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Litigating an ERISA insurance case

AN OVERVIEW OF THE ERISA LITIGATION PROCESS AND PRACTICAL ADVICE ON AVOIDING PITFALLS AND PRATFALLS

You know how to litigate a case. Identify the harm. File a lawsuit asserting all possible claims for relief. Propound written discovery. Conduct and defend depositions. Hire an expert and conduct expert discovery. Pick a jury. Examine witnesses. Make your closing argument, and hope that the jury finds your evidence more compelling than the other side's.

Unfortunately, if you follow this blueprint in an ERISA insurance case, you can cost your client the entire case before it even starts. And even if you follow all of the statutorily required pre-litigation steps, what you already know about litigating and winning a case will be of little use to you in an ERISA case.

What is ERISA?

To successfully litigate an ERISA insurance case, you need to start at the beginning. First, what even is ERISA? The Employee Retirement Income Security Act of 1974 at section 1001 et. seq. of title 29 of the United States Code, otherwise known as ERISA, is a federal law that governs most employer-sponsored benefit plans, including plans that provide disability insurance, life insurance and health insurance to employees. (ERISA also governs pension plans, but those cases are different enough from insurance cases as to require their own article.)

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When ERISA was enacted, the primary purpose of the legislation was to prevent the mismanagement of funds so that employees would be able to access the benefits they were promised. Thus, in addition to imposing funding, vesting and enforcement requirements on employers (who, under ERISA, are usually the plan administrator), it also imposes uniform reporting, disclosure, claims handling and fiduciary obligations on insurers (who, under ERISA, are usually the claim administrator).

Does ERISA apply to your client's case?

Determining which law governs an insurance claim is the first step in litigating a wrongfully denied claim. ERISA governs most – but not all – employer-provided life, health and disability insurance benefit plans. The major exception is when the employer is a government entity (including school districts) or a church-run organization (including church-owned hospitals). Congress explicitly excluded plans from these employers from ERISA. In those cases, disputes over the non- or under-payment of insurance benefits are litigated under state law breach of contract and, if applicable, bad-faith laws. Absent those exceptions, ERISA most likely applies to a claim made under an employer-sponsored insurance policy.

"Individual" policies are not governed by ERISA. An individual policy is purchased by the insured, typically through an insurance agent, without the employer's input or involvement. The individual has the right to pick the insurance company, type of insurance and coverage limits. However, because of the prohibitive cost of individual policies, most people with disability, health and life insurance coverage are insured through an ERISA-governed group policy.

Although not entirely determinative, one quick way to ascertain whether your client's insurance coverage and resulting claim dispute is governed by ERISA is to review the policy and related documents.

Under ERISA, employers are required to provide plan participants with basic information about the plan in a document called either a Summary Plan Description ("SPD") or a Summary of Benefits and Coverage ("SBC"). These plan documents provide the employee with important information as to what benefits are offered, how to file a claim, how (and how many times) to appeal a denied claim and when an employee can initiate litigation to enforce his or her rights. These documents typically include a sectioned entitled "Statement of ERISA Rights," or something similar if the insurance plan is governed by ERISA.

A review of the denial letter will also indicate whether the insurance claim is governed by ERISA, as, under ERISA, denial letters are required to include certain language including the right to appeal, applicable deadlines and whether all administrative appeals were exhausted such that a lawsuit can now be filed. (However, be aware that sometimes insurance companies include this ERISA language in claims that are *not* governed by ERISA. In those cases, you should argue that the insurance companies are acting in bad faith by attempting to mislead the claimant into thinking that she must appeal before filing a lawsuit and/or that her remedies will be severely limited in litigation.)

You've concluded that ERISA applies. Now what?

Once you've determined that your client's insurance claim is governed by ERISA, you have a very important question to answer: Has my client exhausted all administrative remedies? That is, has my client completed the appeal process?

Exhausting administrative remedies

A claimant must pursue at least one ERISA appeal before filing suit. This is known as the exhaustion of administrative remedies doctrine. A claimant can typically file a lawsuit after the first appeal, although some plans do require a mandatory second appeal before litigation can commence. If the claimant files a lawsuit without exhausting all required appeals, the insurance company will likely bring a successful motion to dismiss.

In limited instances, courts will entertain the argument that the claimant was not required to exhaust all administrative remedies due to waiver, estoppel, futility or similar equitable considerations (see, e.g., *Vaught v. Scottsdale Healthcare Corp. Health Plan* (9th Cir. 2008) 546 F.3d 620, 627, fn.2), however, the better course of action is to follow the appeal procedures set forth in the plan.

Once you establish that your client needs to appeal an adverse claim decision, your next responsibility is to make sure that he or she meets all ERISA deadlines.

ERISA imposes strict time limits and deadlines on both sides of an ERISA claim. For example, after an ERISA claim is submitted, pursuant to 29 C.F.R. § 2560.503-1(f)(3), the claim administrator must make a claim decision on a disability claim within 45 days. However, this deadline can be extended twice, by 30 days each time, "provided that the plan administrator notifies the claimant … of the circumstances requiring the extension and the date as of which the plan expects to render a decision." (*Ibid.*)

For the claimant, the regulations include an obligation to appeal an adverse claim decision within a specific time frame. Depending on the type of coverage at issue, the deadline to appeal varies. For health insurance and disability insurance claims, the time limit to appeal is 180 days. Life insurance claim denials must be appealed within 60 days of notice from the insurer.

If the claimant fails to appeal an adverse claim decision within these time limits, she will have forfeited her rights to the claimed benefits. (Some insurance companies will accept late appeals, especially if the claimant's reason for delay is tied to her disability. However, they are under no obligation to do so and you should certainly never bank on the kindness of an insurance company.)

Upon receipt of an appeal, a claim administrator has 45 days to notify the claimant of the decision; however, this deadline can be extended by another 45 days simply upon a notification by the insurer.

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Making sure the administrative record is complete

If you get involved before the final denial, there are steps you can take to help your client. If you are assisting with the appeal, it is imperative that you provide the insurance company with every piece of evidence that can be used to support the claim, because you will *not* have the opportunity to present any new evidence during litigation.

One of the unique quirks of ERISA is that the Administrative Record (that is, the claim file prepared and maintained during the review of the claim) is closed once the final claim decision is made. Accordingly, the development of the Administrative Record during the appeal process is crucial to success in the district court. As discussed below, in most cases, traditional discovery is not allowed and it is this Administrative Record that will form the factual basis of the entire lawsuit. Thus, you and your client must make sure that all of the evidence that can be used to support the claim is in the insurer's file, so that you can refer to it at trial.

In appealing an adverse claim decision, in addition to refuting the purported bases for denying the claim, you should provide additional supporting evidence. For example, for a disability claim, the appeal should include all evidence of disability, including, but not limited to: (1) all relevant medical records, including a prescription history; (2) a narrative authored by your client's treating physician(s) specifically detailing why the claim decision was erroneous; (3) a narrative from your client detailing all of the ways in which the symptoms, restrictions and limitations prevent a return to work; (4) narratives from a spouse, family members, friends and/or former co-workers discussing how the disability limits the claimant from former activities; (5) if applicable, video footage of your client's disability; (6) reports from vocational and/or medical experts that you hire that support your client's claim that she is unable to return to work (this might include an IME or functional capacity evaluation report); and (7) documents evidencing the receipt of other disability benefits, including State disability benefits, Workers' Compensation benefits and Social Security Disability Insurance benefits.

Upon receipt of an appeal, a claim administrator has 45 days to notify the claimant of the decision; however, this deadline can be extended by another 45 days simply upon a notification by the insurer. If the appeal is not overturned (and why would it be, as it is being presented to the very same company that made the initial denial decision?) then your next step is litigation.

Filing the litigation

If your client exhausted all administrative remedies, only to see the insurance company continue to deny the claim, it's time to file a lawsuit.

As with all litigation, the first order of business is to make sure that you are bringing suit within the applicable statute of limitation.

ERISA does not contain a statute of limitations for benefits claims asserted under section 502(a)(1)(B). Given this absence, courts frequently adopt the analogous statute of limitations from the state law that would otherwise be applicable. The general rule is that a statute of limitations cannot begin to run until a claimant can bring a claim for relief, that is until all administrative remedies are exhausted.

However, some ERISA plans contain "contractual periods of limitations" shortening the time to file a suit. These provisions limit the ability to file to a certain time after proof of loss is first due, often three years. Recently, in *Heimeshoff v. Hartford Life & Accident Insurance Co.* (2013) 134 S.Ct. 604, the Supreme Court held that contractual limitations provisions in ERISA plans are enforceable, even those that begin to run before the claimant has exhausted mandatory appeals, so long as it is not unreasonably short or a controlling statute preempts.

Venue

As to venue, because ERISA is a federal statute, ERISA cases are almost always litigated in federal court. Pursuant to 29 U.S.C. section 1132 (e)(2), an action "may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found." For convenience purposes, this usually means in the federal district where the client resides, but any location that fits the above-listed criteria is sufficient.

Next, you need to identify the proper defendants. Should you sue the insurance company who denied the claim, the plan that promised the benefits or both? Under section 1132(a)(1)(B) of title 29 of the United States Code, an action to recover benefits or enforce rights under a plan can be brought against the plan itself and the claims administrator (typically the insurer that issued the group policy).

In some locations, the Ninth Circuit for instance, you do not need to sue that plan, as a lawsuit against the insurance company will typically allow your client to recover all available benefits. However, the best practice is to sue both the plan and the insurer. The reason is that some plans are "self-insured," which means that the plan, not the insurance company, is responsible for the payment of all benefits. You may not always know whether a plan is self-insured before litigation starts, so you are best served by suing the Plan when the litigation begins.

Finally, you need to make sure you are asserting the proper claims for relief. Most litigation over insurance benefits involve a breach of contract claim. However, under ERISA, state law causes of action are all but preempted. Thus, a claimant is not technically bringing an action for breach of contract, but rather is seeking to recover benefits and to enforce and clarify her rights under section 1132(a)(1)(B) of title 29 of the United States Code.

This is this most common, but not only, claim for relief available. For example, a claimant can also bring a claim for breach of fiduciary duty pursuant to section 1132(a)(2) of title 29 of the United States Code or for injunctive relief pursuant to section 1132(a)(3) of title 29 of

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the United States Code. These claims are rare, and depending on the facts of the case, damages can be limited. In most instances, the lawsuit should simply be brought under section 1132(a)(1)(B).

Litigating the case

Standard of review

Once litigation begins, your next goal is to ascertain which standard of review applies. ERISA cases are generally governed by one of two standards of review: (1) de novo or (2) abuse of discretion. Under a de novo standard of review, the district court undertakes an independent review of the Administrative Record, including the plan and the medical and vocational evidence, and evaluates whether the insured satisfied the terms of the Plan. The court freshly evaluates whether the insured is entitled to benefits under the terms of the Plan and decides which party's conflicting evidence is more likely to be true. While under this standard of review the claimant bears the burden of proving his entitlement to benefits, because the court makes a decision without affording any deference to the insurer's findings, de novo is a more beneficial standard of review to claimants.

While the de novo is the default standard of review, a claim decision will be reviewed under the abuse of discretion standard if the plan contains an unambiguous discretionary provision giving the insurer authority to determine eligibility for benefits or to construe the terms of the plan. (See *Metropolitan Life Ins. Co. v. Glenn* (2008) 554 U.S. 105.) However, a growing number of states, including California, New Jersey, Maryland, Texas, Vermont and Washington passed laws that prohibit delegation of discretion, notwithstanding any discretionary language in the plan.

Under the abuse of discretion standard, the question the court asks is different: whether the insurer's decision is supported by evidence in the Administrative Record and was not otherwise arbitrary and capricious. The abuse of discretion standard of review is less beneficial to insureds because the court is required to give some deference to the insurer's decision. Under the abuse of discretion standard of review, whether the insurer's decision was correct is technically irrelevant. What matters is whether the decision was so erroneous as to be deemed arbitrary and capricious.

Reducing discretion

Although the cards are stacked against a claimant if the abuse of discretion standard applies, that does not mean that the court will automatically rubber-stamp the insurer's decision.

If it is established that the insurer is operating under an inherent conflict of interest – that is, if the insurer is both the decisionmaker and is financially responsible for any benefits due under the Plan – the court must decide to what extent its actions are consistent with the conflict of interest. (See, e.g., *Abatie v. Alta Health & Life Insurance Co.* (9th Cir. 2006) 458 F.3d 955, 971.) If you can present evidence that the inherent conflict of interest affected the claim decision, you may be able to get discretion afforded the insurer reduced, or in some jurisdictions, even converted to de novo.

While discretion is reduced on a case-by-case basis, here are some examples where evidence of a conflict, resulting in reduced discretion, has been found:

• failing to comply with ERISA's procedural requirements;
• failing to explain the basis for the denial decision or providing inconsistent reasons for denying the claim;
• offering "clearly erroneous findings of fact" in support of the denial;
• reversing a previously approved claim without a concurrent receipt of new medical evidence;
• failing to advise a claimant of what information was needed to perfect the claim;
• excessive reliance on claimant's activities in the surveillance videos;
• conducing a "paper review" rather than an "in-person medical evaluation;"
• insisting on objective proof of disability, despite the absence of such a requirement in the plan;
• encouraging the claimant to file for other disability benefits and, when benefits are awarded, failing to distinguish the contrary disability decision;
• failure to consult with a health care professional who has appropriate training and experience in the field of medicine involved in claim;
• emphasizing a report that favored a denial of benefits while deemphasizing other reports suggesting a contrary conclusion;
• failure to follow up with claimant or his treating physicians regarding his medical condition; and
• failure to provide sufficient notice of the denial of the claim.

This list is not exhaustive but is rather a sample of evidence that courts have found to be sufficient to reduce the amount of discretion afforded the insurer's claim decision.

Discovery in ERISA cases

Perhaps the biggest difference between ERISA litigation and other types of litigation is the limitation on discovery. While each Circuit has different rules regarding ERISA discovery, given that district court's decision is based on the Administrative Record, traditional discovery is usually unavailable. Written discovery is very limited and depositions are extremely rare.

One factor in determining whether discovery is allowed is the applicable standard of review. Under the de novo standard of review, because the insurer's decision is not afforded any deference, whether that decision was influenced by the inherent conflict of interest or other bias is essentially irrelevant. Accordingly, in most de novo cases, discovery is not permitted. (However that does not mean the court will not consider evidence outside the Administrative Record, as the court may decide it cannot conduct an adequate de novo review of the claim decision without the extrinsic evidence. Generally, when considering whether to admit extrinsic evidence, courts look to factors such as (1) circumstances in which there is additional evidence that the claimant could not present in the administrative process; (2) consideration of complex medical questions regarding the credibility of medical reports; and (3) "instances where the payor and the

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administrator are the same entity and the court is concerned about impartiality." (See *Opeta v. Northwest Airlines Pension Plan* (9th Cir. 2007) 484 F.3d 1211, 1217.)

Under the abuse of discretion standard of review, discovery is much more common, if limited. Discovery is limited to written discovery, third-party subpoenas and, very rarely, depositions. Typically, discovery is limited to attempts to identify evidence of bias. That is, evidence that the inherent conflict of interest improperly influenced the insurer's decision.

Evidence of bias may include situations where the insurer denied a long-term disability claim based on the report of a physician beholden to the insurer. In those situations, discovery can be allowed regarding the compensation paid to these outside, so-called "independent" medical personnel, including how much money they receive and what percentage of their total salary is provided by the insurer/vendor for providing file assessments.

It can also be permissible for claimant to conduct discovery into the number of claims granted or denied based in any way upon medical reviews by the outside medical reviewer, as well as employment agreements, invoices and the amounts paid by the insurer to the third-party medical review company.

Also relevant are the performance evaluations of both outside medical professionals and in-house medical professionals and employees. The goal in this discovery is to ascertain whether a consultant or employee was reprimanded for approving too many claims.

Another valid avenue of discovery is what standards were provided by the insurer for the doctors to follow in assessing the claimant's specific disability. Also, the procedures by which the insurer ensured that its claims reviewers accurately decided claims. Discovery has even been permitted regarding the administrator's general approval and termination rates for long-term disability claims.

On the other hand, insurers rarely attempt to conduct discovery in ERISA cases. This is because they do not want to open the door to additional evidence regarding the claimant's medical condition.

Calculating benefits and available remedies

At some point in the litigation, you will engage in settlement discussions with the defendants. In these situations, you need a firm understanding of what remedies are available in an ERISA case.

Calculating benefits in ERISA cases can be complex, particularly with long-term disability claims. For example, disability plans promise benefits if a disability prevents a claimant from continuing to work. However, disability plans never cover a claimant's entire pre-disability income. Rather, a person is entitled to only a portion, usually between 40 and 65% of pre-disability income.

Further, all plans include offset provisions, by which the monthly benefits owed is reduced by other income and disability benefits the claimant is awarded. Thus, this amount will be offset by any state or federal disability benefits the insured is awarded, including State Disability benefits, Social Security Disability Insurance benefits and Workers' Compensation benefits.

Some plans even offset for disability benefits paid under a different disability insurance policy, retirement plan benefits funded by the employer that issued the group policy, amounts received in a personal injury lawsuit settlement or judgment for loss of earnings and amounts received as sick leave, salary continuation, vacation pay and personal time off. (Sometimes an insured receives so much "other income" that she is entitled to receive only a "minimum benefit," the amount of which is defined in the policy, but typically the higher of 10% of the full monthly benefit or $100 per month.)

Calculating the value of the claim is not as simple as multiplying the monthly benefits by the number of months the person can expect to be disabled. Under ERISA, the district court can only award benefits owed through the date of trial, with interest. The sum total of what your client could be awarded at trial is past due benefits, with interest, and attorneys' fees and costs. She is not entitled to emotional distress damages, bad faith damages or punitive damages.

Nor will she be awarded future benefits by a judge. While future benefits can be negotiated during a settlement, even if your client prevails at trial, she will not be awarded a lump-sum payout of future benefits. Instead, the claim will be remanded back to the insurer for further review. That means, even if you prevail, your client could be shackled to the insurance company for years to come. Thus, it may benefit your client to reach a settlement that includes a lump sum payment of future benefits.

Preparing for trial

Since ERISA is generally viewed to be an action in equity, there is no right to a jury trial. District courts typically require that the parties prepare two rounds of simultaneous trial briefing. Given the page limitations, it can sometime be a struggle to synthesize hundreds or even thousands of pages of medical evidence into a brief, coherent story. After reviewing the briefs, the district court will then conduct a "bench trial" based on the Administrative Record and, in some cases, evidence the court allows outside of the Administrative Record. No witnesses will be called.

Trials can take between 30 minutes and an entire day, but usually last no more than two hours. Or not. A significant number of ERISA trials do not actually happen, as district courts routinely take such matters under advisement.

If, after all of that, you prevail at trial, there is still at least one more motion before you; a motion for attorneys' fees and costs. While attorneys' fees are awarded at the discretion of the court, in all likelihood the court will award reasonable attorneys' fees if your client prevails.

You do not necessarily need to win every issue to collect an attorneys' fees award. The Supreme Court declared that an ERISA claimant need only demonstrate "some degree of success on the

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merits" in order to be awarded attorneys' fees, not the more rigorous "prevailing party" standard initially imposed by some circuits. (See *Hardt v. Reliance Standard Life Insurance Co.* (2010) 560 U.S. 242, 255.)

The issue is then whether your fees are reasonable. The analysis is generally the reasonable number of hours incurred by the attorney in successfully pursuing the claim multiplied by a reasonable hourly rate charged by attorneys with similar experience and qualifications in the area. You will need to submit a declaration, justifying your hourly rate. Declarations from other ERISA attorneys in your area are also advised. The courts will not award flat contingency fees in an ERISA case.

Ordinarily, attorneys' fees are not awarded to the insurance company if you lose your lawsuit. But if the court determines your suit was brought in bad faith, the court has the discretion to award fees to the insurance company or to the plan.

Conclusion

ERISA litigation is different from other litigation. ERISA cases are complex, involving unique limitations that must be heeded and deadlines that must be met at every turn. The above are just a few things to keep in mind when making and litigating an ERISA insurance claim.

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