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Eric Buchanan & Associates, PLLC
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ERISA & DISABILITY BENEFITS NEWSLETTER

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ABOUT OUR FIRM

Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits.

For more Information about Eric Buchanan & Associates, PLLC, visit our website at www.buchanandisability.com.



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INTRODUCTION TO LONG-TERM DISABILITY AND OTHER ERISA WELFARE BENEFITS CLAIMS BY ERIC BUCHANAN

If a person becomes disabled and is unable to continue working, the person may have a claim for social security benefits. However, the person may be entitled to additional benefits from work. Private employers often offer employee benefits to their employees, such as long-term disability benefits, health insurance, dental insurance, life insurance, accidental death and disability insurance, and others. About 28% of employees are covered by long-term disability insurance at work. Long-term disability (LTD) benefits can provide the disabled person an additional income above social security benefits.

Because these types of benefits are offered as employee benefits at work, claims for those benefits fall under a federal law called the Employment Retirement Income Security Act of 1974 (ERISA). Claims for long-term disability benefits, health insurance, and other benefits at work are referred to as "ERISA welfare benefits claims." ERISA also governs disputes over pension claims under a similar set of procedures. ERISA welfare benefits claims are very different from other types of litigation, and can have many pitfalls and traps for unrepresented claimants and for attorneys unfamiliar with ERISA's procedural rules.

The intent of Congress in enacting ERISA was to protect the "interest of participants in employee benefit plans . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). The language of the ERISA statute draws heavily from trust law as well as contract law. Congress instructed 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.

After nearly 30 years of case law, ERISA welfare benefits litigation has become a dangerous landscape, with pitfalls and minefields full of traps for the unwary. For example, ERISA preempts almost all disputes over benefits that are provided by private employers. ERISA limits the remedy of a claim in a benefits case to the benefits that should have been paid under the plan, plus maybe attorneys' fees, but precludes other state law remedies, such as claims for bad faith, failure to pay an insurance claim or fraud, and precludes punitive damages or other state law remedies.

ERISA also lives in its own world of civil procedure, where ordinary rules may not apply. For example, a claimant must first present all evidence to the insurance company and appeal all of the insurance policy's internal appeals before filing a suit. Once a suit is filed, a claimant may not submit more evidence to be considered, and discovery regarding the merits of the claim is very limited; the Court usually reviews only those documents that were considered by the ERISA administrator.

Additionally, courts usually give deference to the decision of the ERISA administrator under an arbitrary and capricious standard of review.

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ERISA Procedures Pre-litigation

Before filing a law suit, a claimant must exhaust the available remedies under the plan, so long as the plan's procedures are reasonable. ERISA's claims procedures are set out in the Federal Regulations at 29 C.F.R § 2560.503-1. Generally speaking, an ERISA administrator must make a decision within 105 days of receipt of an application for disability benefits. 29 C.F.R. § 2560.503-1(f)(3). A claimant who wants to appeal a denial of disability benefits must be given at least 180 days to appeal. 29 C.F.R. § 2560.503-1(h)(4). The decision on appeal must be made within 45 days, which may be extended 45 days. 2560.503-1(i)(3).

If a claimant does not appeal within the time limits, his claim may be denied for failure to exhaust administrative remedies. If the administrator does not make a decision within the required time limit, the claim may be deemed exhausted.

The claims regulations require that every plan shall establish and maintain reasonable claims procedures. 29 C.F.R. § 2560.503-1. At a minimum, a reasonable claims procedure must be described in the summary plan description, and must not be administered in a manner that unduly inhibits or hampers the filing or processing of claims. Pursuant to a "written request," plan procedures must allow claimants to "review pertinent documents" and "submit issues and comments in writing."

A claimant may submit a written request for plan documents; if the administrator does not provide the documents within 30 days, the claimant may seek a penalty of up to $110 per day after the 30 days. 29 U.S.C. § 1132(c)(1). At any time a participant may request copies of any summary plan descriptions, insurance policies and other documents under which the plan is established or operated. 29 U.S.C. § 1024 (b)(4). If there has been an adverse claim determination, the claims regulations require that all the documents pertinent or relevant to the claim should be provided to the claimant.

ERISA Litigation Procedures

A plan participant is entitled to seek judicial review if a plan fails to pay plan benefits. 29 U.S.C. § 1132(a)(1)(B). Many circuit courts have established procedures to guide courts in considering such claims. Usually, there is no trial; rather, the court reviews the written record and the arguments of counsel. Discovery is precluded or very limited. *See, e.g., Wilkins v. Baptist Healthcare Systems, Inc.,* 150 F.3d 609, 617-8 (6th Cir. 1998) (during judicial review of an ERISA claim for plan benefits the district court's review is "based on the record before the administrator." The district court issues a judgment on the record, considering the evidence before the decision-maker, the ERISA documents, and counsel's arguments.)

Standard of Review

The default rule in ERISA cases is that a court will review the claim under a *de novo* standard of review; however, the court will apply a deferential standard of review if the benefit plan gives the plan administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). If the plan grants discretion to the ERISA administrator who makes the decision, the court reviews the claim under an arbitrary and capricious standard of review. Not surprisingly, most ERISA plans now have language granting discretion and declarations of policy regarding ERISA.

However, courts may temper the arbitrary and capricious standard of review by taking into account the administrator conflict of interest. *Metropolitan Life Ins. Co. v. Glenn,*128 S.Ct. 2343 (2008) ("a court reviewing a denial of ERISA benefits should consider the conflict of interest where the ERISA administrator acts in the "dual role" as decisionmaker and payer of plan benefits").

NEED A SPEAKER?

The attorneys at Eric Buchanan & Associates are available to speak to your organization regarding Social Security Disability, ERISA Long-term Disability, Group Long-term Disability, Private Disability Insurance, ERISA Benefits, Denied Health Insurance Claims and Life Insurance Claims.

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