 L. Ed. 2d 442 (2016), and rev'd, No. 16-258, 2017 WL 2407476 (U.S. June 5, 2017).

3 Employee Retirement Income Security Act of 1974, § 502(a), 29 U.S.C.A. § 1132 (a).

4 *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S.Ct. 604, (2013). The first tier of ERISA's remedial scheme is the internal review process required for all ERISA disability-benefit plans. 29 C.F.R. § 2560.503–1. After the participant files a claim for disability benefits, the plan has 45 days to make an "adverse benefit determination." § 2560.503–1(f)(3). Two 30–day extensions are available for "matters beyond the control of the plan," giving the plan a total of up to 105 days to make that determination. *Id*. The plan's time for making a benefit determination may be tolled "due to a claimant's failure to submit information necessary to decide a claim." § 2560.503-1(f)(4).

5 See *Harlick v. Blue Shield of California,* 686 F.3d 699 (9th Cir. 2012); *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282 (9th Cir. 2014).

6 See *Muniz v. Amec Const. Mgmt., Inc.*, 623 F.3d 1290 (9th Cir. 2010).

7 The deadlines facing a potential client may impact your ability to obtain and review the claim file. Typically, the claimant is afforded 180 days to file an appeal. If the deadline to submit the appeal is untenably short, you may wish to reject representation, seek an extension from the claims administrator, or assist the claimant in submitting a "barebones" appeal to preserve the right to ultimately file suit.

8 62 Fed. Reg. 40696-01; 29 CFR § 2570.502c-2.

ERISA imposes higher-than-marketplace quality standards on insurers, requiring a plan administrator to discharge its duties in respect to discretionary claims processing solely in the interests of the plan's participants and beneficiaries. *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105, 128 S.Ct. 2343, (2008).

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Montour v. Hartford Life & Accident Insurance Company, 588 F.3d 623, 635 (9th Cir. 2009).

See *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 676 (9th Cir. 2011) (medical opinions rendered following in-person examination were more persuasive than contrary opinions rendered following administrator's paper-only review).

13 See *Montour*, 588 F.3d at 634; *Melech v. Life Ins. Co. of N. Am.*, 739 F.3d 663 (11th Cir. 2014).

14 *Ladd v. ITT Corp*., 148 F.3d 753, 756 (7th Cir.1998).

15 See *King v. Cigna Corp.*, 2007 WL 2288117, *11 (N.D. Cal. Aug. 7, 2007) ("That Plaintiff is able to bend to put her walker in her car, to run errands or to stay at a restaurant for an hour does not establish that she is able to work an eight-hour-a-day job"); see also *Carugati v. Long Term Disability Plan for Salaried Employees*, 2002 WL 441479, at *7 (N.D. Ill. March 21, 2002); *Clausen v. Standard Ins. Co.*, 961 F. Supp. 1446, 1457 (D. Colo. 1997); *Gessling v. Group Long Term Disability Plan for Employees of Sprint/United Management Co.*, 693 F. Supp. 2d 285 (S.D. Ind. 2010).

16 See *Finley v. Hartford Life & Acc. Ins. Co.*, 400 F. App'x 198, 200 (9th Cir. 2010) ("It was not an abuse of discretion for Hartford to conclude that Finley lacked credibility and therefore to discount the value of her self-reported pain incidence, the heart of her claim and her doctor's assessments of her health, and place more weight on the surveillance video.").

17 *Id.* at *5.

18 See e.g., *Mueller v. CNA Group Life Assur. Co.*, No. C 03–1688 MHP, 2004 WL 1161173, *8 (N.D. Cal. May 24, 2004) (finding that CNA's decision was not based on sufficient reliable evidence in the record where it was supported in part by "evidence from her co-workers and supervisors"); *May v. Metro. Life Ins. Co.*, No. C 03-5056 CW2004 WL 2011460, *8 (N.D. Cal. Sept. 9, 2004) (MetLife abused its discretion by ignoring, among other evidence, witness statements describing how plaintiff's health affected her ability to work).

19 *McDonald v. W.-S. Life Ins. Co.,* 347 F.3d 161, 165 (6th Cir. 2003) (relying significantly on a witness statement that based on plaintiff's poor bridge-playing skills, he believed plaintiff was disabled from working); *Holmstrom v. Metro. Life Ins. Co.*, 615 F.3d 758, 763 (7th Cir. 2010) (relying on family member letters describing how plaintiff's condition affected her everyday life); *DiPietro v. Prudential Ins. Co. of Am.*, 03 C 1018, 2004 WL 626818, *6 (N.D. Ill. March 26, 2004) (relying on letters from plaintiff's family, friends, and co-workers that plaintiff's condition made his work *increasingly* difficult and rendered him disabled).