The Basics of ERISA Benefits Claims

Session I: Counseling the ERISA Claimant

5 Stepping Stones to Cross the Serbonian Bog

First Step. The claimant calls. What does the claimant want? Can ERISA provide it?

Second Step. What does ERISA say? Can you rely on the Act itself?

Third Step. Can the claimant “perfect the claim”?

Fourth Step. What do the courts do with ERISA benefit claims?

Fifth Step. Where does it all end?

First Step. The claimant calls. What does the claimant want? Can ERISA provide it?

The claimant calls.

“I’ve been denied my benefit. Can you help me?”

What can ERISA provide as relief? What cookies are in ERISA’s cookie jar? Does it look like some are missing? Who took them?

ERISA’s remedial provisions are all in 29 U.S.C. § 1132.

That section, sometimes called “section 502,” will give you a hint at what ERISA might provide as remedies. Basically all the remedies ERISA affords must pass through that provision. This presentation concentrates on the benefits due “under the terms of the plan.” (We’ll save ERISA’s “other appropriate equitable relief” provision, sec. (a)(3), for now. Its case law is, as they say, under construction. We are assuming here that the “terms of the plan” do provide for the benefits that have been denied and that the claimant appears to have a right to recover them “under the terms of the plan.”

ERISA provides for the recovery of benefits, clarification of the right to future benefits and enforcement of the terms of the plan in § 1132 (a)(1)(B).

Note well that “under the terms of the plan” is key. What you see is what you get (WYSIWYG) means something. You will need to examine carefully the “terms of the plan” in order to begin to know what benefits are provided.

In *Donovan v. Dillingham* the court sets out the general definition of an ERISA plan.

ERISA plans can shorten statutes of limitation, can provide additional eligibility requirements for enrollees, can provide for the continuation of benefits and for termination of benefits “under the terms of the plan.”

The “terms of the plan” can look to state law. State law cases can determine which state’s law applies.

There are two types of plans, employee welfare benefit plans and employee pension plans. Disability, health and life insurance benefits, for example, generally fall under “welfare benefit plans.” Note that not every benefit program is necessarily an ERISA plan. Short-term disability benefits paid from the employer’s own assets may be a so-called “payroll practice,” as defined by the Secretary of Labor. Despite their appearance, payroll practices are not ERISA plans. Similarly, severance benefit plans may or not be ERISA plans.

So, not only will you need to read the actual terms of the plan, you will also need to know if you have an ERISA plan, as such, at all. Workers’ compensation is expressly excluded in ERISA itself. Governmental and church plans are also not governed by ERISA. What is or is not a church plan may depend on the case law at a given point.

What happens when an ERISA plan is converted to an individual life insurance policy and whether ERISA governs can also be unclear.

What happens when a court concludes that the plan is governed by ERISA and the plaintiffs plead an amended complaint under ERISA only? The “converted” claims continue as ERISA claims.

The plaintiffs complied and won their case in the district court under ERISA in one case only to be told by the appellate court that they had been right in the first instance. The case was not an ERISA case. Neither could the parties confer jurisdiction by consent. The plaintiffs’ victory was nullified.

A trap for the unwary is if defendants attempt to remove a case to federal court arguing that it involves an ERISA plan and ordinary preemption. Once in federal court the defendants argue that it is preempted by ERISA. The courts seem to have caught to this trick thankfully. If relief is not available in federal court akin to the relief sought in the pending state court action, it cannot be removed to federal court. Ordinary preemption can be decided in the state court and provides no basis for invoking federal court jurisdiction. *Butero v. Royal Maccabees* is the 11th Circuit case on point.

The COBRA continuation provisions are tacked on at the end of ERISA and enforced through ERISA's remedial provision.

As you make your way through sect. 1132, you will find that 29 U.S.C. § (a)(1)(a) refers you to a right to sue under 29 U.S.C. § 1132 (c)(1), below.

This "personal liability" provision is called the "penalty provision." It seems on its face to apply to any "administrator" of a plan. The courts restrict its application, though, to the named plan administrator. (Who the plan administrator is can depend though. In general, even in the circuits where the plan administrator is the one which administers the plan, a functional approach, the so-called penalty provision applies just to the named plan administrator and not to the insurance company or third party administrator deciding benefit claims for the plan.)

The penalty provision is generally seen by the courts as a penalty provision, and not as a remedial provision. That means that the courts look to how widespread the violation is, such as how large the employer is, how prolonged the violation was, and so on. Prejudice to the claimant is not required but may affect the outcome as to the amount of the penalty awarded or potentially be referenced if in its discretion the court decides no to award a penalty at all.

Penalties range up to the maximum of $110 a day. This provision requires a written request to the plan administrator for the plan document or other instruments governing the operation of the plan, under sect. 1024(b)(4).

Second Step. The statute. Can you rely on the actual words of the Act? What does "ready access" mean? In any dictionary definition, that word "ready" word seem to mean "fire when ready" or "ready, aim, fire!" Hamlet said: "Readiness is all."

Well, the federal courts say that first, you have to endure the slings and arrows of outrageous fortune," exhausting your "administrative remedies." Your case is not "ripe" until you do.

Basically, even though state courts have “concurrent jurisdiction” over (a)(1)(B) benefit claims, forget about it. Federal question jurisdiction means that any case can be removed to federal court, “concurrent jurisdiction” notwithstanding.

Once there the “ripeness doctrine” of the federal courts means that they are not “ready” to hear your case yet. You have to exhaust your administrative remedies. What administrative remedies? Those that the claims procedures of the plan provide you and the claims procedure regulation of the Secretary of Labor promulgates.

You have to use the claims regulation yourself. Do not count on the Secretary of Labor to help you or your client. So, ready access is meaningless, if you take it literally.

Third Step. Can the claimant “perfect the claim”? In tort terms we have now left “damages” and entered the realm of “liability.” The claims procedure regulation implements ERISA’s full and fair review provision, 29 U.S.C. § 1133.

The Secretary defines what a full and fair review entails at 29 C.F.R. § 2560.503-1. The claims regulation is your key to unlocking the mysteries of what happened to the caller’s claim. You need to study it carefully. You need to know which version applies to your caller’s claim. You need to know what the plan did before you can challenge it. The regulation gives you your best and possibly only chance to do that before filing your so-called “administrative appeal” to the plan or its administrator.

The regulation defines the structure of the plan as requiring guidelines for decision-making, as requiring some sort of verification that they have been applied in your claimant’s case, etc., in order to assure that your claimant has and will enjoy a full and fair review of a claim that is denied in whole or in part.

The claims regulation focuses on procedures required. Generally, your caller will have received a written notification, an adverse benefit determination. That written notification itself must meet certain criteria and

provide certain information, in order to fulfill the claims regulation's requirements. In general, it will not.

Be skeptical especially if the notice drones on and on with lengthy paragraph quotations of plan or policy provisions that seemingly bear little or no relationship to the issue or issues in question. You will find that the "specific reason" or reasons for the decision are generally absent or hard to discern in such a letter.

Also search for some description of what to submit and why. This is almost always absent, although required by regulation.

A mere description of a list of medical tests, laboratory results, office visits to the doctor and so on is insufficient.

The claims procedure regulation functions procedurally as well as structurally. Sufficient procedural violations may give rise in and of themselves to a right to relief according to case law. More recent case law casts doubt on the effectiveness of arguing that point, however. Presumably the violations are then considered not sufficient or egregious enough to allow the courts to grant substantive relief.

In general, what the claimant must do is to "perfect the claim." It is supposed to be handled before suit in a nonadversarial manner. The plan is supposed to disclose why it denied the claim and what the claimant would have to furnish to the plan to perfect the claimant's claim.

You cannot rely on the procedural violations. You must request the "relevant" materials from the party which denied the claim. If you don't, you tread at your peril into the unknown. You need to know what the plan did or did not do in applying the terms to your claimant's case. In invoking an exclusion for alcohol intoxication, one insurer overlooked that other imbibers were diving safely at the same place and the same time as the quadriplegic claimant. Before denying the claim the insurer should have but failed in its duty to conduct an adequate fact investigation.

The one advantage the claimant has is that the claimant has one claim. The insurance company or self-insured plan has many. They are not as focused on the claimant's claim.

It is a bureaucracy with evidence of "groupthink" in the relevant materials. Lots of people with tiny inputs marching like lemmings over the cliff.

If you have taken the case, or even have thought of taking it but not yet decided, this is a good time to ask if the treating medical providers will support the claim or not. It is often the best time to center on the claimant's own occupation and what the requirements were. If the claim is terminated at the later "any occupation" level, it is well to consider whether the insurer supported the claimant's claim for Social Security Disability Insurance benefits and even paid for the claimant's representation.

What information did the insurance company solicit from its own in-house or third party vendors about the claimant's disability or work capacity? Were the issues fairly framed or unfairly focused on disproving the claim?

These are not going to come up on the first phone call, but they need to be considered as almost certain to pose problems or openings for the claimant to perfect the claim administratively or prove the claim in court.

The Act's terminology can cause confusion. The term "administrator" as noted above does not mean any "administrator" when applied in the context of the penalty provision. Rather it means the plan administrator named in the plan document.

An award of attorney's fees means the lodestar calculation of a reasonable number of hours times a reasonable hourly rate. When does the clock start? The administrative exhaustion required by the courts is generally not included? Whose rate? The rate of the locality where the case is heard? The rate where the plaintiff's attorney has his or her office?

What is necessary for there to be an award at all? What considerations did the Supreme Court in *Hardt* say were unnecessary and bore little or no relation to the test for making an award? What guidelines do the courts

nevertheless persist in requiring? Does a plaintiff even have to win the particular issue in question?

Are defendants and plaintiffs on equal footing when it comes to attorney fee awards? Is ERISA a prevailing party statute? At best it can be said safely that generally plaintiffs who have had some success on the merits will receive an award of attorney fees. In general defendants will not.

Fourth Step. The role of the courts. The courts generally will look at the administrative record and use it as the basis for deciding the case. Conflict of interest may open discovery for the plaintiff, but in general discovery will be limited.

The role of whether to decide that the decision was wrong or else whether it was arbitrary-and-capricious, called an abuse of discretion interchangeably, is captioned under "standard of review." For this we can thank the 1989 *Firestone v. Bruch* opinion of the Supreme Court.

Firestone gave the plans free rein to write in their plans provisions entitling their decisions to deny claim to deference. How to handle an insurance company's defense of its own assets as deserving deference might be one way to put it.

The conflict-of-interest aspect received attention by the Supreme Court in *Glenn v. MetLife*, as it is called generally. As regards that aspect, the federal district courts must consider it. Although "tie goes to the claimant" in a close case might be the short version of Chief Justice Roberts's concurrence, in practice, what has come about after *Glenn* seems not to have proven that observation out. Establishing how a conflict of interest tainted the claims process has often been the focus of the courts.

This stage is the "standard of review" stage. The summary plan description, the "SPD" can generally be relied on to claim "discretion," if the plan provides for it.

You will want to ask the claimant if the claimant already has one. If not you will want the claimant to get one or to allow you to write for one with his authorization. The plan administrator, generally, the employer, must furnish

you with a copy of the latest SPD within 30 days of receipt of the claimant's written request. It is not the "plan document," but it will give the eligibility requirements, the benefits description, and in general "the names of the players," that is, who does what and how the benefits are funded.

Assuming that the Complaint is filed, it will need to set forth the facts and the law – the legal conclusions following from the plausibly. This requirement offers the opportunity to put down both the facts and the inferences to be drawn from them coherently.

The result of a successful case may be an award of the benefits, and it may be a clarification of the future rights to benefits or an enforcement of the terms of the plan. Nevertheless, another result not provided for in the statute is a remand to the plan for further consideration of some point or some phase of the claim not already documented in the administrative record. This result may entitle the claimant to a fee award, even if no benefit has been awarded. It may entitle the claimant to benefits up to some point, such as the end of the own-occupation period with the remand to pick up there.

The case continues until the remand is complete and is usually considered abated until that point.

Interest may be awarded on past due benefits if awarded by the court.

Fifth Step. Where do most ERISA cases end up? Mediation is mandated in all ERISA benefit claims cases, even if the parties do not foresee any likelihood of settlement. The claimant has a claim for benefits, interest, costs and attorney fees that have matured as well as a potential claim for benefits that may accrue in the future. The claimant has no claims for punitive damages or consequential damages.

The defendant has many cases and not just this one. What the defendant cannot avoid is ongoing litigation and the uncertainty of the outcome of this case as well as its potential repercussions for future case.

The mediation process generally brings both sides close enough together by means of the payment of money to the claimant by the defendant.

Mediation is a confidential process. A settlement agreement is not necessarily confidential, but confidentiality as well any other terms agreed upon could be bargained for and included or not. If both disability benefits and waiver of premium life insurance benefits are covered by the same insurance company, the settlement of all claims has been considered appropriate for mediation at one time.

If mediation does not result in settlement, the case will continue and will be resolved under the de novo standard of review or the abuse of discretion/arbitrary-and-capricious standard of review.

Upon stipulation of the parties, the U.S. Magistrate Judge may hear the case in lieu of the federal district judge. The parties may consent to magistrate jurisdiction.

Conclusion. The ERISA cookie jar seems to be missing the right to jury trial, claims for consequential damages, claims for punitive damages, broad discovery, evidence of expert qualifications, and clear enforcement of the claims procedure regulations as written.

The claimant caller's concluding question is often: "Do I have a case?" What is your best answer to the question now?