ERISA as zombie apocalypse

When a long-term disability claim is denied, the procedural limitations of ERISA litigation will baffle those seeking recompense

By Rebecca Grey

The zombie apocalypse starts with a nice person. Some perfectly good, well-meaning person sneezes on an airplane carrying your Aunt Nancy back to Hoboken (NJ) from an architectural tour of St. Petersburg. Aunt Nancy, who always baked you cookies or emailed pictures of kittens, turns green and angrily bites Uncle John, who was minding his own business adding a smoke pellet to his favorite toy train.

Uncle John loses an ear and a couple of fingers and gets on the subway to Manhattan. There goes the tri-state area. Soon, no one is safe, the infection spreads and even the heroes and protectors we always assumed would save us have no power. The zombies take over and insert themselves into so much of our lives that the survivors barely remember what life was like before.

Do I exaggerate?

It's surprising how many experienced lawyers well-versed in matters of insurance do not know which law applies to most employer-sponsored employee benefits. Consumers of insurance products received through work, and their lawyers, are often in for a rude awakening when they make a claim for benefits. Enter the zombie.

There is a misconception that when you receive health, life or disability insurance through an employer or through payroll deductions, you have a contract with an insurance company with the panoply of rights and remedies associated with a breach of that contract. Indeed, in California, insurance consumers theoretically enjoy the benefit of extensive consumer protections for insurance coverage.

As most lawyers know, the fancy-sounding *implied covenant of good faith and fair dealing* sets forth a patchwork of rules which requires insurance companies to treat their insureds fairly. Breach of the covenant of good faith and fair dealing, or bad faith, entitles aggrieved insureds to pursue the full range of legal remedies, including past and future

benefits, consequential damages, emotional distress damages, attorney's fees and, importantly, punitive damages where the insurer's conduct is particularly outrageous. Bad faith protection is our superhero, protecting us from the zombies.

This imposition of tort liability is with good reason. The purchase of insurance, particularly Long Term Disability (LTD) insurance, is not like the purchase of any other marketplace widget. Insurance companies sell a vital service which courts have noted is, "quasi-public in nature." (*Egan v. Mutual of Omaha Ins. Co*., 24 Cal.3d 809, 820.) A purchase of LTD insurance is for the insurance company's promise, for a fee, to provide economic protection for the insured's peace of mind and "*protection against calamity.*" (*Id. at* 819.) Protection against zombies.

Despite the crucial nature of the benefit and the potential severity of harm occasioned by its deprivation, insurance contracts are usually "adhesive in nature," couched in obfuscatory terms of art in form language dictated entirely by the insurer. "The availability of tort remedies in the limited context of an insurer's breach of the covenant advances the social policy of safeguarding an insured in an inferior bargaining position who contracts for calamity protection, not commercial advantage." (*Kransco v. International Ins. Co.* (2000 23 Cal.4th 390.) Courts recognize that for these reasons, contract damages (i.e., mere policy benefits) are inadequate to compensate an insured deprived of promised benefits or to deter the insurer from breaching the contract in the first place. (See, *20th Century Ins. Co. v. Sup. Ct.* (2001) 90 Cal.App.4th 1247, 1265-1266.)

It is therefore quite distressing when the insurance consumer learns that the insurance benefits she receives as a workplace benefit do not enjoy these protections, leaving very little recourse in the face of even the most outrageous and damaging coverage denial.

For the most part, benefits received through work are governed by the Employee Retirement Income Security Act of 1974, or ERISA. Employee benefits may include life, health, retirement benefits and often disability, long term care, accidental death and disability benefits. Some of these products are voluntary add-ons employees can opt into by contributing to the premium payment or they may be entirely employer-paid as part of a generous benefits package.

ERISA: A lesson in unintended consequences

ERISA was enacted in 1974 to reform the private pension industry. It sought to protect workers who were promised pension benefits against mismanagement and theft by the employers entrusted with maintenance of those retirement pension funds. The law regulated funds related to retirement income, establishing vesting, funding and disclosure rules along with a means to reinsure those funds through the Pension Benefit Guarantee Corporation. Congress's intent was narrowly directed at private pensions, and not at non-pension employee insurance plans. The law was enacted to protect employment benefit plans or funds entrusted to employers to provide pension benefits for retirees and their families. ERISA is like your Aunt Nancy: focused entirely on good outcomes, on helping people.

The statute's legislative history is devoted almost exclusively to the regulation of pension and retirement funds. Somewhat incongruously, however, ERISA purports to include within its regulatory ambit, employee benefits provided "through the purchase of insurance." 29 USC § l002(1). Because the legislative history reveals the target of the statute to be the funds set aside for retirees, the inclusion of "insurance" benefits is puzzling. Insurance, unlike pension funds maintained by an employer or other fiduciary, is provided through a contract with an outside company and maintained through the payment of premiums.

The confusion is compounded by the express carve out of state insurance laws from ERISA's preemptive scope. The statute expressly permits states to regulate "insurance." 29 USC § 514 (b)(2)(A) In other words, state laws "regulating insurance" are not preempted by ERISA.

ERISA contains a broad preemption clause over all state laws "relating to" ERISA employee benefit plans. However, the competing give and take-away language regarding state insurance law combined with broad preemption provisions, the toothless federal provisions of ERISA have preempted a wide swath of state insurance law protections. The bad marriage of Congress's unintentional overbreadth in including workplace insurance benefits with the expansive preemption clause are the sneeze on the airplane that started this whole mess.

Over the years, ERISA's preemptive scope has overridden many state insurance protections. Despite the savings clause, the Supreme Court held that any state law which provided a remedy not expressly included in the paltry remedies of the ERISA statute was preempted. (*Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41.) *Pilot Life* is when Aunt Nancy bit Uncle John, starting Hoboken's ruin.

Everything ridiculous imagined since Adam

It is not hyperbole to say that for claims governed by ERISA, everything is not only radically different from a tortious breach of contract and bad-faith claim, but upside down; from the way claims are handled, the denial process, the administrative appeal, the procedural rules for litigation, and – worst of all – the lack of meaningful remedies no matter how absurd or harmful the insurance company conduct.

Despite its laudable, worker-friendly "Aunt Nancy" inception, ERISA has been perverted into de facto immunity for dishonest insurance conduct. Now we are stuck with zombies.

ERISA disability denials begin an administrative appeal process the insured is required to exhaust before filing a lawsuit for the denied benefits. While the

requirement to exhaust administrative appeal remedies is purportedly to decrease frivolous litigation, promote consistent treatment of claims, minimize costs of claims settlements and rely on so-called administrative expertise, it generally serves the carrier's interest alone.

First, the administrative appeal is the one and only opportunity for the policyholder to document her claim. Once the administrative appeal process is completed, the "administrative record" is generally considered closed for good, with some exceptions to be discussed below. This presents an inevitable trap for the unwary consumer, lulled into a sense of informality by the administrative process, who fails to adequately document every square inch of her disability claim. If her administrative appeal is denied, the carrier will claim in the litigation that follows that the court's review is limited to the administrative record it created.

The appeal process generally takes six to twelve months. Remember, the person appealing the denial is sick or injured, unable to earn a living, and has been deprived of what is often her only income. She must still muster the resources to meticulously document her medical condition and the ways in which it interferes with her ability to perform her work. Appeals may require the active participation and support of medical providers who are resistant to taking on non-therapeutic tasks like multipage insurance forms or drafting narrative explanations regarding their patients' ability to work in their own or any other gainful occupation. Doctors are often misled by insurance carriers regarding the definition of "total disability" and are actively encouraged to complete forms which undermine their own patients' claims.

This is why administrative appeals are critical to the pursuit of benefits and should be done with the help of a lawyer with a specialty in ERISA. So much for reducing costs.

Not surprisingly, disabled insureds drop off at each stage of this cumbersome process, due to exhaustion and exasperation, confusion and the inability to find legal assistance. When an LTD carrier rejects their own insured's assertion that they are disabled, they are indirectly (and sometimes directly) calling the claimant a fraud, a faker and a liar. This can literally drive disabled claimants crazy. The carriers know this.

If an aggrieved claimant has the support and ability to pursue a denied administrative appeal in litigation and has found a qualified ERISA lawyer to help them, the odds remain ever against them. The procedural limitations of ERISA litigation will baffle any trial lawyer. ERISA cases generally permit little to no discovery.

There is no live testimony, no trial and no jury. The question of disability is determined by a district court judge, typically through dispositive cross-motions. The district court review is generally limited to the so-called "administrative record" created by the insurance company during the claims process. What exactly constitutes the administrative record is the source of continuing litigation and debate on a case-by-case basis.

To make matters worse, courts have permitted insurance companies to insert policy language in group insurance policies unilaterally granting themselves "discretion" to make up or down decisions on claims. Normally, the district court would review a denial of benefits under the *de novo* standard. However, when a valid "discretionary clause" is written into the plan, the district court reviews the decision for an *abuse of discretion*. The reviewing judge may only reverse the denial where it is "arbitrary and capricious." (*Firestone Tire & Rubber Co. v. Bruch*, 489 US 101, 114-115.) However, effective January 2012, California § 10110.6 declared these discretionary clauses void and unenforceable for all disability insurance policies that cover *any California resident*. Thus, California claims are now reviewed de novo.

Smart ERISA practitioners must exploit every single opportunity, including leveraging ERISA's disadvantages against the carriers. For example, where the California ban on discretionary clauses does not apply, rendering the standard of review abuse of discretion, the claimant may undermine the purported discretion the court confers upon on the carrier by calling attention to the company's overt conflict of interest in being both the payor of the benefit and the decider of the claim. Courts may "weigh" the conflict of interest as a factor in determining whether the company abused its discretion. (*Metropolitan Life Ins. Co. v. Glenn* (2008) 554 US 105, 115.)

In abuse of discretion cases in the last decade, the courts have started to permit and expand the right of plaintiffs to take limited discovery. Permissible discovery may include compensation packages and other incentives for employees and captive consultants involved in reviewing claims; historical information regarding disability claims approvals/denials; and the presence or absence of purported internal controls designed to reduce the effect of bias in the decision-making process.

"Winning"

Even with the prohibition of discretionary clauses, the wronged insured has very little recourse in an ERISA lawsuit. As we've said, the administrative exhaustion requirement and procedural limitations tip the scales drastically in favor of multi-million dollar insurance companies and against individual plaintiffs. Even worse, the lack of real remedies means that dishonest carriers are immune from the consequences of the most egregious and harmful denials.

To successfully litigate an employee benefits claim, the disabled claimant must have submitted an administrative appeal, retained counsel with the necessary expertise in ERISA and filed a federal lawsuit asserting a claim for benefits due. Accrued benefits are generally the only type of damages awardable in a victorious ERISA lawsuit. Stop and think about this:

the carrier's downside risk of depriving its insured of deserved disability benefits is the remote possibility it will simply pay those exact benefits in the end!

There is a discretionary fee provision permitting a court to award fees to plaintiffs who have achieved "some degree of success on the merits." (*Hardt v. Reliance Standard Ins. Co.* (2010) 560 US 242, 255.) However, the amount of fees, time spent and the hourly rates are solely within the discretion of the court. When I'm feeling cynical, I tell my clients that attorneys' fees awards depend as much upon what a deciding judge had for breakfast as anything else.

The fee provision also prejudices claimants by only compensating time spent in litigation, excluding the lengthy – and mandatory – administrative appeal process. Even though it may have taken tens or even hundreds of hours to effectively appeal, the attorneys' fee clock does not begin to run until a lawsuit is filed.

The failure to compensate plaintiffs for attorney time spent exhausting administrative remedies compounds the financial prejudice for claimants whether they retain their lawyers on an hourly or a contingency basis. Because the administrative time is not compensable, a portion of the benefits themselves will inevitably go towards their attorney's fees.

Groundhog Day

Another bummer of even a victorious ERISA benefits lawsuit is that winning also means that the disabled client who has just spent over the past year or two fighting the insurance company through the administrative and litigation process is "reinstated" and put back on monthly claim. It's like being forced to remarry an abusive ex-spouse. Winning at the district court level is no deterrent for the carrier to aggressively administer the ongoing claim, whether by asking for duplicative and redundant medical forms, putting the insured under surreptitious surveillance, or requiring her to undergo medical examinations by dishonest hack doctors. The carrier can simply deny the claim again, requiring the claimant to go back to square one and submit a new administrative appeal.

Confused already? But wait, there's more: Exceptions to ERISA

To complicate this already tangled mess, not all employment-related benefits are preempted by ERISA. There are several exceptions to ERISA preemption in which work-related benefits are still covered by state insurance laws. Now that we have illustrated how terrible ERISA benefits claims can be, claimants should look very carefully for any way out of this zombie forest.

"Safe Harbor" Insurance Plans

Policies made available through work are not governed by ERISA where the employer merely offers the insurance product as an optional benefit the employee pays for entirely. These benefits are governed by state law if they satisfy all four of the Department of Labor's "safe harbor" criteria. 29 USC § 1135. Insurance plans purchased through an employer are *not* ERISA preempted if:

1. The employer does not "endorse" the program;
2. Employee participation is completely voluntary;
3. Premiums are paid entirely by the employee; the employer's sole function is to collect and remit the premiums to the insurer (by payroll deductions); and
4. The employer receives no consideration (other than reasonable compensation for whatever administrative service it provides in connection with collecting and remitting the premiums). [See 29 CFR § 2510.3-1(j)]

Governmental plans, church plans, and business owners

Benefit plans covering governmental employees are also generally exempted from ERISA preemption. Thus, employees of cities, counties, courts, police departments, state universities and federal agencies, for example, generally have the full complement of state insurance protections.

So called "church plans" established by churches for their employees are also generally outside ERISA's preemptive scope. As with all things ERISA, what constitutes a church plan is neither clear nor stable. Generally, a "plan, established and maintained by a church" for the purpose of providing benefits is exempt from ERISA. 29 U.S.C. §§ 1002(33)(A).

Plans covering only self-employed persons, owners or partners are also excluded from ERISA. Thus, a small group of self-employed doctors in a corporate partnership who obtain LTD coverage will be considered to have non-ERISA coverage. (See, 29 USC § 1002.) However, if the same benefit plan covering an owner or partner also covers even one common law employee, there is a risk of "ERISA-fying" the entire plan, including the doctors' policies.

Buy a lawyer a cookie

If you meet a plaintiff 's ERISA lawyer, buy them a cookie. Claims governed by ERISA are nothing to be trifled with. They are legally complicated, highly idiosyncratic and present a minefield of traps for the unwary. They are not particularly remunerative for either the claimant or her long-suffering counsel. Claimants need a lawyer with experience and expertise in ERISA benefit claims, preferably before, during and after the administrative appeal when the primary record is being made.

What's the upside?

ERISA's regulations can and should be used as a tool in support of benefit claims. One of the most important and easiest things an ERISA claimant can and should do in the face of a denial is to request her "claim file." In standard insurance parlance, a claim file includes all documentation of every important thing that happens during the claims process. It should include all correspondence, medical records, policy and plan

information, any consultant reviews; internal communications amongst claims staff and with outside file reviewers. It should include surveillance and other "special investigation unit" (or SIU) investigation materials.

Plan fiduciaries, which includes the insurance company funding the benefits (as the "Claims Administrator") and often the employer (as the "Plan Administrator") must provide the entire claim file at no cost to the claimant, upon written request. In some cases, Plan Administrators who fail to provide these documents may be subject to daily penalties.

The claim file tells the story of what documents the carrier considered and should reveal the underlying rationale for denying or terminating benefits. A close read by a savvy practitioner will disclose what information is most likely to reverse the adverse decision in the appeal process.

Speaking of which, the regulations also call for a robust administrative appeals process, including a "meaningful dialogue" between the carrier and the claimant and a "full and fair review" of all necessary information. 29 U.S.C. § 1133. Carriers are required to clearly explain the reasons the claim was denied, including providing a description of any information the carrier needs in order to pay the claim. (*Booton v. Lockheed Med. Benefit Plan,* 110 F.3d 1461, 1463 (9th Cir. 1997).)

The administrator must explain the basis for the denial, including the "specific plan provisions" on which it is based and "any additional material or information necessary for the claimant to perfect the claim." (29 C.F.R. § 2560.503-1(g)). The claimant is entitled to address all the reasons for the denial in the appeal. Carriers may not sandbag appealing claimants with new, post-hoc rationales for their denials after the appeal time has passed. Thus, if the carrier denies the claimant's appeal with new bases – like new medical evidence, surveillance or a new contractual assertion, those claims may be disregarded by the district court.

Insurance defendants resist any efforts at discovery, largely because biased claims handling is usually obvious and vulnerable to cross examination. While plaintiffs often get court orders for discovery, defendants almost never do. This means that, unlike standard litigation, the ERISA plaintiff does not suffer the same sort of intrusive discovery fishing expeditions in litigation.

It is a sad irony that ERISA-governed insurance defendants have a record of treating their sick and injured insureds miserably despite their fiduciary obligations to them. A cynical lawyer on either side of the ERISA bar may lose sight of the sanctity and importance of that duty of loyalty. "ERISA's duty of loyalty is the highest known to the law."(*Bussian v. RJR Nabisco, Inc*., 223 F.3d 286, 294 (5th Cir. 2000).) A "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participant." (29 U.S.C. § 1104(a)(1)(A).) ERISA applies the common law of trusts, in which a trustee, "has a duty in dealing with a beneficiary to deal fairly and to communicate to the beneficiary all material facts the trustee knows or should know in connection with the matter." Rest. (Third) Trusts, § 78 (2007).


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