ERISA Long-Term Disability Claims for Social Security Practitioners: From the Basics to an Update of the Current State of ERISA LTD Litigation

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ERISA Long-Term Disability Claims: What Social Security Representatives Need to Know

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As Social Security representatives, many of us have had disabled clients who tell us they are also being paid long term disability (LTD) benefits, and sometimes that they have been denied LTD benefits. Unless you regularly handle LTD cases, there are many traps and pitfalls that can ruin your client’s LTD case.

If you are a Social Security practitioner who does not handle LTD claims, there are still many things you need to be careful about, because sometimes the way you handle your clients’ social security cases may have a significant affect on your clients’ LTD cases. This paper will address what some of those issues are, and how to avoid them or handle them.

If you are a Social Security practitioner who occasionally helps your client with LTD issues, or are thinking about doing so, this paper will also address common mistakes made by less experienced LTD attorneys so that you can do the best job you can for your clients.

This paper is not a comprehensive overview of all of the law applicable to LTD claims; a comprehensive paper covering all the legal issues related to disability insurance and its controlling law would be a large book. Similarly, a seminar covering all the issues in depth would be a multi-day seminar similar to the NOSSCR conference. This paper does provide an introduction into some of the most common issues that arise in LTD claims. Additional papers on more in-depth topics of LTD law are available on our firm’s website at www.buchanandisability.com under resources and articles, and some of the specific ones are mentioned throughout this paper.

Types of Long-Term Disability Insurance:

Private Individual Disability Insurance:
When an individual person purchases a disability insurance policy directly from an insurance company or insurance company’s agent, those policies typically offer strong protection against a loss of income due to disability. Many such policies insure the person’s own occupation, provide increasing benefits over time under cost-of-living adjustments (“COLA”), have more generous definitions of disability, provide for partial disability, and generally provide strong coverage when a person suffers a medical disability.

Typically, these private policies do not cover a percentage of a person’s pay. Rather, most policies provide for a specific monthly benefit amount if a person becomes disabled, or a portion of that benefit if the person is partially disabled. Additionally, not only do many policies provide for a COLA, many policies have built-in increases in the base coverage (with built-in increases in premiums as well) that apply over the first few years of the policy, to account for the increase in income most professionals typically have. Thus, for example, someone might have a policy...
with a face value of $6000 per month, with an automatic increase of $500 per month for the first five years, so that, if the insured person accepts the increases, the policy is worth a base of $8500 a month after five years.

Another good feature of these policies is that they do not typically allow for an offset of other benefits, such as social security or workers’ compensation benefits.

Further, because these policies are purchased by an individual directly, and not through an employer, any dispute over coverage or a claim falls under state law. That typically allows for a jury trial, the full scope of remedies allowed for breach of contract, and, in many states, punitive or extra-contractual damages for bad faith.

Of course, these policies are expensive to purchase, and typically are purchased by doctors, other professionals, business owners and executives. However, because they are usually paid for by the individual in post-tax dollars, the benefits paid are paid tax free.

In the industry, the private policies are usually referred to as “individual disability insurance” policies, or “IDI” policies. Often this is shortened to “individual disability,” or “ID,” or just “disability insurance, or “DI” policies.

IDI policies are great policies for the people who can afford them and who purchase them. And when a dispute arises, their rights and remedies can be strong. Our firm would vastly prefer to help someone with an IDI policy over group policies, which are discussed next. However, IDI policies are only a small percentage of the types of disability insurance policies in the marketplace.

**Group Long-Term Disability Policies:**

When a policy is offered through work as a group policy, these policies are typically referred to as long term disability, or “LTD” policies. While some of these policies have generous provisions, few are as good as typical IDI policies. And some are so badly written (or written in favor of the insurance company) so as to be worthless.

Almost all LTD policies pay a percentage of the employee’s income before becoming disabled. Most often, this is 60% of the income, but sometimes it is as little as 50% or as much as 70%. Sometimes policies offer a “base” of, say, 50%, and allow the person to pay for a buy-up of another 15%.

However, almost all LTD policies reduce, or offset, the benefits for other income. Other income almost always includes social security disability benefits, and almost always that includes benefits for auxiliaries/dependents. LTD policies almost always also offset for workers’ compensation benefits and similar benefits. Sometimes the policies offset for veteran’s benefits, but not always.

Some policies that are more recently issued are now including offset for money recovered from third parties who caused the disabling injuries, allowing the LTD policies to offset for recoveries from the tort case a person who is injured may have.

About the only thing that group policies don’t typically offset for is for income from individual disability policies a person may have purchased outside of work.

Further, most LTD policies purport to allow the insurance company or plan to recover back from the disabled person when full LTD benefits are paid for a while, and later the person wins a social security case, tort case, or whatever. The good news is that most policies don’t offset for the attorneys’ fees paid to recover social security benefits or other recoveries, although a few even try to recover that amount.
Many policies also only cover a person’s base salary or hourly pay, so that the 60% calculation (or whatever percentage the person is eligible for) is limited to the forty hours of base pay, and overtime is excluded. Also, in too many policies, when someone gets a substantial amount of income from commissions or bonuses, the policies are written to only calculate the benefit based on the much lower base pay.

Another limitation in some policies is that the policies cap the maximum pay that is covered. Sometimes that is a high limit, such as $10,000. However, one really bad policy we have seen (offered by a large carpet company in north Georgia) caps benefits for hourly employees at $1000 per month, yet still offsets for social security benefits.

Group LTD policies also typically have more restrictive definitions of disability than individual policies. The most common policies provide only two years of disability coverage if a person is disabled from his or her “own occupation;” after that, the disabled person has to prove disability from “any occupation.”

Another common provision in group LTD policies is that coverage is limited to 24 months for people who are disabled due to “mental and nervous,” or psychiatric, conditions. Many policies have begun to also limit benefits to 24 months for disabilities that are manifest by “self-reported symptoms.” Thus, many insurance companies will try to cut off benefits after 24 months if the person is disabled due to headaches, for example. Some hotly contested issues occur when an insurance company tries to extend this provision to disabilities such as fibromyalgia, chronic fatigue syndrome, or Lyme disease.

In addition to policy provisions that provide for less coverage than private IDI policies, group policies also typically fall under the federal ERISA law as employee benefits. As is discussed in more detail throughout much of the rest of this paper, ERISA limits the remedies for disabled people who have been wrongfully denied to only the benefits due, plus maybe attorneys’ fees. ERISA also often allows for a more restrictive standard of review, so that the insurance companies and plans often have a large advantage in court.

Also, as explained in more detail below, ERISA case law provides that the review of a denial of benefits is limited to the record before the insurance company. The question for the court is typically not, is this person disabled, or even was the insurance company wrong, but more accurately, “based on the information provided to the insurance company and obtained by the insurance company, was the insurance company’s decision to deny benefits arbitrary and capricious.”

Another limitation in ERISA cases is that the case is “tried” (if we can even use that word) based on written arguments, and maybe oral arguments, in front of a federal judge. There is no jury trial, almost never live witnesses, and sometimes not even oral arguments.

**ERISA v. Non-ERISA Cases and Case Selection**

Because the majority of disability policies are offered as group policies through work, the majority of this paper discusses the rules that apply to ERISA LTD policies. Again, a separate discussion of litigating non-ERISA IDI policies would be a multi-day seminar.

While IDI policies are usually more advantageous for the people who buy them than group LTD policies, there are still plenty of LTD cases that are worth helping people with. However, I submit that, when taking an ERISA LTD case, attorneys need to be more vigilant, and pay attention to the facts at the beginning of the case.
If you are going to help a client with an ERISA LTD claim, it is hugely important that the person has a well-documented factual disability case. However, there are other factors to consider early on.

It is crucial to look at the financial picture and to attempt to calculate the net benefits after offsets. As discussed more below, in a typical case where a client has a chance of winning an LTD case, the same client has almost always got to have a good chance of winning the social security case. So, in calculating the benefits in dispute, we recommend that in almost every case, you assume the client is going to win both cases.

Thus, a client who made $36,000 per year, of $3000 per month, who has an LTD benefit at 60%, is fighting over $1800 a month in LTD benefits. If that same person is 40 and has a 3-year old, and has a $1000 PIA, and Aux benefits of another $500, that means for the next 15 years or so, the person's LTD is likely to be offset down to just $300.

On the other hand, a person making $100,000 per year, would often have an LTD benefit of $5000 per month (at 60%). Let's say the social security benefit for that person is $2600 a month; that leaves another $2400 a month in LTD benefits to fight for.

**Introduction to ERISA:**

Because most group LTD policies are offered through work, these policies are usually considered to be employee benefits that fall under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA is a comprehensive federal statute that applies to many claims related to employee benefits, including LTD, medical insurance, life insurance, or pension benefits. ERISA benefits claims involve a complicated area of the law that throws up many hurdles that stand between employees (and their attorneys) and their employee benefits.

ERISA was passed in response to a significant perceived problem, that employee benefits were subject to varying and often conflicting state laws, and employees’ rights were not adequately protected by state laws. Employees often had significantly different rights depending on the state in which they worked, while large, multi-state companies often had conflicting obligations. Also, large employers and unions could avoid liability for mishandling employee benefits by picking and choosing what state would be the home state for their employee benefit plans.

Congress also perceived problems involving possible corruption and self-dealing involving large pension plans. In order to provide federal oversight of employee pensions and uniform national standards, Congress drafted ERISA to regulate employee pension plans. At the last minute, ERISA was amended to include other employee benefits, referred to as ERISA welfare benefits; this includes LTD, health insurance, life insurance, and other benefits offered by private employers. Thus, ERISA covers two broad areas of employee benefits: pension benefits and welfare benefits.

The intent of Congress in enacting ERISA was to protect the “interest of participants in employee benefit plans . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts. . . .” 29 U.S.C. § 1001(b). The language of the ERISA statute draws heavily from trust law as well as contract law. Congress instructed the courts to develop a common law of ERISA, using both trust and contract principals. The Department of Labor also has authority to issue regulations governing the processing of ERISA claims. Despite
language in the ERISA statute purporting to protect employees, over time, ERISA case-law has developed into more of a shield for employers, insurance companies, and unions, and offers little protection for employees.

ERISA Preemption

ERISA applies to almost all disputes over employee benefits offered by private employers. Any state law claims, such as breach of contract or bad faith, do not apply because the rules under ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .” 29 U.S.C. § 1144(a).¹

ERISA preemption means that almost all employee benefits plans that provide health insurance, life insurance, long-term disability insurance, or similar benefits are governed by federal ERISA law; however, plans sponsored by governmental employers and churches are not usually preempted by ERISA. 29 U.S.C. § 1004(b). If ERISA applies, most claims should be filed in federal court (except for claims that are limited to claims for benefits over which state courts have concurrent jurisdiction), and if a plaintiff files a claim that is properly preempted by ERISA, the defendant may remove the claim to federal court without regard to the well-pled complaint rule (29 U.S.C. § 1132(e)); therefore, most ERISA claims are litigated in federal court.

Overview of ERISA Welfare Benefits Claims:

The ERISA statute divides employee benefits into two broad categories: pension benefits and welfare benefits. Long-term disability benefits, as well as other benefits such as health insurance, life insurance, dental insurance, or other similar benefits fall under “ERISA welfare benefits.” If an ERISA plan participant or beneficiary is denied those benefits, the person must go through the ERISA plan’s required appeal procedures. If the claim is still denied, the person can bring an action under ERISA § 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)).

After over 40 years of case law, ERISA welfare benefits litigation, especially claims for long-term disability benefits, 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, and attorneys that file claims for such benefits in state court under breach-of-contract theories run the risk of having the claim dismissed, or, at best, they start out from the beginning not looking like they know what they are doing.

Because ERISA law preempts any state law remedies, a plaintiff may only obtain those remedies available under the ERISA statute and case-law. Usually, this is a remedy to obtain the benefits that should have been paid under the plan, plus maybe attorneys’ fees, and interest. Other remedies, such as punitive damages, made whole damages, bad faith damages or similar remedies are preempted.

ERISA benefits litigation lives in its own world of civil procedure, where ordinary rules of do not apply; in fact, the procedure is more similar to how social security cases are handled in federal court. But there are significant differences between social security cases and ERISA cases as well.

Unlike ordinary civil cases, and more like social security cases, a claimant must first present all evidence to the insurance company and appeal all of the insurance policies internal appeals before filing a suit. Once a suit is filed, a claimant may not submit more evidence to
be considered, and no discovery is permitted regarding the merits of the claim; a court instead reviews only those documents that were before the administrator. Unlike social security cases, there is not even an exception for new and material evidence; however, there may be an exception for information an insurance company of ERISA decision-maker should have obtained.

Unlike social security cases, some discovery may be permitted into any conflict-of-interest by the insurance company or administrator, but the extent of that discovery is often litigated and often limited. Like social security cases, and unlike most civil litigation, most courts hold that no jury trial is available, and typically review the case based on the record and arguments from counsel.

Additionally, when reviewing the limited record, courts usually review the decision under an arbitrary and capricious or abuse of discretion standard of review that is deferential to the decision made by the insurance company. Technically, the rule is that courts should review denials of ERISA benefits de novo, according to the Supreme Court in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), but that same decision held that if the parties agree to a different standard of review, that courts should apply the more deferential standard of review. Id, at 115. And, of course, most ERISA plans and insurance policies contain the deferential standard of review, and that exception has virtually swallowed the default rule.

Unlike social security cases used to be, and now like the new SSA rules, there is no treating physician rule in ERISA claims; rather the terms of the plan apply. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834, (2003). And, unlike social security cases, there are few regulations and rules outside of the plan documents that plans must follow. There is a set of claims regulations under ERISA, at 29 C.F.R. § 2560.503-1, and a few other regulations that apply to ERISA plans, but nowhere near the extensive and comprehensive regulations that apply to social security cases.

Further, even if a plaintiff is successful in convincing a court that the ERISA administrator or insurance company acted arbitrarily, sometimes the only remedy awarded by the court is to send the claim back to the insurance company for another review, which often simply gives the insurance company or administrator an opportunity to write a better denial.

Lastly, in ERISA welfare benefits claims (including LTD claims), if a claimant successfully convinces the court to award benefits, the most the court can award is the back benefits that are due, with a little interest, and, maybe, attorneys’ fees. However, once the case is “won” the best the person can do is be put back on claim, and then the case is back in the hands of the insurance company or administrator to decide if the person is still entitled to benefits going forward.

Some Statistics on ERISA Claims:

An article from just a few years ago in the The ABA Journal of Labor and Employment Law compiled various statistics about ERISA benefits claims. Sean M. Anderson, ERISA Benefits Litigation: An Empirical Picture, 28 ABA Journal Lab. & Emp. Law 1 (2012). This paper studied ERISA benefits litigation from 2006 to 2010, and took a sampling of approximately 13,900 ERISA benefits cases filed during that five-year window.

Among the interesting statics in this paper, slightly less than 70% of ERISA benefits cases were originally filed in federal court, while a little over 30% of cases were originally filed in state court, but were removed to federal court. Id, at 5. Of those that were filed in state court originally, only about 22% plead ERISA, while approximately 78% only plead state law claims.
Mr. Anderson points out that this means that almost a quarter of cases that fell under ERISA were originally filed in state court as non-ERISA cases but were removed. Mr. Anderson surmised that this is because many attorneys were trying to avoid the application of ERISA despite clear law that ERISA would apply. However, based on my own experience, I strongly suspect that, rather than intentionally trying to avoid ERISA, rather, many plaintiffs’ attorneys just do not realize that ERISA applies to these types of claims.

Another interesting observation from this article is that about 75% of ERISA benefits cases settled and the court issued a decision in about 25% of the cases. Of the total cases where the court made a decision, the court denied the claim for benefits about 47% of the time. The court granted the claim for benefits only about 16% of the time, although this number actually includes only 14% where benefits were awarded outright and about 2% where the court ordered a remand with a strong suggestion that benefits be paid. Over 31% of the outcomes resulted in a wide range of outcomes, including, “cases that were remanded to state courts, transferred to other federal courts, dismissed for want of prosecution, voluntarily dismissed without a settlement, and terminated due to the bankruptcy of a party.” Unfortunately, the article does not differentiate the number that were remanded to the administrator for further proceedings. However, from the statistics reported, it does appear that, generally speaking, the court found for the defendant and denied benefits about three times more often than those cases where the court granted benefits outright (47% to 16%).

ERISA Welfare Benefits Procedures Pre-litigation and ERISA Claims Regulations

Before filing a law suit, a claimant must exhaust the available remedies under the plan, so long as the plan’s procedures are reasonable. This typically means that a claimant must apply for benefits in accordance with the plan’s reasonable application procedures. If the claim is denied, the claimant must appeal under the plan’s appeal procedures. Also, if the plan requires it, the claimant can be required to appeal a second time. A claimant is required to “exhaust” his or her administrative remedies before filing an action in court, which usually means timely filing all of the required appeals.

The plan procedures and appeal rights that apply pre-suit in ERISA benefits cases are controlled by the regulations issued by the U.S. Department of Labor, found at 29 C.F.R. § 2560.503-1. These regulations set out certain standards built on the foundation that every plan shall establish and maintain reasonable claims procedures.

Unlike the regulations that apply to social security disability cases, the regulations applicable to ERISA LTD claims are very short and limited. While social security disability regulations fill up a huge portion of a Federal Social Security Laws book many of us use, the regulations applicable to ERISA benefits claims amount to less than 20 pages.

The primary ERISA regulations that apply to LTD claims (and other claims for benefits, such as life insurance, health insurance, dental insurance, etc. issued through work) are found at 29 C.F.R. § 2560.503-1. These regulations were first published in 1977, and have been amended several times. The most important amendments were in the early 2000’ and then most recently in 2016.
While ERISA claims regulations still favor employers and insurance companies in many ways, most attorneys who represent plaintiffs in LTD cases agree that the changes to the ERISA Department of Labor claims regulations in the early 2000’s were a significant improvement over the previous claims regulations. Among the improvements were shortened time frames for insurance companies to make decisions, additional time for employees to appeal claims, and some specific requirements about what useful information must be in ERISA claims decisions.

In late 2016 the Department of Labor issued new amendments to the ERISA claims regulations. While the new amendments were technically “effective” January 18, 2017, most of the new provisions that govern claims for benefits, such as LTD benefits, only apply to claims filed after January 1, 2018.

“New” Regulations Issued in 2001:

Among the changes in the early 2000’s, that apply to claims filed after January 1, 2002, (and that apply to most claims right now), are requirements that, for example, require that 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 2001 claims regulations also establish maximum time limits for an administrator to consider a claim and minimum time for a claimant to appeal. If a claimant does not appeal within the time limits, his claim will likely be denied for failure to exhaust administrative remedies. For a disability claim, the administrator must make a decision within 45 days; however, if the administrator determines that “special circumstances” require an extension of time” the administrator may take two extensions of 30 days each if it notifies the claimant in writing that it needs more time. 29 C.F.R. § 2560.503-1(f)(1) and (3). If the claim is denied, the time given to a claimant to file an appeal must be reasonable, but not less than 180 days. 29 C.F.R. § 2560.503-1(h)(4). After the appeal is made, the administrator must make a decision within 45 days, which can be extended by another 45 days, for a total of 90 days. 29 C.F.R. § 2560.503-1(i)(3)(i).

If the claimant fails to appeal during the time allowed by the plan, his or her claim is most likely over, because the failure to appeal on time will not likely be found to be a failure to exhaust. On the other hand, if the administrator fails to make a decision within the time required, the claimant’s claim is “deemed exhausted” and the claimant may file a complaint in court under ERISA § 502(a)(1)(B).

“New” New Regulations Issued in 2016:

In late 2016 the Department of Labor issued new amendments to the ERISA claims regulations. While the new amendments were technically “effective” January 18, 2017, most of the new provisions that govern claims for benefits, such as LTD benefits, only apply to claims filed after January 1, 2018.

Several new rules will apply to those claims filed after July 1, 2018, such as a rule that is supposed to avoid bias by decision makers and against using biased experts. The new regulations requires that plans must ensure that claims are adjudicated in a way that ensures the “independence and impartiality of the persons involved in making the decision.” New 29 C.F.R.
§ 2560.503-1(b)(7). Under the new rule, “decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.” Id.

The new amendments to section 2560.503-1(g)(1)(vii)(A) (dealing with the required content in benefit determinations letters) have added several requirements that the decision maker must explain the reason for denying a claim. The “adverse benefit determination” must explain the “basis for disagreeing with or not:”

(i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration; Another new requirement is that the notification of an “an adverse benefit . . . shall be provided in a culturally and linguistically appropriate manner.” New 29 C.F.R. § 2560.503-1(g)(1)(viii).

New regulation 29 C.F.R. § 2560.503-1(h)(4)(i) requires that, when the plan obtains or generates new evidence, that evidence must be provided to the claimant “sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided.” Similarly, section 2560.503-1(h)(4)(ii) requires that, if the plan changes rationale, the plan to provide the claimant with the new rationale for the decision to deny benefits, and “the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided.”

Another change in the new regulations will address the confusion regarding contractual periods of limitations. Courts have held that ERISA plans and insurance policies can shorten the statute of limitations. Also, in Heimeshoff v. Hartford Life & Acc. Ins. Co., ___ U.S. ___, 134 S. Ct. 604, 610 (2013) the Supreme Court held that the time to file a suit can run while the administrative process is being exhausted. The Supreme Court explained that, absent a statute to the contrary, “a participant and a plan may agree by contract to a particular limitations period, even one that starts to run before the cause of action accrues, as long as the period is reasonable.” However, this results in a lot of confusion about calculating the resulting deadline to file in court, especially when policies begin to run the time from some ambiguous provision such as “three years from when proof of loss is due;” and, proof of loss is due “90 days after the end of the elimination period.”

Therefore, the new regulations, thankfully, now have a requirement that the adverse determination letter, “shall . . . describe any applicable contractual limitations period that applies to the claimant’s right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.” New 29 C.F.R. § 2560.503-1(j)(4)(ii).
Obligation to Build the Record Before the Final Denial:

In addition to understanding how the ERISA regulations apply to the administrative process, it is also crucial to understand that the record closes when the insurance company or ERISA administrator issues its final decision. Claimants must submit all the evidence they want considered during the administrative appeal process, and may not submit new evidence regarding the merits of their claim once the case is in court.

The reason that courts will not consider new evidence is that most circuits have held that in district court these cases are treated more like a review of an administrative decision. For example, the Court of Appeals for the Sixth Circuit explained in *Wilkins v. Baptist Healthcare Systems, Inc.*, 150 F.3d 609 (6th Cir. 1998) that during judicial review of an ERISA claim for plan benefits the district court’s review is “based on the record before the administrator.” *Id.*, at 617-8. The Court of Appeals held that such cases are neither properly resolved using a bench trial, nor by ordinary summary judgment procedures, but rather by means of judicial review of the record, wherein a district court issues a judgment on the record, considering the evidence before the decision-maker, the ERISA documents, and counsel’s arguments.

In other words, the basic rule is that the record closes when the insurance company makes its final denial, and it is almost always impossible to get in new evidence to the court that was not sent to the insurance company before they denied the claim. Most circuits agree with this rule; however, in the Fifth Circuit, the rule is that the court should consider all the evidence submitted to the administrator or insurance company at any time prior to filing the complain. *Vega v. National Life Insurance Services*, 188 F.3d 287, 300 (5th Cir.1999).

ERISA Welfare Benefits Litigation Procedures

Once a claim has been denied by the ERISA administrator or insurance company, or is deemed exhausted, a plaintiff may sue in Federal Court under ERISA § 502(a)(1)(B).

Standard of Review

A plan participant or beneficiary is entitled to seek judicial review if a plan fails to pay plan benefits. 29 U.S.C. § 1132(a)(1)(B). However, that judicial review is not treated as a fair fight between two private litigants, as it arguably should be. Instead, as discussed above, in a Supreme Court decision from 1989, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. at 115, the Court reasoned that the employer and ERISA administrator could agree on a more deferential standard of review.

In *Firestone Tire*, the Court reasoned that the default standard of review for ERISA benefits cases should be *de novo*; but, because plan administrators are the equivalent of “trustees” or otherwise can act in a fiduciary capacity, the *de novo* standard does not apply if the “plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” *Id.*, at 115.

In reality, this has become the exception that has swallowed the rule. Very quickly after *Firestone Tire* was decided, ERISA administrators and insurance companies amended policies and other ERISA plan documents to include language granting discretion to the administrator; now almost every plan claims that its decisions should be reviewed under the arbitrary and capricious standard of review.
However, even though many, and perhaps most, plans’ decisions are now reviewed under an “arbitrary and capricious” or “abuse of discretion” standard of review, the Supreme Court recently held in Metropolitan Life Ins. Co. v. Glenn, 128 S.Ct. 2343 (2008) that when courts consider cases where the ERISA decision-maker also has a financial interest in the case, such as when an insurance company both makes a decision and would pay any benefits due out of its own funds, that this creates a conflict of interest. The Supreme Court explained that courts should consider the “dual role” of an entity as an ERISA plan administrator and payer of plan benefits as a factor in determining whether the plan administrator has abused its discretion in denying benefits, with the significance of the factor depending upon the circumstances of the particular case. Following Glenn, more courts are allowing discovery into the conflict of interest.

Further, as discussed above, some states now ban such discretionary clauses, and some courts have held that those bans are laws regulating insurance that are not preempted by ERISA under the savings clause. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

However, just because a state has banned discretionary clauses, that is not the end of the discussion. As addressed above, such a clause must apply only to insurance policies, otherwise it does not fit in the savings clause. This also means that such clauses cannot apply if LTD benefits are provided under self-funded ERISA plans where benefits are not provided through insurance policies.

Further, sometimes the rule banning discretionary clauses may only apply to new policies issued after the date of the rule. Also, such clauses may only apply to policies issued in a given state, and often policies are issued on one state may cover a client in a different state, especially where an employer is large enough to have employees in more than one state. On the other hand, some states have issued the ban to apply to residents of that state, no matter where the policy was issued.

Examples of cases that discuss such bans include Am. Council of Life Insurers v. Ross, 558 F.3d 600 (6th Cir. 2009), where a group representing various insurance companies filed a declaratory action seeking to have the Michigan ban on discretionary clauses to be found invalid. Michigan’s regulation “prohibit[s] insurers and nonprofit health-care corporations from issuing, advertising, or delivering to any person in Michigan, a policy, contract, rider, indorsement, certificate, or similar contract document that contains a discretionary clause and provide that any such clause is void and of no effect.” Id, at 602. The Court of Appeals for the Sixth Circuit found that the Michigan was a law regulating insurance, such that is survived ERISA preemption under the savings clause. Id., at 604-607. The rule also did not create an additional state law “remedy,” such that it would still be preempted despite the savings clause. Id., at 607-609.

The Illinois Department of Insurance issued a similar regulation banning discretionary clauses. The Illinois Regulation provides:

No policy, contract, certificate, endorsement, rider, application or agreement offered or issued in this State, by a health carrier, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or of disability may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are consistent with the laws of this State.
Novak v. Life Ins. Co. of N. Am., 956 F. Supp. 2d 900, 905 (N.D. Ill. 2013), citing 50 Ill. Adm. Code tit. § 2001.3. The court went on to explain that the regulation set out its purpose, which was to:

prohibit all such policies from containing language reserving sole discretion to interpret policy provisions with the insurer. The legal effect of discretionary clauses is to change the standard for judicial review of benefit determinations from one of reasonableness to arbitrary and capricious. By prohibiting such clauses, the amendments aid the consumer by ensuring that benefit determinations are made under the reasonableness standard.

Id., at 905-906. Despite such a ban, the Defendants in Novak argued that the court should still apply a deferential standard of review, because the wrap-around master ERISA plan document granted discretion, not the insurance policy. Id., at 906. The court rejected that argument by finding that insurance companies could not avoid the Illinois regulation by entering into a separate agreement outside the insurance policy. Id. The court also decided that the Illinois regulation was a law regulating insurance, and was not preempted by ERISA. Id., 906-909.

In Standard Ins. Co. v. Morrison, 584 F.3d 837 (9th Cir. 2009), an insurance company challenged the Montana Commissioner of Insurance’s practice of disapproving policies containing discretion under a broader Montana law that “requires its commissioner of insurance to “disapprove any [insurance] form . . . if the form . . . contains . . . any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract. . . .” Id., at 840. Even though the Montana law did not specifically prohibit discretionary clauses, the Court of Appeals for the Ninth Circuit found that the practice by the Montana Commissioner of insurance was a law regulating insurance, and was not preempted by ERISA. Id., at 842-845.

California has also issued a ban on discretionary clauses, and that ban applies to policies issued in California and in other states that cover California residents. Cal Ins Code § 10110.6(a). The California rule applies to both new policies and when policies are renewed, and policies are deemed to renew each year on the policies anniversary date. Cal Ins Code § 10110.6(b). Because every policy is deemed to renew on its anniversary, when each policy renews any provision purporting to grant discretion became “void and unenforceable.” See, e.g. Polnicky v. Liberty Life Assur. Co., 999 F. Supp. 2d 1144, 1148 (N.D. Cal. 2013). Because the discretionary ban in California was effective January 1, 2012, all policies should have renewed so that no California resident should be covered under a policy with a discretionary clause.

However, not all bans have been upheld. For example, in Hancock v. Metro. Life Ins. Co., 590 F. 3d 1141 (10th Cir. 2009), the court found that Utah’s ban on discretionary clauses was preempted by ERISA. Weirdly, the Utah statute banning discretionary clauses exempted from the ban policies subject to ERISA, and only required ERISA policies to “disclose certain matters and conform with the rule’s font requirement. See Rule 590-218-5(3), (4).” Hancock, 590 F. 3d at 1149. The court reasoned that the Utah rule “relates to the form, not the substance, of ERISA plans; it has no impact on risk pooling and fails to satisfy” the second prong of the test of laws regulating insurance. Id. The Court of Appeals clarified that, “If Rule 590-218 imposed a blanket prohibition on the use of discretion-granting clauses, we would have a different case.” Id.

New Jersey’s regulation on discretionary clauses was passed in 2007 and made effective January 1, 2008. It states:

Discretionary clauses prohibited:

No individual or group health insurance policy or contract, individual or group life insurance policy or contract, individual or group long-term care insurance policy or contract, or annuity contract, delivered or issued for delivery in this State may contain a provision purporting to reserve sole discretion to the carrier to interpret the terms of the policy or contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State. A carrier may include a provision stating that the carrier has the discretion to make an initial interpretation as to the terms of the policy or contract, but that such interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction.

N.J.A.C. 11:4-58.3. The Plaintiff in *Baker* argued that this language, by prohibiting “sole discretion” to a carrier, means that the *de novo* standard of review should be used. The district court in *Baker* first acknowledged that under Supreme Court precedent, that *de novo* review is the default rule in ERISA cases. *Citing, Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115, (1989) (“a denial of benefits under ERISA is to be reviewed ‘under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.’ ”) *Baker*, 2010 U.S. Dist. LEXIS 52724, at 24.

Despite acknowledging that the *de novo* standard of review would be the default rule, the first reason the district court in *Baker* gave for rejecting Plaintiff’s argument was,

First, nothing in the text of § 11:4-58.3 states that it mandates application of a *de novo* standard of review. Rather, according to the Third Circuit, the text simply declares that certain “discretionary clauses are void as contrary to public policy….” *Evans v. Employee Benefit Plan, Camp Dresser & McKee, Inc.*, 311 Fed.Appx. 556, 560 (3d Cir. 2009). Plaintiff’s argument appears to be that the statute implicitly authorizes a *de novo* standard of review, but she has pointed to nothing in the text nor any case law to support such an interpretation.

*Baker*, at 29. This reasoning by the district court in *Baker* is difficult to understand. It is true that the New Jersey regulation does not explicitly state that the *de novo* rule would apply, but it does state that the clause granting discretion is prohibited. If such a clause is ineffective, then
the court should have applied the default rule from *Bruch*, that without a proper grant of discretion the court should review claims *de novo*. Since that is the default rule, there should be no requirement that the state regulation specifically set that the review be *de novo*, yet that is part of the rationale from the district court.

The district court in *Baker*'s second reason for refusing to apply the New Jersey regulation is similarly confusing. The court in *Baker* explained,

Second, because ERISA explicitly [*30] grants claimants the right to judicial review, delegations under ERISA do not actually reserve sole discretion to the carrier in the manner Plaintiff suggests. While the Plan here grants Hartford sole discretionary authority, n7 its statement of “YOUR RIGHTS UNDER ERISA” acknowledges that the exercise of Hartford’s discretion may be challenged in a court of law. AR at HLI00025 (“If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court.”). The inclusion of this language in the Plan is significant because N.J.A.C. § 11:4-58.3 permits carriers to “include a provision stating that the carrier has the discretion to make an initial interpretation . . . but that such interpretation can be reversed by . . . a court of law. . . .” Thus, by incorporating the ERISA’s rights language, the Plan comports with the statute.

*Baker*, at 29-30. It is true that the plan allowed for judicial review of its decision, which is required by both the New Jersey regulation and under ERISA § 502(a)(1)(B), this rationale does not explain why, if the New Jersey regulation bans the grant of discretion, and allows judicial review (as does ERISA), why that also means that the review by a court should still give deference to the insurance company, rather than applying the default rule from *Bruch*. The question is what standard of review the court should apply, and if the discretionary clause is invalid, why the court should still defer to the insurance company? The fact that judicial review still takes place should only result in the court then applying the default rule.

The third rationale provided by the court in *Baker* does make more sense. The court stated, “Third, it is questionable whether the statute applies at all, given that its effective date (January 1, 2008) was after Plaintiff filed her initial application for benefits on August 12, 2007.” *Id.*, at 30. However, under this reasoning, future cases, where the plaintiff files an application after January 1, 2008, then presumably the New Jersey regulation should apply.

The last rationale by the court in *Baker* is also troublesome. The court explained:

Most importantly, if I were to adopt Plaintiff’s interpretation and application of § 11:4-58.3, so as to void the Plan’s grant of sole discretion to Hartford, the regulation would face an ERISA preemption attack. “[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004) (citation omitted). Plaintiff’s construction of section 11:4-58.3 would in effect change the standard of review of every civil enforcement action under ERISA within the state of New Jersey whenever the plan
in question grants discretionary authority to the plan administrator. This would
directly violate the purpose of ERISA “to provide a uniform regulatory regime
over employee benefit plans.” Id. at 208. Moreover, the Supreme Court’s recent
decision in Glenn, addressing the same conflict-of-interest concern underlying
the New Jersey regulation, expressly set forth the applicable standard of review
under ERISA. As district courts are obliged to “dispose of cases on the narrowest
possible ground, which in this case is the state-law ground,” as opposed to fed-
eral pre-emption grounds, see New Jersey Payphone Ass’n, Inc. v. Town of West
New York, 299 F.3d 235, 249 (3d Cir. 2002), I reject Plaintiff’s interpretation of
the New Jersey regulation and review the case under the traditional arbitrary and
capricious standard.

Id., at 31-32. One big problem with this reasoning by the district court is that it completely
ignores the ERISA savings clause. While it is true that ERISA preempts most state laws (“[ERISA]
shall supersede any and all State laws insofar as they may now or hereafter relate to any employee
benefit plan. . . .” ERISA § 514(a), 29 U.S.C. § 1144(a)), it is also true that ERISA contains a “sav-
ings clause” that provides that some state laws are not preempted: “nothing in this subchapter
shall be construed to exempt or relieve any person from any law of any State which regulates
insurance, banking, or securities.” ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Because the
New Jersey regulation affects only those policies that purport to grant discretion to insurance
companies, this regulation appears to fit squarely into the savings clause, yet the court did not
discuss that at all. Further, the court says that such an interpretation would frustrate the purposes
of ERISA, yet fails to acknowledge that, a) the Supreme Court in Bruch has held that de novo
review is the default rule in ERISA cases, which this regulation is consistent with; and, b) while
the purpose of ERISA is “to provide a uniform regulatory regime over” ERISA plans, nothing in
ERISA mandates a standard of review, much less the deferential standard of review. Lastly, the
court hangs its hat on the assumption that the arbitrary and capricious standard of review is the
“traditional” standard, when, again, Bruch holds that the default standard is de novo, absent a
proper grant of discretion.

Despite this questionable analysis by the district court, the Court of Appeals for the third
circuit offered almost no analysis of the district court’s holding on the applicability of the New
Jersey regulation. In fact, the entire discussion by the Court of Appeals is as follows:

a different standard of review. There are a variety of reasons why this is not so. Most
importantly (and as discussed by the District Court), an employee may challenge
a claim determination in federal court. Thus, the Plan does not, as Baker suggests,
reserve “sole discretion to the carrier.” See N.J. Admin. Code § 11:4-58.3 (stating
that a group health insurance policy may not contain a provision “purporting to
reserve sole discretion to the carrier to interpret the terms of the policy or contract”).

no sense. Judicial review is always allowed in ERISA cases, and no plan would comply with ERISA
that attempted to preclude such review. See, e.g. ERISA § 502(a)(1)(B) and 29 C.F.R. 2560.503-1(l).
Again, the question is what standard of review the court should apply, and since the default rule is *de novo* under *Bruch*, and courts should only apply deference where there is a valid grant of discretion, and the New Jersey statute bans attempts by insurance companies to retain such discretion, this reasoning by the Court of Appeals does not offer a very satisfactory rationale.

The best explanation for the decision by the district court and Court of Appeal for the Third circuit is two-fold. First, it appears that the courts here have a mind-set that ERISA calls for a discretionary standard of review, and struggle with understanding the history of ERISA law that establishes when a discretionary standard of review is *not* the default rule, and should be applied only where there is a valid grant of discretion. Further, the New Jersey regulation is not written very well to accomplish its purpose of banning discretionary clauses in a way that is easy for courts to understand.

The bottom line is that if your client lives in a state with such a ban, or had the policy issued in such a state, you should research whether the ban can be used to argue that your client's claim is decided under a *de novo* standard of review. In most states, federal courts have upheld the ban, but some courts have not.

**Financial 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. These can vary from plan to plan, so attorneys should 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. If a person's Social Security PIA is $1100 a month, the LTD case is only worth $400. If the disabled person's dependants receive another $550 per month, the LTD benefits will be reduced down to nothing or to some nominal minimum.

On the other hand, people who had relatively high incomes prior to becoming disabled may have net LTD benefits, after the Social Security offset, that are as much or more than the Social Security benefits.

**A Favorable Social Security Decision Can Be Important Evidence in the LTD Case:**

Because most LTD plans allow the LTD benefits to be reduced by the amount of Social Security benefits paid, most ERISA LTD plans require claimants to file claims for Social Security Disability. A question that frequently comes up in ERISA LTD cases is, if the Plaintiff is found disabled by the Social Security Administration, how much weight should the disability insurance company give to that finding of disability.
The short answer is that an LTD insurer or administrator is usually not bound by the decision of the Social Security Administration, but it is evidence they must consider. Further, the more the LTD insurer benefits from the offset, and encourages the person to apply for LTD, the more weight the insurer should give to the Social Security decision.

The treatment of Social Security decisions by the circuits vary some, but generally, courts are critical if the LTD insurer does not take it into account. For example, there are several cases in the Sixth Circuit that show the SSA decision is important. In Darland v. Fortis Benefits Insurance Company, 317 F.3d 516 (6th Cir. 2003), the Court of Appeals found that Fortis’ decision to deny benefits was arbitrary and capricious on several grounds, including holding that where an insurance company requires a claimant to apply for Social Security benefits, and reaps the benefit of a favorable Social Security decision which reduces the amount of benefits that the insurance company must pay out of its own funds. Id, at 530. See, also, Calvert v. Firstar Finance, Inc., 409 F.3d 286, 294-5 (6th Cir., 2005), (“SSA’s disability determination does not, standing alone, require the conclusion that Liberty’s denial of benefits was arbitrary and capricious. The SSA determination to award benefits to Calvert is, instead, just one factor the Court should consider, in the context of the record as a whole, in determining whether Liberty’s contrary decision was arbitrary and capricious.”)

Further, where an insurance company actually assists the claimant in her claim for Social Security benefits, and benefits financially from the decision, the insurer’s failure “to consider the Social Security Administration’s finding of disability in reaching its own determination of disability does not render the decision arbitrary per se, but it is obviously a significant factor to be considered upon review. Glenn v. MetLife, 461 F.3d 660, 669 (6th Cir. 2006).

More recently, the Court of Appeals for the Sixth Circuit explained in, DeLisle v. Sun Life Assur. Co of Canada, 2009 FED App. 0082P (6th Cir. March 4, 2009), that while a Social Security award does not automatically mean the claimant is entitled to benefits under a private disability plan, the court cited Bennett v. Kemper Nat’l Servs., 514 F.3d 547, 554 (6th Cir. 2008) for the proposition that “[i]f the plan administrator (1) encourages the applicant to apply for Social Security disability payments; (2) financially benefits from the applicant’s receipt of Social Security; and then (3) fails to explain why it is taking a position different from the Social Security Administration on the question of disability, the reviewing court should weigh this in favor of a finding that the decision was arbitrary and capricious.” DeLisle, 2009 FED App. 0082P at 5-6.

**Common Issues That a Social Security Representative Who Are Not Handling the LTD Case Should Be Aware of:**

If you regularly represent clients in Social Security disability claims, but do not regularly help your clients with LTD issues, there are several issues that you should be concerned about. Even though you may not be representing a client in an LTD claim, what you do on the Social Security case could have a significant affect on the ability of your client to win or keep LTD benefits.

1. **Ask If Your Client Has LTD Coverage.**

   Surprisingly, some attorneys don’t even ask their clients if they are receiving long-term disability benefits, or if they have such a policy and need to apply, or if they have been denied.
If your clients have not applied for LTD, you should usually encourage them to do so. While there are offsets between Social Security and LTD, there are many advantages to a person applying for both types of benefits. Often, if the LTD claim is successful, those benefits come through much faster than many Social Security cases. Also, even though LTD benefits typically are offset for Social Security benefits, the LTD benefits do not offset for Social Security COLA's, and usually do not offset for Social Security attorneys fees. Additionally, because many disabled people are in difficult financial situations, applying for both Social Security benefits and LTD benefits gives them two chances to get some income coming in. Also, in some, but not all, cases, employers provide certain collateral benefits to employees who are found disabled under a company LTD plan, such as continued health insurance, pension contributions, etc.

There are time limits that may limit a person’s ability to apply for LTD benefits, so if they are not thinking about applying, you can encourage them to do so. Also, sometimes our clients misunderstand, and think they have to win their Social Security cases before they can apply for LTD; this is almost never the case, and you can point that out to them.

If they have already applied for LTD and are receiving it, you should be aware of that, so that your representation in the Social Security case does not adversely affect the Social Security case, for one of the reasons I will explain below. Also, if your client is receiving LTD benefits, they may be mad at you when the LTD company wants a repayment when the person wins SSA benefits, if you don’t explain to the person up front what may happen.

If your client is denied LTD benefits, and you are not going to help them appeal that denial, you are still in a crucial position, because you can advise them about the importance of seeing an experienced LTD attorney as soon as possible, before they take any other action that might jeopardize the LTD claim.

2. Understand How Amending the Social Security Onset Can Affect Your Client’s LTD Claim.

Even though a favorable Social Security decision is not binding on the LTD insurance company, a favorable decision is evidence that the LTD insurance company should consider. While it is very common for an LTD insurance company to deny the claim of someone who has been found disabled by the Social Security Administration, it is also common for LTD insurance companies to look for any ammunition they can find in a Social Security decision to support the denial of a claim.

One common argument LTD insurance companies use to deny a claim is when the person’s Social Security onset date does not match the date the person stopped work for the employer that provided LTD coverage.

LTD coverage is different from the concept of insured status for Social Security claims. In Social Security cases, a person can be covered under Title II of the Social Security Act for insured benefits if he or she becomes disabled whenever they have worked enough to earn credits for 20 out of the last 40 quarters; if the person works steady, they are covered for five years after they stop working. Because of that rule, if a claimant is found disabled under the Social Security Act a year or two after they stop working, it is usually no big deal, they still get paid “insured” benefits.
However, most LTD policies only provide coverage while a person is working. The coverage usually ends the last day they work, or the first day after they stop working. Thus, in order to win LTD benefits, an LTD claimant must prove that he or she became disabled at the time he or she stopped working.

When the claimant amends his or her onset in a Social Security disability case to some date after he or she stopped working, this becomes ammunition for the LTD insurance company to argue that the person admitted he or she was not disabled until after LTD coverage ended.


LTD insurance companies look for any ammunition they can use to deny benefits, or to limit the benefits that are paid. Almost all LTD policies limit benefits if a disability is “caused or contributed to” by a mental or nervous disorder; typically that limit is 24 months, but it can vary. Also, the language varies; sometimes the person can still be paid ongoing LTD benefits if he or she is disabled independently for a physical reason, while other policies allow the insurance company to argue that if mental impairments contribute even a small portion of limitations that make the person disabled, then the 24 month limit can apply. This is a frequent area of ERISA litigation.

Because of this common clause, if you are helping your client with a Social Security case, and you know the client is also receiving or applying for LTD benefits, you should be aware that overemphasizing mental limitations can help the insurance company limit benefits.

I also represent clients in Social Security cases, and I understand that it is our job as Social Security attorneys to zealously represent our clients and do the most we ethically can to help them win their benefits. But, I have also experienced cases where the Social Security decision-maker focuses on mental limitations as the easiest way to pay a claim.

My advice is to keep this issue in mind when you client has both an LTD case and Social Security disability case. If you are fortunate enough to have a sympathetic ALJ, maybe you can explain this problem to the judge, so the judge can understand how important basing the decision on physical limitations can be. In any case, you should try your best to emphasize your client’s physical limitations.

4. Be Aware How the LTD/Social Security Offset Works, So Your Clients Are Not Mad at You If They Are Told They Have to Repay All of Their Social Security Benefits.

If your client has been receiving LTD benefits, the LTD insurance company will usually want to offset its payments for any Social Security benefits your client is paid, and will even want your client to pay back LTD benefits for past months, based on the amount the LTD insurance company will claim is “overpaid” once your client receives Social Security benefits.

Even if you are not representing your client in the LTD case, your client still might be calling you to ask some tough questions about whether he or she has to pay the LTD company back, and if he or she does, then why did he or she pursue the Social Security case in the first place.

If you are aware that your client is receiving LTD benefits, you can have a conversation with your client early on to explain how this will work, so they are not mad or surprised later on.
Your advice can be very helpful to your client. For example, it is very common for LTD insurance companies to ask for all of your clients’ back social security money once it is received, but if you or your client asks, the insurance company will often agree not to try to recover the amount your client paid in Social Security attorneys’ fees, or expenses related to the Social Security case.

Additionally, there are some arguments that can be made that your client does not have to pay the money back at all. For example, the LTD insurance company can only collect from your client if the ERISA plan or insurance policy expressly allows them to do so, because an ERISA administrator’s only cause of action is to enforce the terms of the plan under ERISA § 502(a)(3) (29 U.S.C. § 1132(a)(3)). Also, there are arguments that your client cannot be forced to hand over Social Security benefits under 42 U.S.C. § 407.13

5. Work with the LTD Attorney If Your Client Is Denied LTD Benefits.

If your client is denied LTD benefits, and you are not going to represent your client in that case, the best advice you can give your client is to talk to an LTD attorney as soon as possible. Because courts almost never allow new evidence to be submitted after the insurance company denies the claim on appeal, the most help an LTD attorney can give your client is during the appeals process before the insurance company.

Unless you are very comfortable appealing and litigating ERISA LTD cases, you should be very careful before giving the client advice or “helping out” a little by working on the case just enough to be involved without helping with your client’s full appeal. For example, one of the worst things an inexperienced attorney will do is to send in an appeal letter to the insurance company asking them to change their mind, with little or no supporting evidence. Filing that appeal letter gives the insurance company permission to conduct their review and issue their next denial, which often ends the appeal process. Once the appeal process ends, the record closes. But, because the appeal is not well-supported with evidence, the record may not be adequate to take to court later on. Do not appeal for your client unless you are willing to learn all the ins-and-outs of LTD work and are willing to work up the file and submit a full stack of medical records, opinions of restrictions and limitations, and other evidence of disability. But, at the same time, do not let your client miss an appeal deadline, because that can also be a reason that the client loses the case and has not right to appeal later, or ever take it to court.

You can also be very helpful to your client if you share your records and development with the LTD attorney, and ask the LTD attorney to do the same for you. Typically, much of the development you do for the Social Security case will be helpful in the LTD case, and vice-versa. If you obtain a good RFC or medical opinion form, share it with the LTD attorney. Conversely, ask the LTD attorney to share with you any good reports, letters, or sworn statements he or she obtains.

Also, it really helps if you can find out your client’s Social Security PIA and auxiliary benefits amount (if any) as soon as possible. Not only will this help you understand how much your client is fighting for in the Social Security case, but it also allows the LTD attorney to determine how much the net LTD benefits will be after the Social Security offset. Unfortunately, many LTD cases are reduced so far, that there is no practical way an attorney can afford to help with the LTD case.
If You Are Thinking About Helping Your Client Appeal an LTD Denial, There Are Many Common Mistakes You Must Not Make.

If you are helping a client with a Social Security case, and also decide to help with an LTD case, you should consider my advice above about issues the Social Security attorney should be aware of. However, once you agree to represent your client in the LTD case, there is much more you need to know and be aware of.

Representing clients in LTD cases can be rewarding and fulfilling, but there are many rules and issues you need to learn before you can do a good job for your client. The following list is just a small part of what you will need to learn to do a good job for your LTD clients.


Unfortunately, when we screen cases, one of the first things I have to find out is how much the person’s Social Security disability benefits are, including any dependants/auxiliary benefits, and whether the client has any other income such as workers’ compensation benefits or pension benefits that offset the LTD benefits. Because those other benefits are so common, it is also common that the LTD benefits are not large enough after offsets to be meaningful.

If you are working on the Social Security case, find out the PIA right away. If you are only handling the LTD case, find out from the Social Security attorney the PIA and auxiliary benefits. Very carefully interview your client to determine if there are any other benefits being paid.

If the other benefits are too large, and the net LTD benefits too small, you will have to think very hard about taking on the obligations and expense of the LTD case. The reality is, that there are many cases where the person has very serious disabilities, but the LTD case is almost worthless, because the offsets are too great.

If you determine the person’s benefits are enough to make the case potentially worthwhile, you also need to be very careful in your case selection. Our experience is that LTD cases are typically harder to win than Social Security cases, and the litigation against the insurance company is much more adversarial than what we experience in Social Security cases.

The bottom line is that there are some LTD cases that are very good to work on, and can be very rewarding, but there are also very many that you probably cannot justify working on.

2. Get the Plan Documents Early and Read Them Carefully.

Unlike Social Security cases, each LTD policy or ERISA plan, has different rules. The definition of disability may be “own occupation” or “any occupation.” Some policies will pay benefits for “own occupation” for 24 months, others for only 12. Some policies exclude disabilities based on “self-reported symptoms” or limit such benefits to 24 months. There are many other variations in terms of appeal procedures, numbers of appeals required, and other differences from policy to policy and plan to plan.

Fortunately, one of the good rules under ERISA is that ERISA Plan administrators must provide a copy of plan documents when your client requests them in writing (or if you request them on behalf of your client). ERISA § 502(c), 29 U.S.C. § 1132(c) provides for penalties for an administrator’s refusal to supply required information. Under that section of ERISA,
(1) Any administrator [who fails to provide certain information]14... (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 $10015 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 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.”

As a matter of technical ERISA rules, courts have read the provisions above to only apply to written requests to ERISA “Plan Administrators.” The “Plan Administrator” is usually not the insurance company, but is whoever is named in the plan as the administrator. Often that is the employer. Also, under ERISA, if no one is named, ERISA deems the plan sponsor (i.e. employer) to be the Plan Administrator. Therefore, if you do not have a copy of the policy or plan, the best thing to do is to write a letter on behalf of your client to his or her employer, addressed to the attention of the “Plan Administrator of the Long-Term Disability Plan.” It is best to send the letter certified, so you can prove it was received.

If the plan administrator does not provide the plan documents within 30 days, we usually write and ask again until we get the documents. If the documents are not provided within 30 days, you can seek a penalty on behalf of your client for up to $110 per day. As a matter of technical pleading, if the Plan Administrator fails to provide the documents within 30 days, in violation of ERISA § 502(c), “a civil action may be brought (1) by a participant or beneficiary (A) for relief provided for in subsection (c) of this section.” In other words, you filed a cause of action under ERISA § 502(a)(1)(A), alleging the Plan Administrator violated ERISA § 502(c).16

3. Know the Statute of Limitations, But 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.

Attorneys who are new to ERISA benefits claims often ask me, “So what is the statute of limitations for this claim?” The short answer is that there is not one in the ERISA statute, but the longer answer is much more complicated, because courts will apply limitations of time found in ERISA plans, or if there is no such provision, will look to state law to create a statute of limitations(“SOL”).
When an employee or former employee is denied benefits under an ERISA plan, the employee’s cause of action is brought under ERISA § 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)). The ERISA statute does not contain a specific statute of limitations for those claims. When a federal statute does not have a statute of limitations, courts have stated that federal courts should look to the most analogous state law statute of limitations for the analogous claim. See, e.g. DelCostello v. Teamsters, 462 U.S. 151, 158-160 (1983) (applying an analogous state law statute of limitation to an NLRB action where the federal statute contained none.) Courts have applied this to ERISA benefits claims, and have usually applied the statute of limitations for a state breach of contract action. See, e.g., Meade v. Pension Appeals and Review Committee, 966 F.2d 190, 194 -195 (6th Cir. 1992) (applying the 15 year Ohio statute of limitations for breach of contract under Ohio Revised Code § 2305.06 to an ERISA claim).

However, applying the state law statute of limitations for breach of contract is not always the correct answer; courts have held that where a more specific analogous law applies that has a shorter statute of limitations, that shorter statute may apply, such as the statute for employment disputes. See, e.g. Syed v. Hercules Inc., 214 F.3d 155, 159, 161 (3d Cir. 2000) (applying a one-year SOL, rather than the three year SOL under Delaware law); see also, Adamson v. Armco, Inc., 44 F.3d 650, 653 (8th Cir.1995) (applying Minnesota’s two year SOL for an action for recovery of wages, rather than the six-year SOL for breach of contract); and Redmon v. Sud-Chemie Inc. Retirement Plan for Union Employees, 547 F.3d 531, 535-6 (6th Cir. 2008) (applying the Kentucky five-year statute of limitations for “an action upon liability created by a state statute” rather than the fifteen year SOL for breach of contract.)

But, and this is a very big “but,” in many cases, the time period for bringing a claim may be even shorter than the state law statute of limitations. Courts have held that when the ERISA plan at question, or an insurance policy that provides an ERISA plan benefits, provides for a shorter period of limitations, that shorter period will apply. As the court in Massengill v. Shenandoah Life Ins. Co., 459 F. Supp. 2d 656, 660 (W.D. Tenn. 2006), explained, “Courts have also recognized that in the ERISA context, as with other types of contractual arrangements, the parties may agree upon a shorter limitations period, so long as the period is not unreasonably short.” See, also Wilkins v. Hartford Life & Accident Ins. Co., 299 F.3d 945, 948 (8th Cir.2002); Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan, 160 F.3d 1301, 1303-04 (11th Cir.1998); and Doe v. Blue Cross & Blue Shield United of Wis., 112 F.3d 869, 873-74 (7th Cir.1997).

When benefits are provided under an insurance policy, the policies typically contain language such as, “a claimant cannot start any legal action earlier than 60 days after proof of loss is provided nor more than three years after the time proof of claim is required.” This type of language is very common, and is required in many states in order to have a contract approved by the state department of insurance. Typically, plans require proof of loss to be filed within 90 days after the end of an elimination period. If the elimination period is 180 days, then the Plaintiff has three years and 270 days to file a claim. See, e.g., Rice v. Jefferson Pilot Financial Ins. Co., 578 F.3d 450, 456 (6th Cir. 2009). Of course, these deadlines may be different, depending on the policy, so it is imperative for an attorney to obtain the actual policy as soon as possible.

However, attorneys need to be even more careful when ERISA benefits are provided through self-funded plans, where state insurance laws do not apply. When ERISA benefits are not provided through an insurance policy, the Plan is free to place any limitation on actions, so long as the
time is “reasonable;” a limitations period as short as 90 days has been held to be reasonable. Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan, 160 F.3d 1301, 1304 (11th Cir. 1998).

One more confusing issue arises in ERISA plans, because it is not always clear when the clock for the statute of limitations or the contractual period of limitations begins to run. Under ERISA, claimants are normally required to exhaust administrative remedies before they can bring an action. While some courts have held that the contractual period of limitations should not begin to run until the plaintiff has the right to file suit after administrative remedies are exhausted, other courts have held that the contractual period of limitations runs in accordance with the terms of the plan or policy, see, e.g. Rice, supra, so that when administrative remedies are exhausted, the plaintiff may have much less than three years to start a suit. These conflicting cases were resolved in by the Supreme Court in Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 616 (U.S. 2013), holding that contractual limitations in an ERISA plan are enforceable. The Court did explain that where the conduct of the administrator precludes filing before the contractual period of limitations, courts may allow for equitable tolling, Id, at 615-6, but where there is a reasonable time to file suit after administrative remedies are exhausted, the plan language would be enforced.

The bottom line is that attorneys who are helping clients who have been denied ERISA benefits need to obtain a copy of the ERISA plan from the Plan Administrator very early in the process, calculate the time period under the plan, and be sure to file at the earliest possible time. Because the rules for administrative exhaustion and the limitations on time to file suit in ERISA cases are so harsh, attorneys should learn these rules early on in order to best represent clients with ERISA claims.

4. Do Not Assume You Can Add More Evidence Later; Submit All Your Evidence Early to Ensure It Will Be Before the Court.

Just like the importance of “location” in real estate, my opinion is that the three most important things to know about LTD litigation is: closed record, closed record, closed record.

The record closes when the insurance company issues its final denial. Courts will not allow you to submit new evidence of disability once the case is in court. The biggest mistake attorneys make is not understanding this rule. Your only chance to put on proof to help your client win an LTD case is during the time the insurance company is administratively considering the claim.

The good news is that there are no rules of evidence or restrictions on what you can submit when the record is open. You can submit medical records, opinions, RFC forms, letters, videos, sworn statements, and many other types of evidence.

The bad news is that attorneys who do not regularly handle these claims often just don’t seem to get the importance of this stage. I cannot tell you how many times an attorney has tried to refer a case to me after the attorney has filed an appeal letter, supported by some medical records, and not much else. By the time the insurance company denied the appeal, it is too late to add more evidence and really address the best arguments in the case.
5. **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.**

Attorneys who normally handle personal injury cases and other types of litigation often don’t understand this rule, but those of us who regularly handle Social Security disability cases understand why this is important.

In order to best present your clients’ cases to LTD insurance companies, and have the best arguments later in court, you need to not only present the insurance company with your client’s medical records, but also with opinions of restrictions and limitations.

Also, you need to provide evidence that the restrictions and limitations actually preclude work or cause a disability under the terms of the policy. Unlike Social Security cases, you will not have an independent vocational expert available to testify at a hearing. Therefore, in order to prove your clients’ restrictions and limitations actually preclude work, you should consider hiring a vocational expert to provide an opinion. Further, unlike Social Security cases, there are no grid rules to help your older clients. You often need vocational evidence of total disability, even when your client would be disabled under the grids.

Also, remember that, unlike Social Security cases, there is no treating physician rule in ERISA claims; rather the terms of the plan apply. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834, 123 S.Ct. 1965, 1972, (2003). So, when you develop the medical evidence, you need to consider all the ways you can shore up the opinions you have, so you can explain why they are more reliable than the opinions of the doctors hired by the insurance company.

6. **Do Not Rely on the Forms Provided to Your Client’s Physicians by the Insurance Company.**

As Social Security attorneys, we are used to forms created by DDS or SSA that don’t define “marked” or only give the treating doctor limited choices to check boxes to show the person is disabled. In LTD cases, the insurance companies’ forms are often much worse.

For example, I know of one company that regularly issues policies that require people to show they are disabled from all occupations, yet they send out forms to the treating doctors that simply ask the doctor to check the range of work the person can perform. The choices are “Very Heavy,” “Heavy,” “Medium,” “Light,” and “sedentary.” There is no box to check anything less than sedentary!

My advice is to use your own forms, and get the doctors to explain their limitations as clearly and in as much detail as possible.

7. **Do Not Ignore the Insurance Company’s or Plan Administrator’s Deadlines.**

As Social Security attorneys, we are used to dealing with the deadlines for appealing from an initial denial to the recon level, to the hearing, etc. But, if our client misses a deadline before coming to us in a Social Security case, it is usually not a disaster, because the client can file a new application for Social Security benefits, so long as the person is not passed his or her date last insured.
LTD cases are different. Because your client's LTD coverage usually ends when employment ends, your client must prove he or she was disabled at the time he or she stopped working. The time deadlines to apply for LTD and to appeal LTD only apply to that one time when employment ended. Unless you client returns to work, the LTD coverage is gone if you client does not apply or appeal on time.

Further, if your client does not timely appeal, and exhaust all his or her remedies, the federal court will usually dismiss any ERISA case you file.

8. Do Not File Suit Until You Have Exhausted All Your Remedies.
This rule is an extension of the previous rule; until the insurance company has issued a final denial, or has failed to issue a decision within the time deadlines under the ERISA regulations, your client do not have the right to file a civil action. Courts almost always dismiss ERISA claims for failure to exhaust if the claimant does not present his or her claim to the insurance company, and follow all the appeal procedures, before filing suit.

As Social Security attorneys, we have all probably seen cases where our client's entitlement to Medicare or Medicaid is even more important than the monthly benefits. In LTD cases, there is a similar concern.

In many cases, if a person is found disabled under an employer-sponsored LTD plan, some employers may offer additional benefits. These additional benefits can be very valuable for the employee, and can be a significant liability for the employer.

Not all employers do this, but in some cases employers allow a person receiving LTD benefits to also continue to receive other employee benefits. For example, some employers set up their benefits so that if a person is receiving LTD benefits, the person automatically can continue to be covered under the company health insurance plan. Some employers may offer other specific benefits for employees receiving LTD, such as continued pension contributions. Other employers have written policies that employees who become disabled and eligible for LTD benefits are treated as active employees and continue to receive all of their other employee benefits.

On the other hand, employers may offer other benefits that provide continued coverage to people who are disabled, but the person has to apply for that coverage separately. One common example of this is a life insurance “life-waiver of premium” or (“LWOP”) claim. If an employer offers life insurance with an LWOP provision, then an employee who becomes disabled can file an application with the life insurance company, and, if the employee proves he or she is disabled, then the employee can keep the life insurance coverage in place without paying premiums while the employee is disabled.

So, if you represent the employee who is claiming disability, how do you determine what other benefits your client is entitled to? The simple starting place is to ask the plan administrator, who is usually the employer, in writing. Under most ERISA plans, the employer is designated as the Plan Administrator, but some other person may be named. So, the first question an attorney should ask is, “Dear employer, please provide me with copies of all plan documents or other documents describing what benefits an employee may be entitled to if he or she becomes disabled. If you are not the plan administrator for any such plans, please tell me who the plan administrator is.
administrator is and provide me their address so I can request the documents from them.” The second question to ask is, “because my client is disabled, please tell me what actions my client needs to take to file a claim for any benefits he or she may be entitled to under any of those plans on account of his or her disability.”

Plan Administrators are fiduciaries under ERISA, and courts have held that an ERISA fiduciary is specifically charged with the obligations of a trustee, who “is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection.” Krohn v. Huron Memorial Hospital, 173 F.3d 542, 548 (6th Cir. 1999) (citing Restatement (Second) of Trusts).

A fiduciary must give complete and accurate information in response to participant’s questions. Drennan v. General Motors, 977 F.2d 246, 251 (6th Cir. 1992). “Misleading communications to plan participants regarding plan administration (for example, eligibility under a plan, the extent of benefits under a plan) will support a claim for breach of fiduciary duty.” Id., citing Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154, 1163 (6th Cir. 1988). A fiduciary breaches its duties by materially misleading plan participants, regardless of whether the fiduciary’s statements or omissions were made negligently or intentionally. Berlin, 858 F.2d at 1163-64. The Sixth Circuit has explained:

The duty to inform is a constant thread in the relationship between beneficiary and trustee; it entails not only a negative duty not to misinform, but also an affirmative duty to inform when the trustee knows that silence might be harmful.


In addition to having an affirmative fiduciary duty to explain to an employee who is a plan participant about any benefits the employee may be entitled to, a Plan Administrator who fails to provide requested documents within 30 days of a written request may be liable to the employee for a penalty of up to $110 per day. See, discussion, supra, and see ERISA § 502(c), 29 U.S.C. § 1132(c).

10. A Little Knowledge Is a Dangerous Thing.

If you want to start helping your clients with LTD claims, I encourage you to do so. It can be a very rewarding area of the law, in addition to helping your clients with Social Security benefits.

However, LTD litigation can be very complicated. The learning curve starts out steep and stays steep for quite a while. While there are some conceptual similarities with Social Security cases, there are also dramatic differences. If you start handling LTD claims, think of it as a “license to learn” and try to keep improving you knowledge for as long as you work on these cases.

About the Author:

Eric Buchanan represents disabled people and other policyholders across the United States in both ERISA and non-ERISA disputes, focusing primarily in the areas of disability, life, and health insurance.
Eric served as President of the Tennessee Trial Lawyers Association (TTLA, also known as the Tennessee Association for Justice, or TAJ) for the year 2015–6, and is also a lifetime member of that organization.

Eric Buchanan regularly chairs conferences and speaks to both national and local audiences on disability insurance, ERISA, insurance law, and social security disability. He has been the program chair and repeated speaker for the AAJ Social Security Section National CLE and at the AAJ Annual Convention’s Disability Law program. Eric has twice been program chair and has been a repeated speaker for the Tennessee Bar Association’s Disability Law Conference, has been program chair and speaker for several Tennessee Association for Justice CLE’s on social security disability and on ERISA litigation. Eric has also spoken ten previous times at the National Disability Law Conference held by NOSSCR. He has spoken seven times at the American Conference Institute Disability Law Conference. He has also spoken numerous times at local and regional CLE’s on social security, disability, insurance, and subrogation. A list of the 54 times that Mr. Buchanan has spoken on these and related issues can be found on the firm’s website at http://www.buchanandisability.com/conferences-and-topics/.

In 2007 Eric Buchanan was certified as a Specialist in Social Security Disability Law by the National Board of Trial Advocacy. In 2008 he was selected by the National Board of Legal Specialty Certification to be an examiner for the National Board of Social Security Disability Certification exam. He also represents disabled people before the Social Security Administration, having represented over 1200 people in social security hearings. Eric has also has represented hundreds of people in federal court law suits involving social security and ERISA disputes.


Eric graduated from the Washington and Lee University School of Law Magna Cum Laude and in the top 10% of his class. While in law school he was also inducted into the Order of the Coif and the Omicron Delta Kappa honorary leadership fraternity. Eric is also a graduate of the Virginia Military Institute, and served as an officer in the U.S. Navy from 1989 to 1994 where he served as a naval aviator (pilot), plane commander, and mission commander of P-3C Orion aircraft.

Endnotes:

1. Whether the insurance company or plan can recover from a claimant who later wins other benefits is an entire topic on its own. A paper covering much of this complicating topic can be found at my website at http://www.buchanandisability.com/helpful-resourcesandarticles/erisa-update-subrogation-post-serboff/.

2. How to determine if your client’s long-term disability claim is preempted by ERISA is an example of a topic that cannot be covered adequately in this paper; however, the author has a paper entitled “How to Tell if an Insurance Claim is Preempted by ERISA” found on our firm’s website at http://www.buchanandisability.com/helpful-resourcesandarticles/how-to-tell-if-an-insurance-claim/.
3. A saving clause in ERISA does provide that some state laws are not preempted, such as laws which regulate insurance. 29 U.S.C. § 1144(b)(2)(A). However, in a series of Supreme Court cases, the Court has limited that exception to laws providing procedural protections, but state laws that provide additional remedies or causes of action outside of ERISA are still preempted. Compare, e.g., UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999)(California’s state law notice-prejudice rule was a law regulating insurance and was not preempted by ERISA) with Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (Mississippi’s bad faith law provided a remedy beyond those remedies set out in ERISA, and thus would be preempted).

4. One bit of good news is that in recent years, about half the states have passed laws banning discretionary clauses in insurance policies, and since such a law is “regulating insurance” courts have found those laws not to be preempted. See, e.g., Am. Council of Life Insurers v. Ross, 558 F.3d 600 (6th Cir. 2009) (holding that Michigan’s ban on discretionary clauses was not preempted by ERISA).

5. 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 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. Because of the way the rules were written, if a person first applied for LTD before January 1, 2002, and is paid benefits for a while, then denied years later, the “old” regulations apply. And now, an even newer set of regulations has been issued. On December 19, 2016 the Department of Labor issued new amendments to the ERISA claims regulations. 81 FR 92316-01. The most important parts of the new regulations applicable to disability claims and other similar claims will be effective for claims filed after January 1, 2018. “new” new regulations, 29 C.F.R. § 2560.503-1(p)(3).

6. Claims for benefits under ERISA § 502(a)(1)(B) may be filed in either federal court or state court, but generally may be removed to federal court under federal subject matter jurisdiction.

7. There are a few other regulations that might occasionally apply in ERISA LTD claims, but those other issues are very rare, such as whether ERISA applies to a claim that is provided by a church plan or a claim for STD benefits that might fall under the sick-pay exception to ERISA.

8. The original regulations were published May 27, 1977. 42 FR 27426. They were amended in 1981(46 FR 5884), 1984 (49 FR 18295), 2000 (65 FR 70245), 2001 (66 FR 35885) and 2017 (81 FR 92316-01).

9. A claimant may submit a written request for plan documents; if the administrator does not provide the documents within 30 days, the claimant may seek a penalty of up to $110 per day after the 30 days. 29 U.S.C. § 1132(c)(1) (ERISA § 502(c)). At any time a participant may request copies of any summary plan descriptions, insurance policies and other documents under which the plan is established or operated. 29 U.S.C. § 1024(b)(4). If there has been an adverse claim determination, the claims regulations require that all the documents pertinent or relevant to the claim should be provided to the claimant. For a more complete discussion of what documents
must be provided by whom, and when penalties should be paid for the failure to provide the documents, see the article on our website about ERISA § 502(c) penalties at: http://www.buchanandisability.com/helpful-resourcesandarticles/erisa-502c-actions/

10. The same regulations also provide time limits for appealing health benefits claims, and the time limit to make decisions on those claims, that vary depending on the urgent need of the claim. For other claims that do not involve disability benefits or health care claims, such as life insurance claims, the administrator may take up to 90 days to make a decision, which can be extended for another 90 days if “special circumstances require” additional time, as determined by the administrator. 29 C.F.R. § 2560.503-1(f)(1).

11. Whether or not an insurance company can recover from your client when your client wins a Social Security case is a separate seminar topic itself. An article discussing the coordination of such benefits, and arguments that can be made, can be found at the author’s website at http://www.buchanandisability.com/helpful-resourcesandarticles/coordination-of-benefits/

12. As discussed above, the new amendments to the DOL ERISA regulations at 29 C.F.R. § 2560.503-1 will include a requirement that plans must explain why they disagree with a finding of the Social Security Administration that a person is disabled. This is effective for claims filed after January 1, 2018. Of course, if a person loses a Social Security claim, the insurance company can use that as evidence to help deny an LTD claim.

13. As explained above, an article discussing the coordination of such benefits, and arguments that can be made, can be found at the author’s website at http://www.buchanandisability.com/helpful-resourcesandarticles/coordination-of-benefits/

14. ERISA § 502(c)(1) also provides for similar penalties for an administrator’s failure to provide COBRA notices and required notices related to transfers of excess pension plan assets to a health benefits account.

15. As required by the Debt Collection Improvement Act of 1996, the $100 limit has been increased to $110 for violations after July 29, 1997. 62 Fed. Reg. 40696.

16. For a full discussion of what plan documents must be provided by whom, and when penalties might be awarded, see the article on ERISA 502(c) penalties on our firm’s website: http://www.buchanandisability.com/helpful-resourcesandarticles/erisa-502c-actions/

17. ERISA provides a statute of limitations for claims for breach of fiduciary duty under ERISA § 413 (29 U.S.C. § 1113) that is the earlier of either six years from the breach or three years from when the plaintiff had actual knowledge of the breach, which is extended to six years if there was fraud or concealment.

18. See discussion above. Under ERISA, the plan “administrator” is the person who is named in writing in the plan as the administrator; if no administrator is named, the administrator is deemed to be the plan sponsor (i.e. the employer, or, in the case of a union plan, the union). ERISA § 3(16)(A)(i) and (ii).
ERISA Long-Term Disability Claims: What Social Security Representatives Need to Know

Eric Buchanan, Esq.
ERISA Long-Term Disability Claims: What Social Security Practitioners Need to Know

NOSSCR DISABILITY LAW CONFERENCE
Phoenix, AZ
September 13-16, 2017

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LTD Claims

• Introduction to LTD cases for SS practitioners who do not handle LTD cases (first hour)
• Advice to SS practitioners who are going to start handling LTD cases (second hour)

VERY COMPLICATED
DO NOT DABBLE!
Types of Disability Insurance and Long Term Disability Claims

- Two Broad Categories:
  - Group long term disability ("LTD") policies offered through work
  - Private individual disability insurance policies ("IDI," "DI," or "ID" policies)

Types of Disability Insurance:

Long-term Disability Insurance (LTD)

- Usually refers to group insurance policies offered through work
- Also applies to group plans offered by employers through a self-funded plan
- Also applies to group plans offered by unions

Long-term Disability Insurance (LTD)

- Usually fall under ERISA
  - unless offered by an employer that is a government entity or
  - a church
    - (though church plans can opt in to ERISA)
    - Church exception can apply to church schools and hospitals (think Notre Dame University)
### Types of Disability Insurance

#### Long-term Disability Insurance (LTD)

- Typically pay a percentage of pre-disability earnings (usually base pay).
- Most commonly 60%, but 50%, 65%, and 70% possible.
- Occasionally cover 50% or 60% with another 10% to 15% optional buy-up.

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#### Long-term Disability Insurance (LTD)

- Most policies only cover person’s base salary or hourly pay (but not all)
- Some policies cap the maximum pay that is covered

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#### Long-term Disability Insurance (LTD)

- Almost always offset for social security disability and worker’s compensation
- Most offset SS primary and dependent’s (aux) benefits
- May offset for other benefits such as VA
- Most recent policies offset for recoveries from third parties (like subrogation in tort cases)

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Types of Disability Insurance

Long-term Disability Insurance (LTD)

- Example calculation of benefits:
  - Earnings $60,000 per year
  - 60% of $60,000 ÷ 12 = $3000 per month
  - Subtract PIA of $1800 = $1200 net LTD benefits
  - If auxes @ $900 per month = $300 net LTD benefits
  - Until aux benefits end for youngest child

Types of Disability Insurance

Long-term Disability Insurance (LTD)

- Usually have more restrictive definitions of disability than private individual policies

- Have other terms that can diminish the value of the policy

Types of Disability Insurance

Long-term Disability Insurance (LTD)

- Usually requires “total disability” with no provision for working part time
  - But some policies offer “partial disability” or “residual disability” coverage
Types of Disability Insurance

Long-term Disability Insurance (LTD)

- Definition of “Disability” is usually 24 months of “own occupation” coverage (but can be 12 or 36 months)
- After 24 months, must be disabled from any occupation
  - But some better policies have a “gainful” wage provision, so higher income people don’t get denied if they can only do a low-income, unskilled occupation

Types of Disability Insurance

Long-term Disability Insurance (LTD)

- Coverage for “mental and nervous” disorders (i.e. psychiatric conditions) usually limited to 24 months.
- Coverage for conditions “established by self-reported symptoms” usually limited to 24 months.
  - i.e. migraines
  - Ins. companies claim fibromyalgia falls under this, but there is good case law to the contrary.

Types of Disability Insurance

Long-term Disability Insurance (LTD)

- Some more recent policies (especially those issued by MetLife) limit benefits to 24 months for several other categories
  - i.e. “musculoskeletal conditions” that are not verified by very specific testing
  - Disorders where limitations caused by pain or fatigue
### Types of Disability Insurance

#### Long-term Disability Insurance (LTD)

- Most LTD policies were originally written to pay to age 65.
  - Some still say that
  - Some pay until social security normal retirement age
  - Some have more limited coverage (i.e. 5 years)

#### Private Disability Insurance

- Usually purchased directly from an insurance company or agent
- Occasionally professional business owners buy policies through their company that just cover owners and are individual policies
- Often referred to as “DI,” “IDI,” or “ID” policies
Types of Disability Insurance

Private Disability Insurance
- Usually offered to professionals and other high income people, such as doctors, lawyers, business owners and executives
- Benefits can be high, but premiums are high
- These policies are only a small percentage of the types of disability insurance policies in the marketplace

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Types of Disability Insurance

Private Disability Insurance
- Most policies provide for a specific monthly benefit amount if a person becomes disabled
  - Usually provide increasing benefits over time under cost-of-living adjustments (“COLA”)
  - Many policies have built-in increases in the base coverage that apply over the first few years of the policy

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Types of Disability Insurance

Private Disability Insurance
- Usually provide coverage for “own occupation” definition of disability, not “any occupation”
- Some even have an “own specialty” rider, that covers even more. For example, a surgeon who becomes disabled, but can still work in an office, can collect benefits
  - Some of the best policies in the 1990’s even said there is no requirement for a loss of earnings.
Types of Disability Insurance

Private Disability Insurance

- Typically do not limit benefits for “mental and nervous” conditions
- Usually provide coverage for “partial disability” or “residual disability” when someone has some loss of earnings. Typically 20% loss will trigger this.

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Types of Disability Insurance

Private Disability Insurance

- Most IDI policies were written to pay to age 65
- But, many versions or riders offered “lifetime” benefits
  - If totally disabled before age 65 (or 60 or 55),
  - If disabled due to injury, not illness, or
  - Other similar conditions that varies in different policies
  - This is a “hot” area of litigation right now!

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Types of Disability Insurance

Private Disability Insurance

- Do not typically allow for an offset of other benefits, such as social security benefits
- Some even have a “social benefit” rider, that pay extra benefits until social security disability approved

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### Types of Disability Insurance

#### Private Disability Insurance

- Litigated as breach of contract cases under state law; some states allow other causes of action, such as bad faith.
- These are great cases when you can find a client who has one of these policies and needs help.

### ERISA v. Non-ERISA Cases

The majority of disability policies are offered as group policies through work, and the majority of this presentation discusses the rules that apply to ERISA LTD policies.

A separate discussion of litigating non-ERISA IDI policies would be a multi-day seminar.

### ERISA LTD policies

**Back to Group Plans:**

ERISA § 4(a), 29 U.S.C. § 1003(a) provides that ERISA shall apply to any employee benefit plan if it is established or maintained—

1. by any employer.
2. by any employee organization or organizations representing employees (i.e. a union), or
3. by both.
ERISA does not always apply

(1) such plan is a governmental plan
(2) such plan is a church plan [unless the church opts in]
(3) such plan is maintained solely for . . . complying with . . . workmen’s compensation laws or unemployment compensation or disability insurance laws;
(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens;

ERISA Applies!

Bottom Line:
• If an employer was involved at all in providing the coverage (even if the employer paid for it) it is most likely ERISA
• Unless provided by a government employer
• Maybe not if employer is a church
• There is also a very narrow exception for individual policies if all the employer does is withhold the premiums, but these can even be ERISA policies if the employer was involved in negotiating a discount for group billing.

ERISA Application and Preemption

Whether ERISA applies can be a separate lecture.

I have a paper on my website, “How to Tell if Your Client’s Insurance Case is Preempted by ERISA” at: www.buchanandisability.com
Section E  

National Social Security Disability Law Conference

So What if ERISA Applies?

- Preempts state law causes of action (breach of contract, etc.) 29 U.S.C. § 1144(a).
- Preempts state law defenses
- Causes of action other than ERISA § 502(a)(1)(B) must be brought in Federal Court; §502(a)(1)(B) usually removed to Federal Court.
- Courts apply ERISA statutory and common law

So What if ERISA Applies?

- Claimant must exhaust “administrative” remedies
- Claimant must submit all evidence to the insurance company
  - No new evidence may be submitted in court
  - No equivalent to the “new and material evidence” rule
- Cases typically litigated on closed record, with briefs, and maybe oral arguments allowed

So What if ERISA Applies?

- In many cases, the insurance company’s decision will be reviewed under an “arbitrary and capricious” standard of review
- No discovery allowed in court on the merits, but sometimes discovery into insurance company’s conflict of interest
### So What if ERISA Applies?

- Remedy in court is either affirmance or reversal.
- But, reversal is often a remand for further proceedings (i.e. remand back to the private insurance company that already denied the claim).
- If benefits awarded, you might get interest and attorneys' fees, but nothing else.

### ERISA v Non-ERISA Cases and Case Selection

**When taking on an ERISA LTD case:**
- Understand the financial picture and any offsets that might apply.
  - Unfortunately, it is crucial to pay attention to the money first.
  - More than half the LTD cases we look at are so offset that the net benefits are not worth fighting over, no matter how disabled the person is.

**When taking on an ERISA LTD case:**
- Be vigilant, and pay attention to the facts at the beginning of the case.
- It is important that the person has a well-documented factual disability case.
- It is crucial to respond to the reasons the insurance company is denying the claim.
ERISA LTD Procedures

Two big phases:

1. "Administrative" appeal at the claims level to the insurance company or plan

2. Litigation in court

Much more on this in the next hour

Issues SSA Reps Not Handling LTD Should Be Aware Of

1. Ask if your client has LTD coverage
   - Be aware, so your representation does not interfere with LTD
   - Advise your client to get help with LTD if you are not going to handle it
   - It is almost always best for person to pursue both claims
     - Two chances to get benefits
     - SS COLA not offset

Issues SSA Reps Not Handling LTD Should Be Aware Of

2. Understand how amending the Social Security onset can affect your client's LTD claim
   - LTD carriers love to look to an amended onset in the SS case to say the person was not disabled until later than the onset
   - Most LTD policies only cover the person through the end of employment
     - Only once chance to win
     - Must prove onset coincided with end of employment
Issues SSA Reps Not Handling LTD Should Be Aware Of

3. Understand how LTD companies use mental limitations against the claimant
   - Most LTD policies limit benefits to 12 or 24 "mental and nervous" conditions, so you need to be careful to over-emphasizing your client’s mental disability in the Social Security case
   - Obviously, do what you need to do win the SS case, but be aware of this issue

Issues SSA Reps Not Handling LTD Should Be Aware Of

4. Be aware how the LTD/Social Security offset works
   - LTD policies usually reduce LTD benefits by the amount paid in SS
   - LTD policies usually allow a recovery if LTD is paid and SS is won later
   - If your clients are not aware, they will be mad at you for not telling them that, after they win SS, the LTD company wants their SS backpay

Issues SSA Reps Not Handling LTD Should Be Aware Of

5. Work with the LTD attorney if your client is denied LTD benefits
   - If your client has an LTD attorney, or you refer the case to one, be sure to share information
   - The LTD attorney may have a better doctor’s opinion, for example
   - The LTD attorney will need to know the PIA and aux PIA to determine benefits payable
10 comparisons between SS cases and LTD cases

1. Closed Record:
   - **SS claims**: The record is closed after the “final decision” of the Commissioner, but there is a “new and material evidence” rule that can sometimes be used to get in new evidence.
   - **LTD**: The record is closed when it goes to court and there is no rule to allow in new evidence on the merits of the claim in court

2. Levels of appeal:
   - **SS claims**: two administrative levels (initial and recon) then a due process hearing, then an administrative review (AC) then USDC
   - **LTD claims**: two internal levels of appeal, maybe three, NO due process hearing, but rather, straight from internal levels of appeal, then USDC

3. Covered Time Period
   - **SS claims**: Date Last Insured (DLI) can be up to five years after the person last worked and paid FICA taxes
   - **LTD claims**: The person is covered only while working or while receiving benefits, so the person must prove disability at the time he or she stopped working and/or remain continuously disabled if benefits are cut off
10 comparisons between SS cases and LTD cases

4. Treating Physician Rule
   • SS claims: Old Rule: The treating physician’s opinion is given controlling or great weight, depending on how well-supported and whether it is contradicted. New Rule: not controlling
   • LTD claims: There is no treating physician rule; rather, each plan establishes its own rules. However, courts are often skeptical if an insurance company relies on the opinion of a doctor who only reviewed records over a doctor who actually examined the claimant. Also, new proposed ERISA claims regulations may require more weight be given to a treating physician.

5. Standard of Review
   • SS claims: The USDC will affirm if the decision of the Commissioner is supported by substantial evidence.
   • LTD claims: Technically, the default standard of review is de novo; however, the plan can grant discretion to the insurance company so that, in reality, the USDC will affirm the decision of the insurance company unless it is arbitrary and capricious.

6. Submission of evidence:
   • SS claims: The federal rules of evidence do not apply, although there are some rules, such as CE reports must be signed. Attorneys can develop the record using hearsay evidence.
   • LTD claims: The federal rules of evidence do not apply. Attorneys can develop the record using hearsay evidence.
Section E

NATIONAL SOCIAL SECURITY DISABILITY LAW CONFERENCE

10 comparisons between SS cases and LTD cases

7. **Time Deadlines**
   - **SS claims**: most deadlines give claimant 60 days to appeal. No timeframe for SSA to make a decision.
   - **LTD claims**: 180 days for first administrative appeal. The insurance company or ERISA plan administrator must make a decision within certain time frames or it is deemed denied.


10 comparisons between SS cases and LTD cases

8. **Attorneys fees at the court level**
   - **SS claims**: Once in court, EAJA fees available to the prevailing party, but capped at $125 per hour plus COLA's.
   - **LTD claims**: Once in court, attorneys fees available under ERISA § 502(g) paid at the prevailing market rate. There is no prevailing party requirement, but courts apply several factors and are more reluctant to order fees than are awarded under EAJA.

10 comparisons between SS cases and LTD cases

9. **Regulations**
   - **SS claims**: The Commissioner has issues hundreds of pages of regulations setting out the rules for DIWC and SSI claims.
   - **LTD claims**: The Secretary of Labor has issues less than 10 pages of regulations addressing LTD claims procedures. New regulations are not much longer, and go into effect, mostly, for claims filed January 1, 2018.
10 comparisons between SS cases and LTD cases

10. Litigation

- **SS claims:** In USDC you get a copy of the transcript from the Commissioner and argue why the decision of the Commissioner was not supported by substantial evidence or was contrary to the law, with no trial and often without a hearing.

- **LTD claims:** In USDC you get a copy of the “ERISA administrative record” from the ERISA Plan Administrator or Claims administrator and argue why the decision of the Commissioner was not supported by substantial evidence or was contrary to the law, with no trial and often without a hearing, but perhaps with some discovery into the conflict of interest.
ERISA Long-Term Disability Claims: What You Need to Know to Begin Handling LTD Claims

Eric Buchanan, Esq.
ERISA Long Term Disability Claims: What You Need to Know To Begin Handling LTD Claims

NOSSCR DISABILITY LAW CONFERENCE
Phoenix, AZ
September 13-16, 2017

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LTD Claims

• Introduction to LTD claims for SS practitioners who do not handle LTD cases (first hour)
• Advice to SS practitioners who are going to start handling LTD cases (second hour)

VERY COMPLICATED
DO NOT DABBLE!
The Least You Need to Know!

When taking on an ERISA LTD case:
- Understand the financial picture and any offsets that might apply
  - Unfortunately, it is crucial to pay attention to the money first
  - More than half the LTD cases we look at are so offset that the net benefits are not worth fighting over, no matter how disabled the person is.

The Least You Need to Know!

When taking on an ERISA LTD case:
- Biggest mistake: The record closes when the insurance company issues its final denial, so get in everything you want considered with the final appeal!
  - Don’t think you can add to the record later.

The Least You Need to Know!

When taking on an LTD case:
- If you are not sure it is ERISA or not, treat it like ERISA
  - Get in all the evidence
  - Exhaust appeals
- But, if it might not be ERISA, also send over bad faith magic language to preserve a state bad faith claim.
Make Sure it is ERISA

If your client comes in with a denial of a disability insurance policy:

• If it is ERISA one set of rules apply

• If not, state law applies (with bad faith and punitive damages in some states)

Q&A: Log on to NOSSCR.cnf.io

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ERISA Applies!

Bottom Line:

• If an employer was involved at all in providing the coverage (even if the employee paid for it) it is most likely ERISA

• Unless provided by a government employer

• Maybe not if employer is a church

• Small, limited, exception if person buys an individual policy and employer only withholds premiums, but still ERISA if employer even negotiates a group-billing discount.

Q&A: Log on to NOSSCR.cnf.io

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ERISA Application and Preemption

Whether ERISA applies can be a separate lecture.

I have a paper on my website, “How to Tell if Your Client’s Insurance Case is Preempted by ERISA” at:
www.buchanandisability.com

The rest of this lecture will concentrate on the rules if ERISA applies

Q&A: Log on to NOSSCR.cnf.io
Not Sure if ERISA Applies?

• Because you must exhaust your remedies administratively, it usually does not hurt to treat every case like it is ERISA when you appeal to the insurance company
• But, beware of any SOL issues if it is really a state law claim
• Sometimes there is a conflict or it is not clear; that is why you get paid the big bucks

ERISA LTD Procedures

When taking on an ERISA LTD case:

• Be vigilant, and pay attention to the facts at the beginning of the case (and pay attention to the $$)
• It is important that the person has a well-documented factual disability case
• It is crucial to respond to the reason the insurance company is denying the claim

ERISA LTD Procedures

Two big phases:

1. “Administrative” appeal at the claims level to the insurance company or plan
2. Litigation in court
### ERISA LTD Administrative Procedures

- Claimant must file a claim in time required by policy or plan
- Must appeal on time as set out in the policy or plan
- May be required to appeal a second time if plan requires
- May be offered additional voluntary appeals

### ERISA LTD Administrative Procedures

- ERISA plans must establish maintain reasonable claims procedures. 29 C.F.R. § 2560.503-1
- Administrator must make timely decision
- Administrator must give written explanation
- Administrator must provide copy of all relevant documents if requested

### ERISA LTD Procedures

- ERISA Claim procedures 29 C.F.R. § 2560.503-1
- Administrator may not require more than two appeals, but may offer additional voluntary appeals
- Administrator may not charge a fee to appeal
- Administrator must allow claimant to submit comments, records and other information
- Administrator must recognize a representative
ERISA LTD Procedures

Written notice of the decision must provide:
• The specific reason or reasons for the adverse determination;
• Reference to the specific plan provisions on which the determination is based;
• A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
• A description of the plan’s review procedures and the time limits applicable to such procedures . . .

ERISA LTD Procedures

• Administrator must make a decision on the initial application within 45 days, but can extend two 30 day periods
• Claimant must be given at least 180 days to appeal
• Administrator must make decision on appeal within 45 day which can be extended 45 days
• If decision not made on time, it is “deemed exhausted”

ERISA LTD Procedures

Practical Advice:
• Never miss an appeal deadline
• Always submit all evidence in support of the claim during the process, because the court will not consider anything not submitted
• If you need more time, file the appeal on time and ask for more time to submit additional evidence; that will often be granted
### ERISA LTD Procedures at the “Administrative level”

**Practical Advice:**
- There are no rules of evidence that apply; submit whatever will support the claim
- Ask for the claim file from the administrator
- Ask for the actual plan documents from the Plan Administrator (usually the employer)
- Read the policy and denial letters closely and address the reasons for denial and the policy requirements, but be sure to prove disability

### New regulations issued in 2016

In late 2016 the Department of Labor issued new amendments to the ERISA claims regulations

- For claims filed after July 1, 2018:
  - The plans must ensure that claims are adjudicated in a way that ensures the “independence and impartiality of the persons involved in making the decision.” New 29 C.F.R. § 2560.503-1(b)(7).

### New regulations issued in 2016

- Under the new rule, “decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.” Id.
New regulations

The new amendments to section 2560.503-1(g)(1) (vii)(A):

The “adverse benefit determination” must explain the “basis for disagreeing with or not:

(i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
New regulations

**New Evidence:**

29 C.F.R. § 2560.503-1(h)(4)(i) requires:

When the plan obtains or generates new evidence, that evidence must be provided to the claimant "sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided."

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New regulations

**Changing Rationale:**

Section 2560.503-1(h)(4)(ii) requires:

If the plan changes rationale, the plan to provide the claimant with the new rationale for the decision to deny benefits, and "the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided."

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New regulations

The new regulations address the confusion regarding contractual periods of limitations.

In *Heimeshoff v. Hartford Life & Acc. Ins. Co.* ___ U.S. ____, 134 S. Ct. 604, 610 (2013) the Supreme Court held that the time to file a suit can run while the administrative process is being exhausted: "a participant and a plan may agree by contract to a particular limitations period, even one that starts to run before the cause of action accrues, as long as the period is reasonable."
New regulations

The new regulations now have a requirement that the adverse determination letter, “shall . . . describe any applicable contractual limitations period that applies to the claimant’s right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.”

New 29 C.F.R. § 2560.503-1(j)(4)(ii)

ERISA litigation

- Your complaint is filed under ERISA § 502(a)(1)(B), which can be filed in state or federal court
  - Ins Co will usually remove to federal court
- Normally the ERISA administrator or insurance company will provide a copy of the ERISA administrative record as an initial disclosure or in accordance with a scheduling order

ERISA litigation-Discovery

- If you want discovery into the conflict of interest, normally you will need to ask the court for time to do it, and you may even need to ask the court for permission
  - Courts are all over the place whether to allow conflict discovery at all, whether to require an initial showing, or allow discovery when a conflict is alleged
    - Again, this could be another whole lecture
Once discovery is done, the parties argue whether the decision was arbitrary and capricious based on the ERISA record.

**Firestone Tire & Rubber Co. v. Bruch (1989):**
- Default standard of review is *de novo*
- Parties could agree on a more deferential standard of review
- Most plan documents grant discretion, so standard of review is usually arbitrary and capricious or abuse of discretion

**Good News:**
- Some states have banned discretionary clauses
- Such bans are laws “regulating insurance” and may not be preempted by ERISA
- Lots of issues:
  - Is ban “regulating insurance?”
  - Is policy issued or renewed after ban in effect?
  - Have courts upheld the ban?

This is discussed at length in the paper for this presentation.
ERISA litigation - Standard of Review

Under arbitrary and capricious standard of review, courts should take into account the conflict of interest.

*Metropolitan Life Ins. Co. v. Glenn, (2008):*

- Where the ERISA decision-maker both makes a decision and would pay any benefits due out of its own funds, that is a conflict.

**Q+A:** Log on to NOSSCR.cnf.io

ERISA litigation - Remedies

**So what can a court award?**

1. Remedies under ERISA limited to benefits due under the plan and, maybe, attorneys’ fees and small amount of interest

2. Court can order back benefits, can affirm, or can remand back to ERISA administrator

**Q+A:** Log on to NOSSCR.cnf.io

ERISA Remedies Exclusive

**No Punitive or extra-contractual damages:**

The 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. Thus, ERISA’s civil enforcement remedies were intended to be exclusive.

*Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (U.S. 1987):*

**Q+A:** Log on to NOSSCR.cnf.io
### Issues When You Start Handling ERISA LTD Claims

#### 1. Screen your cases carefully
- The standard of review gives a huge advantage to the insurance company
- Many claims are so offset by SS benefits that they are not practical to work on
- LTD clients tend to be more demanding
- Rules are different from case to case

#### 2. Get the plan documents early and read them carefully
- Each policy or Plan is different
- Contractual period of limitation in policy is usually shorter than SOL, and is enforced
- Definition of disability may be different
- Any occupation vs. own occupation
- Many other important provisions

#### 3. Know the statute of limitations:
- But 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
- Many policies require legal action “within 3 years of when proof of loss is first due”
- This time can run while administrative appeal is going on, and even while claimant is being paid benefits, so long as there is a “reasonable” time to appeal. See: Heimeshoff v. Hartford Life & Accident Ins. Co., 134 S. Ct. 604, 616 (U.S. 2013)
4. Do not assume you can add more evidence later
   • Submit all your evidence early to the administrator to ensure it will be before the court
   • While the claim is still open with the insurance company or ERISA administrator is the only time to submit evidence
   • Once it court THE RECORD IS CLOSED

5. Do not rely just on your client’s treating doctor’s conclusory opinion of disability
   • There is no treating doctor rule in ERISA LTD cases
   • You need to get as much evidence as you can to support your client’s restrictions and limitations

6. Do not rely on the forms provided to your client’s physicians by the insurance company
   • Most LTD carriers have forms that ask very leading questions
   • Many have check boxes where the most restrictive answers still allow for sedentary work
   • These forms are even more unfair than those used by DDS or SSA
7. Do not ignore the insurance company’s or plan administrator’s deadlines
   • Your client must exhaust available administrative remedies
   • If your client misses the deadline to appeal, then your client failed to exhaust and the claim is basically dead
   • There is no “do-over” or new application unless your client goes back to work and is covered based on new work.

8. Do not file suit until you have exhausted all your remedies
   • Exhaustion is a prerequisite to filing in court.
   • There is an exception if exhaustion would be “futile” but it is tough to meet.
   • Courts love to throw out ERISA LTD cases for failure to exhaust, and sometimes that is with prejudice.

9. Pay attention to the collateral benefits
   • Some ERISA LTD plans provide that the disabled former employee can continue to get other benefits, such as health insurance while disabled
   • Some employer offer other benefits if the person is disabled, such as waiver of premium under a life insurance policy, but you have to ask
### Issues When You Start Handling ERISA LTD Claims

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<thead>
<tr>
<th>10. A little knowledge is a dangerous thing</th>
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<tbody>
<tr>
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</tr>
<tr>
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### Issues When You Start Handling ERISA LTD Claims

**A little knowledge is a dangerous thing**

- Develop the ERISA “record”
- Understand the closed record rule
- Do not concede “no discovery”
- Learn the ERISA claims regulations (especially the deadlines) in 29 C.F.R. 2560.503-1
- Never tell your client to appeal on his or her own, and never offer to just write an appeal letter.