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ERISA Disability Benefit Claims: What all General Practice Attorneys Need to Know

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About the Presenters...

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ERISA DISABILITY BENEFIT CLAIMS:
WHAT ALL GENERAL PRACTICE ATTORNEYS NEED TO KNOW

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LIFE CYCLE OF AN ERISA DISABILITY CLAIM

I. FILING A CLAIM

a. **Why File a Claim for ERISA Disability Benefits**
   i. Benefits provide a reliable source of income in the event of disability.
   ii. An employee's claim for ERISA benefits is generally processed faster than a claim for SSDI benefits, thereby connecting disabled workers with a stream of income much sooner than other avenues.

b. **Who Files the Claim**
   i. A claim can be initiated by either the claimant themselves or an attorney or representative acting on their behalf.

c. **When to File a Claim**
   i. Usually filed after an employee has ceased working due to disability.
   ii. Review and comply with the plan's deadline to provide proof of loss.
   iii. Wisconsin's notice prejudice rule (Wis. Stat. § 631.81) permits the untimely filing of an insurance claim if the insurer is not harmed by the late claim.

d. **What Must be Filed to Initiate the claim**
   i. An employee's HR department supplies the forms necessary to initiate the claim (these forms are also typically available from the insurer).
   ii. These claims forms are generally comprised of 3 parts:
      1. The employee's statement requests information related to the claimant's daily activities, other sources of income, treating providers, medication lists, and education/employment histories.
      2. The employer's statement requests information related to the employee's rate of pay and job duties, and whether they've satisfied the eligibility requirements to be eligible for benefits.
      3. The attending physician's statement is completed by the employee's doctor and requests information related to their medical conditions, symptoms, restrictions, limitations, and date they became disabled.

e. **Where Should the Claim be Filed?**
   i. Claim forms are submitted to the plan administrator (generally, but not always, the insurance carrier).

II. CLAIM DETERMINATION

a. **Timing**
   i. The plan administrator must render a decision within 105 days of the date the claim is filed.
   ii. During the 105 day-period, the administrator will review the claim forms and conduct their own investigation to determine whether the claimant is eligible to receive benefits and meets the definition of disability.
   iii. The administrator may request additional information, such as medical records, or request a telephone interview with the claimant to aid their review. Responding to these requests as quickly as possible can avoid delays in processing the application.

b. **If the Claim is Approved…**
   i. Benefits will continue until the claimant no longer meet the plan's requirements to receive benefits (e.g., is no longer determined to be disabled) or until they reach the plan's maximum benefit period (MBP).
      1. For STDI plans, the MBP is usually between 90 and 180 days.
      2. For LTDI plans, the MBP usually lasts until the claimant turns 65 or reaches their normal social security retirement age.

c. **If the Claim is Denied…**
   i. If a claim is denied at the initial application stage (or at any point thereafter), the claimant has the right to file an administrative appeal.
   ii. ERISA mandates claimants exhaust their internal administrative remedies before filing suit. Thus, the failure to timely file the administrative appeal results in a total waiver of the claimant's right to pursue the claim.

III. FILING AN APPEAL

a. **Timing**: Appeals must be filed within 180 days of the date of denial.

b. **Evidence to Support the Appeal**
   i. Evidence should be specifically tailored to rebut the insurance carrier's reason for denying the claim. For example, the evidence submitted to rebut a denial based on the pre-existing condition exclusion will differ from the evidence needed to rebut a non-disability determination.

c. **Legal Arguments**
   i. In addition to submitting evidence to support a claimant's eligibility to receive benefits, it can also be helpful to include arguments as to why the insurer's decision was unreasonable.

ii. Evidence of an unreasonable claim determination include:
    1. Cherry-picking statements from the medical records
    2. Ignoring treating physician's opinions
    3. Denying based on subjectivity of complaints

IV. APPEAL REVIEW

a. **Timing**
    i. The plan administrator must render a decision within 90 days of the date the appeal is submitted.
    ii. During this 90-day period, the plan administrator may refer the claimant's medical records for a peer review in which a physician hired by the insurance company reviews the claimant's medical records and renders an opinion regarding their functional capacity. They may also refer the claim for a vocational analysis to assess the claimant's employability based on their restrictions and limitations.
    iii. During the appeal review process, the plan administrator is required to provide the claimant with any new evidence generated on appeal and an opportunity to respond to the same. The plan is permitted to toll their time to render a decision while awaiting a claimant's response to the newly generated information.

b. **If the appeal is approved…**
    i. The claimant should receive back pay and monthly benefits will usually commence on an ongoing basis

c. **If the claim is denied…**
    i. In some cases, there may be a second level administrative appeal that can be voluntary or mandatory
    ii. Otherwise, the claimant has the right to file a lawsuit.

V. LITIGATION

a. **Cause of Action**
    i. Different types of actions may be brought by plan beneficiaries under ERISA, but typically, claimants sue for wrongfully denied benefits pursuant to ERISA § 502(a)(1)(B).

b. **Who to Name as Defendant**
    i. Most LTD plans are insured, which means the employer purchases an insurance policy from an insurance company to provide benefits to employees who become disabled. In this case, the insurance company is the proper defendant.

ii. Other LTD plans are self-funded by the employer. In this case, the employer and the plan itself are usually the proper defendants.

c. **Statute of Limitations**
   i. ERISA § 502(a)(1)(B) does not specify a SOL.
   ii. Review the plan document to see if a SOL is specified in the plan terms.
   iii. Otherwise, the most analogous state law SOL will govern (in Wisconsin, the SOL for the enforcement of contracts is 6 years)

d. **Jurisdiction & Venue:**
   i. ERISA cases must be filed in federal court
   ii. The plan terms may dictate venue. If the plan is silent as to venue, venue is appropriate:
      1. Where the plan is administered,
      2. Where the breach took place (meaning, where the beneficiary resides and should have received the benefits),
      3. Where a defendant may be found, or
      4. Where the defendant resides.

e. **Standard of Review**
   i. Claims will be reviewed de novo, unless plan gives the administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," as most plans do. This language triggers the deferential "arbitrary and capricious" standard of review.
   ii. Under the arbitrary and capricious standard of review, a denial of benefits will only be overturned if it was unreasonable.

f. **Discovery**
   i. Generally, discovery beyond the administrative record is disallowed unless the plaintiff can:
      1. identify a specific conflict of interest or instance of misconduct on the part of the insurer, and
      2. make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination.
   ii. If discovery is granted, the scope will be limited to the conflict of interest.

g. **Summary Judgment Briefing**
   i. ERISA disallows trial by jury.
   ii. Cases are generally decided on summary judgment.

VI. DAMAGES

a. If you prevail on summary judgment, the following damages are available:
    i. Past due benefits (29 U.S.C. § 1132(a)(1)(B))
    ii. Prejudgment interest
    iii. Attorney's fees and costs (29 U.S.C. § 1132(g)(1))
b. ERISA preempts state law that allows for recovery of other categories of damages (i.e., compensatory and punitive)
c. Generally, claimants cannot recover future disability benefits. Thus, even if you prevail at summary judgment, the claim will be returned to the plan for ongoing evaluation of the claimant's eligibility for benefits.

COMMON MISTAKES

I. UNFAMILIARITY WITH IMPORTANT PLAN PROVISIONS THAT AFFECT A CLAIM'S VALUE

a. **Elimination Period**
    i. The elimination period is the time between when a claimant becomes disabled and when they can begin receiving benefits.
    ii. For STDI plans, the elimination period is usually 7 days and for LTDI plans, the elimination period is typically 90 to 180 days and often correlates with the STDI plan's maximum benefit period so that, in theory, a claimant can seamlessly transition from STDI benefits to LTDI benefits.

b. **Pre-Existing Condition Exclusions**
    i. If a plan has such an exclusion, it will typically define a pre-existing condition as a condition for which the claimant received medical care in the 90 days preceding their effective date of coverage under the plan.
    ii. If such a condition causes disability within the first 12 months of LTDI coverage, benefits are typically not payable.
    iii. If a pre-existing condition causes disability after the first 12 months of LTDI coverage, this exclusion generally does not apply, meaning benefits are payable.

c. **Mental Health Limitations**
    i. Mental health limitations limits the payment of benefits for disabilities based on mental health conditions to just 24 months unless the disability is severe enough to require hospitalization.
    ii. These same plans often provide benefits to individuals with physical disabilities – regardless of hospitalization – until age 65 or later.

d. **Other Limited Conditions**

i. Plans may impose similar limitations on other conditions, such as chronic pain conditions (e.g., fibromyalgia) and neuromusculoskeletal and soft tissue disorders.

II. NEGLECTING TO DEVELOP THE CLAIM FILE

a. **What comprises the claim file?**
   i. The claim file is comprised of all evidence submitted by claimant during the administrative review process and all information considered by plan administrator to make its benefit determination.
   ii. Once the administrator renders a final denial, the claim file is closed and no additional documentation can be submitted for inclusion therein.

b. **Why is it important?**
   i. During litigation, the judge's review is generally limited to the claim file.
   ii. Thus, failing to develop the claim file during the administrative review process will handicap the claim in court.

c. **How to develop it?**
   i. Submit any and all supporting evidence during the administrative appeal process.
   ii. Examples of evidence for submission include:
      1. Complete medical records from all clinics for all relevant dates
      2. Statements from friends, family, and/or coworkers describing their observations of the claimant's limitations
      3. Statements from the claimant's treating providers detailing their restrictions and limitations and the ways in which those restrictions and limitations translate into functional impairments
      4. Independent evaluations

III. FAILING TO CONSIDER THE RISK OF SURVEILLANCE

a. **When and Where is a Claimant at Risk?**
   i. Insurers utilize surveillance to investigate LTD claims, especially in cases where it is suspected that a claimant is exaggerating their impairments.
   ii. Surveillance is permitted where there is no reasonable expectation of privacy (e.g., gyms, restaurants, parks, businesses).
   iii. Additionally, anything shared publicly on the internet, including on social media sites, is available to insurance companies and can be used against claimants to deny benefits.

b. How to Mitigate the Effects of Surveillance?

i. Ensure claimants are accurately and honestly reporting their activities of daily living, and are acting within their doctor-imposed restrictions, especially when in public spaces.
ii. As to internet surveillance, best practice is to set accounts to private, ensure postings are consistent with the claimant's reported restrictions and limitations, or refrain from posting altogether during the pendency of the claim.

IV. FAILING TO POPERLY COORDINATE BENEFITS

a. **LTD Benefits are Reduced by Other Sources of Income**
   i. ERISA plans reserve the right to offset LTDI benefits and request reimbursement for certain other sources of income claimants receive due to their disability, such as worker's compensation and social security disability benefits.

b. **SSDI Benefits:**
   i. Most ERISA plans require claimants to apply for social security disability benefits. If a claimant fails to do so, the insurer may estimate the value of the claimant's SSDI benefit and offset the LTDI benefit accordingly. Thus, prompt application for SSDI benefits is important.
   ii. Likewise, retroactive approval of SSDI benefits or other benefits will likely result in an LTDI overpayment, which the claimant will be required to repay. Thus, it is important to advise claimants to avoid spending any back pay they receive from the SSA or similar entities until the overpayment has been repaid.

c. **Workers Compensation Benefits:**
   i. In most cases, a claimant cannot claim short term disability benefits if their disability is due to a work-related injury, but they can still claim long term disability benefits.
   ii. If a claimant has a worker's compensation claim, special language can be used in the workers compensation compromise agreement to minimize any LTDI overpayment.

EMERGING TRENDS

I. DISABILITY CLAIMS DUE TO LONG COVID

a. **Basis:** While most people who become infected with COVID-19 fully recover in just a few weeks, some experience symptoms that persist well beyond this timeframe. This chronic condition has come to be known as "long COVID," and is most commonly associated with symptoms of fatigue, brain fog, difficulty

breathing, and headaches. This means many COVID-19 "long-haulers" will find it difficult to work, leading them to file claims for disability benefits.

a. **The Challenge:** These claims are often denied due to a lack of "objective medical evidence." Indeed, the disabling symptoms of long COVID are subjective in nature and cannot readily be objectively tested.

b. **The Trend:** Claimants have been looking to cases based on other subjective medical conditions, such as fibromyalgia, for guidance. In sum, these cases stand for the proposition that insurers generally cannot deny disability claims simply because the claimant's symptoms are subjective. *See, e.g.*, *Hawkins v. First Union Cor. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003).

II. ADMINISTRATORS' TOLLING

a. **When is tolling permitted?**
   i. During the claim review or appeal review process, plan administrators are permitted to toll their time to render a decision pending the claimant's submission of requested information.

b. **When is tolling not permitted?**
   i. Tolling is not permitted when the outstanding information is due from someone other than the claimant (i.e. when a claimant does not have control over the delivery of the outstanding information).
   ii. Nonetheless, there has been an increase in plan administrators' attempts to toll their time for impermissible reasons, such as a delay in obtaining a claimant's medical records from a clinic or a delay in scheduling an independent medical examination for a claimant.

c. **What's a claimant to do?**
   i. If a plan administrator has improperly tolled their time, there is not much a claimant can do until the administrator officially misses their deadline to render a decision.
   ii. At that point, the claimant can deem their claim denied and their administrative remedies exhausted, and file a lawsuit.
   iii. This is a less than ideal situation as litigation is both expensive and timely.

III. POTENTIAL PARITY IN DISABILITY INSURANCE POLICIES

a. Most LTDI policies limit the payment of benefits for mental health disabilities to just 24 months. Comparatively, benefits for physical disabilities typically continue until a claimant reaches retirement age.
b. This practice is legal at the federal level (MHPAEA only applies to health insurance policies) and in most states.
c. In recent years, there has been an increased dialogue about potential parity expansion.

ERISA Disability Benefit Claims:
What General Practice Attorneys Need to Know

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The Life Cycle of an ERISA LTDI/STDI Claim

Filing the Initial Claim

- **Why** file a claim for ERISA disability benefits?
- **Who** files the claim?
- **When** does the claim get filed?
- **What** must be filed?
- **Where** should the claim be filed?

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The Initial Claim Determination

- approved ⟹ Benefits continue until the claimant no longer meets plan's requirements or they reach the plan's maximum benefit period
- denied ⟹ Must follow the plan's internal administrative appeal process

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Filing an Appeal

- **Timing:** 180 days from denial
- **Grounds for reversal**:
  - Conducting a selective review
    (Holmstrom v. Metro. Life Ins. Co., 615 F.3d 758, 777 (7th Cir. 2010)*)*
  - Failing to address "reliable, contrary evidence"
    (*Love v. Nat'l City Corp. Welfare Benefits Plan*, 574 F.3d 392, 397 (7th Cir. 2009))
  - Failing to address opinion of claimant's doctors (*Id.*)
  - Summarily dismissing subjective complaints
    (*Hawkins v. First Union Corporation Long Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003))

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Appeal Review

- 90 days to render a decision (29 CFR § 2560.503-1(i)(3)(i))
- Claimant has the right to review and respond to "any new or additional evidence considered, relied upon, or generated by the plan" before a decision is rendered. (29 CFR § 2560.503-1(h)(4)(i))

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Appeal Determination

- If approved ⟹
  - Lump sum payment for retroactive benefits + monthly check for ongoing benefits
  - Benefits continue until you no longer meet plan's requirements or you reach the plan's maximum benefit period
- If denied ⟹
  - Possible second-level appeal, which can be voluntary or mandatory
  - Right to bring civil action

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ERISA Lawsuits: Preliminary Considerations

- **SOL**
  - Governed by plan terms, otherwise by state law (*see* Wis. Stat. § 631.83(1)(b))
- **Jurisdiction**
- **Standard of Review**
  - De novo, unless plan gives the administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Then, standard of review becomes deferential. (*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989))

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Litigating the Case

- Court's review is limited to the Administrative Record
- Generally, discovery beyond the AR disallowed *Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 814-15 (7th Cir. 2006); *but see Met. Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008)*
- No right to jury trial

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Damages

- Types of Damages:
  - Past due benefits (29 U.S.C. § 1132(a)(1)(B))
  - Prejudgment interest
  - Attorney's fees and costs (29 U.S.C. § 1132(g)(1))
- ERISA preempts state law that allows for recovery of other categories of damages (i.e., compensatory and punitive)

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Common Mistakes in ERISA STDI/LTDI Claims

MISTAKE:
Unfamiliarity with Important Plan Provisions

- Elimination Period
- Pre-Existing Condition Exclusion
- Mental Health Limitation
- Other Limited Conditions

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MISTAKE:
Neglecting to Develop the Claim File

- Complete medical records
- Witness statements
- Supporting letters from treating providers
- Independent expert reports (functional capacity testing, vocational evaluations, neuropsychological evaluations)

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MISTAKE:
Disregarding the Risk of Surveillance

- Permitted where there is no reasonable expectation of privacy
- Surveillance extends to internet, including social media profiles

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MISTAKE:
Failing to Properly Coordinate Benefits

- Workers Compensation Benefits
- Social Security Disability Insurance Benefits
- Prepare clients for risk of overpayment and need to reimburse insurer

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Emerging Trends in ERISA LTDI/STDI Claims

Long COVID Claims

- Symptoms include brain fog, headaches, fatigue
- Subjective nature of disability makes claims difficult to prove
- But, case law supports that claims cannot be denied simply because the symptoms are subjective

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Administrators' Tolling of Time to Render Decisions

- When is tolling permitted?
- When is tolling not permitted?
- What is a claimant to do?

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Parity in Disability Insurance Policies?

- Currently, parity only applies for health insurance claims
- Potential for expansion to disability insurance claims

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Questions?

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