ABC's of Handling ERISA Insurance Claims

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A lawyer will almost always encounter issues which fall under the Employee Retirement Security Act of 1974 (ERISA), codified at 29 U.S.C. § 1001 *et. seq*. Many attorneys are tempted to glaze over at the mere mention of this complicated but all-encompassing enactment, but it is an unavoidable part of the practice of law, especially in the area of insurance. If your client's insurance claim arises from a policy obtained as part of the policyholder's employment, your client's rights may well be governed by ERISA.

The most common question asked by non-ERISA practitioners is "how can I tell if ERISA applies?" That question is then followed by the obvious concern, "What do I do now if it does?" This presentation provides an overview on what to do when you encounter these cases.

I. WHAT IS ERISA?

ERISA is a comprehensive Federal statute that applies to many claims for employee benefits. ERISA is a complicated area of the law that, at the end of the day, creates a number of often-byzantine hurdles that an employee or employee's beneficiary (and their attorneys) must clear before they can obtain their benefits.

Congress enacted ERISA in 1974 to address perceived problems of employee's rights not receiving uniform or, in some instances, adequate protection by the laws of the different states in which they worked. Due in part to rising reports of corporate mismanagement, Congress also sought to address corruption and self-dealing involving large pension plans. ERISA's beginnings, therefore, arose out of Congress's intent to afford employee pensions more protection from employers, to empower employees by addressing the disparity in bargaining power between employers and employees in the context of pensions, and to establish uniform national standards. Thus, ERISA was originally intended to apply only to "pension benefits." Fatefully, at the last minute, ERISA was amended to include other employee benefits as well, including "employee welfare benefits" such as health, disability, and life insurance.

The language of the ERISA statute draws heavily from trust law as well as contract law. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111-113 (1989). Accordingly, when enacting ERISA, Congress has called upon 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.

II. SO … WHAT IF ERISA APPLIES?

From your client's perspective, the largest consequence of ERISA is the limitation on the relief available, a fact that many clients are surprised to learn. In a benefits case, ERISA may limit your client's remedies to include only the recovery of the benefit that should have been provided. Although in some instances it may be possible to recover interest on past-due monetary benefits and to recover attorneys' fees (an event that can be unusual in Eleventh Circuit courts), no other award is typically permitted, including punitive damages.[1] Furthermore, all state law remedies, including insurance bad faith and fraud, are (with very few exceptions) precluded. 29 U.S.C. § 1144(a).2 This "super-preemption" also means that even though ERISA grants concurrent jurisdiction to both state and federal courts, ERISA cases may land in federal court if defendants want them there due to the existence of "federal question" jurisdiction. So, you may find the first notice you receive that your claim implicates ERISA is when you receive notice of removal from state court.

Many lawyers are also often surprised that in ERISA litigation, courts often suspend the normal rules of civil procedure, especially in the realm of discovery. Under ERISA, a claimant typically must present all of his or her evidence to the insurance company before filing suit. The claimant may also be required to pursue internal appeals with the insurance company and "exhaust" administrative remedies before a court will entertain suit. Once suit is filed, in the vast majority of cases the court will prohibit all merits-related discovery, limit the scope of review to the materials before the claim administrator who denied the claim and review that claim decision under a highly deferential "abuse of discretion" standard. The court then will decide the case based on briefs or, in rare circumstances, upon conducting a bench trial; in ERISA there are no jury trials.

The unusual degree of difficulty inherent to most ERISA claims is not insurmountable if the attorney is knowledgeable about ERISA's procedures. The subject of ERISA litigation strategies, however, is a more advanced topic that is beyond the scope of this article/presentation.

[1] The United States Supreme Court has suggested "surcharge" remedies should be available but the case law on such remedies in the context of ERISA claims is extremely limited. *See Cigna Corp. v. Amara*, 563 U.S. 421, 131 S.Ct. 1866, 179 L.Ed.2d 843 (2011).

III. IDENTIFYING AN ERISA-GOVERNED PLAN

An "employee welfare benefit plan" under ERISA includes any insurance plan "established or maintained by an employer or by an employee organization, or by both…." 29 U.S.C. § 1002(1). Although 29 U.S.C. § 1102(a)(1) requires plans to be "established and maintained pursuant to a written instrument," the Eleventh Circuit nevertheless has held that ERISA plan may exist even without a "formal, written plan." *Donovan v. Dillingham*, 688 F.2d 367, 1372 (11th Cir. 1982)(*en banc*). In *Dillingham*, the Court held this "established and maintained" requirement can be satisfied "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Id.* at 1373. This same test is used in all other circuits. *See Williams v. WCI Steel Co., Inc.*, 170 F.3d 598, 602 n.3 (6th Cir. 1999) (reporting that "every other circuit" has adopted the *Dillingham* test).

Importantly, not all employee insurance plans are ERISA-governed plans. The Department of Labor has clarified through the issuance of regulations that some policies made available through work are not ERISA plans because they fall under ERISA's "safe harbor" provisions. *See* 29 C.F.R. § 2510.3-1(j); *see also*, *e.g., Anderson v. Unum Provident Corp.*, 369 F.3d 1257, 1262 (11th Cir. 2004). This "safe harbor" exception applies if: (1) the employer or employee organization does not make any contributions to the plan; (2) the employee's participation in the plan is voluntary; (3) the involvement of the employer or employee organization with the plan is limited to permitting the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check-offs and to remitting them to the insurer, but without endorsing the plan itself; and (4) the employer or employee organization receives no consideration in connection with the program, other than reasonable compensation, excluding any profit, for very limited administrative services. 29 C.F.R. § 2510.3-1(j). Reported decisions, however, show this exception to be difficult to meet, especially where the employer involved itself even in the slightest in assisting employees in procuring the insurance. In this regard, an employer can "establish and maintain" an ERISA plan even if it never had any intent of doing do. *See Anderson,* 369 F.3d at 1263-64.

Equally uncommon is having a benefit scheme that qualifies not as an ERISA plan, but as simply a "payroll practice," which Department of Labor regulations exclude from ERISA's application. 29 C.F.R. § 2510.3-1(b). Employee benefits of this nature include, naturally, compensation the employee receives for things like overtime and also vacation pay. They also include, however, compensation paid to an employee on account of his or her inability to work due to disability or other medical reasons, as long as the compensation is paid out of the employer's "general assets." *See generally Stern v. International Business Machines, Corp.*, 326 F.3d 1367 (11th Cir. 2003).

The most successful means to escape ERISA's clutches is based on the kind of entity the employer is. For instance, ERISA does not govern welfare benefit plans established and maintained by governmental entities. 29 U.S.C. § 1003(b)(1); 1002(32). Neither does ERISA apply to plans created by religious organizations that are tax-exempt pursuant to 26 U.S.C. § 501 or their associated corporations, *see* 29 U.S.C. § 1003(b)(2) and § 1002(33), unless the religious organization has elected to "opt in" pursuant to 26 U.S.C. § 410(d). Determining whether a valid election has occurred requires obtaining the forms and examining whether they comply with 26 C.F.R. § 1.410(d)-1.

IV. THE MOST COMMON – AND <u>SERIOUS</u> -- MISTAKES MADE BY ATTORNEYS UNFAMILIAR WITH ERISA-GOVERNED DISABILITY CLAIMS.

1) Failing to Identify and Pursue Potential "Ancillary," "Collateral," or "Follow-On" Benefits When There Is a Disability.

When a person becomes disabled, he or she may have disability coverage from his or her employer. This disability coverage provides a monthly benefit that usually is in an amount equal to a percentage of the employee's pre-disability earnings, minus applicable offsets for things like Social Security disability benefits. In many cases (but not all), the employer has also provided for additional benefits for disabled employees. These are often termed "ancillary," "collateral," or "follow-on" benefits. Sometimes, these benefits automatically are provided, meaning the employee receives the benefit without needing to go through a separate application process under the plan. For example, some employers allow individuals receiving LTD benefits to receive continued coverage under the company's health insurance plan. Meanwhile, other employers may provide those individuals with continued pension accruals even though the individual is no longer working.

Other forms of ancillary benefits, however, may require the individual to take action to obtain them that goes beyond applying just for his or her LTD benefit because the benefit pertains to a separate insurance coverage. A common example of separate coverage of this sort is life insurance where the policy may allow the employee to continue that coverage without any premium obligation for as long as that person remains disabled. This is generally known as a "waiver of premium" benefit. Typically, this benefit must be obtained through an application separate from the LTD application. If the application is not timely submitted, or if that benefit is otherwise not separately pursued through its own administrative process, that employee may have forfeited forever valuable and important coverage.

2) Delay in Filing for LTD Benefits Because of a Policy Offset for Social Security Disability, Worker's Compensation or Similar Incomes – or Vice Versa.

When a person becomes disabled, he or she may have access to several different income streams depending on the circumstances. If the disability is caused by a workplace injury, for example, workers' compensation benefits may be available. Sometimes, someone who is disabled may be able to draw a special "early retirement" income. But in almost every case, that person will at least be able to apply for Social Security disability insurance.

Two versions of the same mistake often get made at this juncture as the individual or the handling attorney try to navigate through the LTD insurance plan's offset provision, a near-universal provision found in LTD plans, especially when the plan involves an insurance policy. Because an offset provision provides for a reduction of the LTD benefit on a dollar-for-dollar basis equal to the amount of other forms of disability income received, some individuals and their attorneys may decide the LTD benefit is not worth pursuing. Or for a benefit like workers' compensation where the other benefit payment may expire after a certain time, they may decide not to apply for the LTD benefit until after that other benefit ends.

Even if this impacts the workers' compensation benefit in some way, this can be risky where the LTD benefit is concerned. ERISA LTD insurance, like other forms of insurance, typically requires a claim to be submitted within a specified amount of time after the disability occurs. If the claim is not submitted within that amount of time, the insurer likely will seize upon that delayed submission as a basis for denying the claim. If your client is inclined to delay filing an LTD claim for any reason, it is important to explain the possible implications that delay may have on his or her ability to pursue this LTD benefit later.

The converse of this occurs where an individual may be inclined to delay filing for Social Security or for some other form of disability benefit thinking that doing so will avoid reduction of their LTD benefit under its offset provision. This is not advisable either. The concern that arises is that Social Security benefits generally are more accessible to claimants than ERISA-governed LTD benefits. At the very least, Social Security gives that person a second and usually substantial chance at an income stream while he or she remains disabled. It also has the secondary benefit of lending support to that person's LTD claim, because courts generally require insurance companies to give meaningful consideration to favorable Social Security decisions.[2] Thus, pursuing both Social Security and LTD is in that person's best interests. An additional reason it is important is that many LTD policies allow the insurance company to reduce the LTD benefit by the amount

[2] *See Melech v. Life Ins. Co. of N. Am.*, 739 F.3d 663 (11th Cir. 2014)

that person would have received in Social Security benefits if they had applied. Accordingly, choosing not to apply for Social Security to avoid the reduction caused by an offset provision ultimately may serve no purpose at all.

3) Failing to Obtain Important Evidence Supporting the Claim During the Administrative Appeal

Attorneys not accustomed to ERISA litigation are surprised to learn that courts often suspend the normal rules of civil procedure, especially in the realm of discovery, when ERISA is invoked. Under ERISA, a claimant typically must present all of his or her evidence to the insurance company before filing suit. The claimant may also be required to pursue internal appeals with the insurance company and "exhaust" administrative remedies before a court will entertain suit. Once suit is filed, in the vast majority of cases the court will prohibit all merits-related discovery, limit the scope of review to the materials before the claim administrator who denied the claim and review that claim decision under a highly deferential "abuse of discretion" standard. The court then will decide the case based on briefs or, in rare circumstances, upon conducting a bench trial. There is no right to a jury trial in ERISA.

Because of the manner in which many courts limit – or altogether forbid – discovery, the actual "trial" in an ERISA case occurs during the administrative process with the insurance company, not the court, because that is where the "trial record" is made. This means that evidentiary defects committed during the administrative phase generally are set in stone. For example, if you fail to address a disability carrier's vocational review during the administrative phase, you will not be able to correct that mistake later in litigation. It is wrong to assume that medical records alone are enough to support a disability claim. Evidence of a diagnosis, no matter how severe, almost always will not be enough, because the outcome of a disability case also depends on whether there is evidence of specific restrictions and limitations. How that evidence is presented is important and is something that experienced ERISA attorneys are well-versed in doing.

4) Conceding "There Is No Discovery" in an ERISA Case

Litigating an ERISA claim almost always involves confronting a defending insurance company's position that there is no discovery in an ERISA case. It also frequently involves a court that at least initially may operate under the assumption that the insurance company is correct. In the vast majority of instances, it is a mistake to succumb to this pressure.

As an initial matter, nothing in ERISA supports the wholesale abolition of discovery. As the United States Supreme Court and Eleventh Circuit have made clear, discovery is not only permitted but is often required in ERISA cases to reach

the heart of matters at issue.[3] To this end, a number of courts have held that discovery seeking information such as the insurance company's claims-handling procedures or evidence showing the insurance company's financial motivation to deny the claim is proper.[4]

Conceding there is no discovery on such matters means you effectively have yielded to the insurance company's nominal suggestion that the manner in which they handled the claim was above-board. While it remains true as discussed above that discovery into the merits of the claim itself is almost always prohibited, procedural concerns about the way the insurance company has decided the claim are another matter. If you have reason to believe the claim procedurally was handled improperly, concession of this point is a mistake.

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[3] *See Burks v. American Cast Iron Pipe Co.*, 212 F.3d 1333, 1338 (11th Cir. 2000) (holding that "[t]he district court should allow discovery before considering summary judgment against the plaintiffs."); *see also Adams v. Hartford*, 589 F. Supp. 2d 1366, 1368 (N.D. Ga. 2008) ("Th e court concludes that the plaintiff is entitled to pursue any discovery [in this ERISA case] that 'is relevant in itself or that appears reasonably calculated to lead to the discovery of admissible evidence"). ERISA was "enacted to promote the interests of employees [such as Plaintiff] … and protect their contractually defined rights" and certainly does not eliminate the procedural safeguards provided by the Rules of Civil Procedure. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 113, 109 S. Ct. 948 (1989).

[4] A partial sampling of cases includes *Melech v. Life Ins. Co. of N. Am.*, 857 F. Supp. 2d 1281, 1285 (S.D. Ala. 2013) (ordering the production of LINA's claims manual and documentation on its compensation and performance evaluation structure in an ERISA case governed by a deferential review standard); *Branch v. Life Ins. Co. of N. Am.*, 2009 WL 3781217, *4-*6 (M.D. Ga. Nov. 11, 2009) (allowing discovery in an ERISA case against LINA which included LINA's internal policies and procedures and information relevant to whether LINA's claims department was not properly insulated from LINA's financial conflict of interest); *Kruk v. Metropolitan Life Ins. Co.*, 267 F.R.D. 435, 439-442 (D. Conn. 2010) (interpreting 29 C.F.R. § 2560.503-1(m) and ordering MetLife in an ERISA case to produce its policies and guidelines pertaining to the plaintiff 's claim regardless of whether such were actually consulted or relied upon in making the benefit determination); and *Anderson v. Unum Life Ins. Co. of America*, 414 F. Supp. 2d 1079 (M.D. Ala. 2006) (citing to a services agreement produced in discovery to determine what entity denied Plaintiff 's claim for benefits and thus the standard of review to be employed by the Court).

5) Failing to Quickly Identify and Adhere to Plan Deadlines, Including Hidden Limitations Provisions for Bringing a Lawsuit

Nothing keeps attorneys awake at night more than the thought of having missed a deadline. And it just so happens that this is one of the more frequent mistakes – and the most serious – made by those who are relatively unfamiliar with the day-to-day aspects of handling ERISA cases. The first deadline (aside from the deadline for applying for the benefit at the outset) is the deadline for appealing the initial denial of the claim by the insurance company or plan. Claimants must submit their appeals on time and in writing strictly in the manner set forth under the governing policy or plan, though within the limits set forth in Department of Labor claims regulations at 29 C.F.R. § 2560.503-1. A failure to appeal within the time provided means the claim is forever abandoned – ERISA requires plaintiffs to pursue and exhaust all administrative remedies the policy or plan provides as a condition precedent to bringing a lawsuit.[5]

Assuming the appeal is unsuccessful, the next deadline requiring immediate attention is the limitations period for bringing a lawsuit. Unlike with the appeal deadline, there is no set standard about when that limitation period either begins or ends. ERISA does not have its own limitations provision for bringing a lawsuit to recover a benefit. Instead, it looks to the various states for their respective statutes of limitations that most closely resemble the ERISA claim for benefits, like states' statutes for pursuing breaches of insurance contracts. But those statutes only apply in the absence of terms within the policy or plan itself that may establish its own limitations period. Depending on policy or plan terms, that statute can be as short as 120 days or as long as six years. It also possibly may start running as early as the day the disability arose (that being the loss event) or as late as the date the administrative appeal of the claim was denied. It simply varies. But in the end, the plan or policy controls, so it is critically important to locate the governing limitations provision within that plan or policy and calculate correctly the limitations date applicable to the claimant as soon as possible. Failure to do so can result in an outright loss of the claim.

V. CONCLUSION

When handling an ERISA claim, it is important to be aware of all the pitfalls that can occur so you can protect your client and serve his or her needs fully and faithfully. All too often, attorneys not versed in ERISA or familiar with this special area of litigation proceed blindly without knowing all they need to know to protect

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[5] Although the Act itself includes no express provision requiring the exhaustion of remedies before the filing of a lawsuit, the Eleventh Circuit and other courts generally require exhaustion as a precondition to litigation. *Perrino v. Southern Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000).

their clients' interests. In those instances, the last and final mistake those attorneys may have made will have been the failure to seek assistance from another attorney whose regular practice involves knowing where these pitfalls are and how to avoid them.