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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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## IS "ISSUE EXHAUSTION" REQUIRED IN ERISA CLAIMS? - BY: JEREMY L. BORDELON

Many disabled people, after having been denied long-term disability benefits by an insurance company, decide to file an appeal on their own – they feel certain their claim will be paid because they think they are so disabled, and because their condition is so obvious. Sometimes, even attorneys who do not understand the ERISA long-term disability process advise their clients to file an appeal on their own, and to only come back if denied. These are usually big mistakes, because one of the strict rules in most ERISA disability cases is that a court will not consider any medical records, opinions, or other proof of disability, that were not first sent to the insurance company to be considered. *See, e.g. Wilkins v. Baptist Healthcare Systems, Inc.*, 150 F.3d 609 (6th Cir. 1998). Furthermore, a claimant must timely file all appeals in order to administratively exhaust a claim before taking the case to court.

With that said, the administrative appeals process, the appeals of the claim to the insurer or administrator leading up to a final decision, is supposed to be non-adversarial, and ERISA fiduciaries have a duty to communicate with claimants and inform them about what information is needed to perfect their claim. For example, the ERISA claims regulations, at 29 C.F.R. § 2560.503-1(g) (Manner and content of notification of benefit determination), require that

> (1). . . the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. . The notification shall set forth, in a manner calculated to be understood by the claimant --
> (i) The specific reason or reasons for the adverse determination;
> (ii) Reference to the specific plan provisions on which the determination is based;
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

In addition to the specific duty to communicate specific information set out in the regulations, courts have held that ERISA fiduciaries, such as insurance companies, have a duty to communicate other information a claimant may need to know. Courts have held that an ERISA fiduciary is specifically charged with the obligations of a trustee, who "is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection." *Krohn v. Huron Memorial Hospital*, 173 F.3d 542, 548 (6th Cir. 1999).

So, the rules and case law make it clear that a claimant must file all the required appeals on time, and must submit all evidence that the claimant wants considered. This is referred to as "administrative exhaustion," or "claims exhaustion." In response, an ERISA fiduciary must state all the reasons for its decision, and communicate those reasons with the claimant. However, insurance companies sometimes argue that, beyond submitting all the evidence needed to support the claim, ERISA claimants should also make all the arguments about why their claim should be paid, or else be barred from making those arguments in court. This position held by insurance companies is contrary to the well-established principle that the ERISA claims process is supposed to be non-adversarial, and that the duty is on the fiduciary to communicate with the claimant, not the other way around. This theory, that a claimant must set out all the arguments supporting the claim in the appeal letters is known as "issue exhaustion," and it has not been well-taken by the courts.

The argument by insurance companies, that an ERISA claimant must make all the arguments supporting a claim, has been argued many times, and rejected by a majority of, if not all, federal courts. *See Vincent v. Lucent Techs., Inc.*, 733 F. Supp. 2d 729, 737 (W.D.N.C. 2010) (noting that question has not yet been presented to the 4th Circuit, finding 3rd and 9th Circuit law persuasive in holding no "issue exhaustion" requirement); *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182, 186 (3d Cir. 1984), ("Section 502(a) of ERISA does not require either issue or theory exhaustion; it requires only claim exhaustion."); *Pearson v. Group Long Term Disability Plan for Emples. of Tyco Int'l (US), Inc.*, 538 F. Supp. 2d 1073, 1085-1086 (E.D. Ark. 2008) ("While it would defeat the purpose of this non-adversarial proceeding not to require claim exhaustion, it also would be inconsistent with the nature of the proceeding to require issue exhaustion as though the proceeding were adversarial."); *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 631-33 (9th Cir. 2008) ("issue exhaustion is not applicable in the ERISA context"; plaintiff "exhausted his administrative remedies by requesting review of his claim denial and obtaining the Plan's final decision on his claim."); *Farr v. Hartford Life and Accident Ins. Co.*, 322 F. App'x 622, 628 (10th Cir. 2009) (dicta) ("We have . . . applied a rule barring ERISA claims that were not previously pursued administratively (i.e., claim exhaustion). But we have not extended this rule to bar subsidiary arguments urged on judicial review in support of a claim itself fully exhausted in the administrative process (i.e., issue exhaustion).").

Insurance companies arguing that "issue exhaustion" is required have cited *Chorosevic v. MetLife Choices, et al.*, 600 F.3d 934, 942 (8th Cir. 2010); however, this case illustrates the opposite. In fact, this case stands for the usual rule that *claim* exhaustion, not *issue* exhaustion, is required. *Id.* (quoting *Wolf*, 728 F.2d at 186-87, as holding that "Section 502(a) of ERISA does not require either issue or theory exhaustion; it requires only claim exhaustion."). In *Chorosevic*, the Plaintiff was appealing several different claims for payment of healthcare benefits, and had only exhausted her remedies as to one particular claim. *Id.* The Tenth Circuit held that although only claim exhaustion, not issue exhaustion, was required, the Plaintiff had multiple claims for benefits and needed to appeal all of her claims. *Id.* Having failed to do so, she failed to exhaust her remedies as to the un-appealed claims.

*Chorosevic* does teach an important lesson that illustrates the differences between healthcare claims and disability benefits claims, and the difference between claims exhaustion and issue exhaustion. Typically, if a worker becomes disabled and unable to work, he files one claim for disability benefits, or perhaps two claims if he has separate short-term and long-term disability plans. If that claim is denied, he must appeal the claim, but his appeal need not be anything more than a simple letter saying, "I appeal the denial of my claim." As long as such a letter is sent within the appeal timeframe included in the plan description (usually 180 days, for a disability benefits claim), the claim has been appealed, and the remedies will be exhausted once a final decision is reached. On the other hand, every single healthcare service one receives is usually considered a separate claim under a healthcare plan. If you go to your family physician on Monday, and to the hospital on Tuesday for lab work, and to an imaging center on Wednesday for an MRI, you would likely have three separate healthcare claims, even if they are for the same medical condition. If they are all denied by your ERISA healthcare plan, you would need to make clear to the administrator that you are appealing each individual claim, because you must exhaust each claim (although you could choose to appeal them all in the same letter, so long as you listed all claims).

So, for a disability benefits claim appeal, keep in mind that there is no requirement that one point out exactly what is wrong with the denial. Because the administrative process is non-adversarial, and many claimants appeal *pro se*, courts have properly held that an ERISA claimant need not raise all arguments in support of a claim, and need not exhaust all issues. If the insurer misinterpreted some piece of medical information, you can feel free to point it out – it might give you a better chance of being approved on appeal. Then again, there is always a possibility that the insurer might just use your arguments as a road map showing it how to shore up its decision. No matter what the appeal letter says, it is important to remember that a claimant must still file appeals on time, and exhaust each *claim* (but not each *issue*), in order to preserve the ability to take the case to court.

## UPCOMING SPEAKING ENGAGEMENTS

Eric Buchanan will be speaking at the American Association for Justice Annual Convention scheduled for July 28 - August 1, 2012 in Chicago. He will be speaking on social security disability offsets in ERISA disability cases.

## 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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