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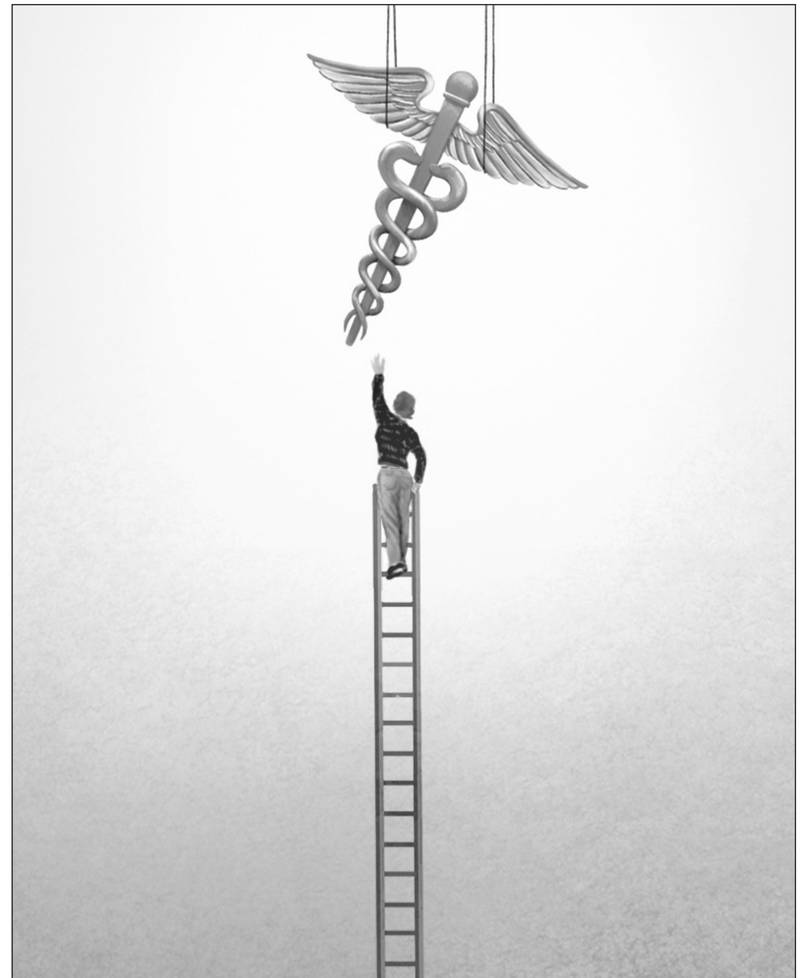
PERSPECTIVE

Disability Insurance Is Not a Widget



It is a rude surprise to many that half a century of judicial precedent establishing California's bad faith remedies does not apply to most insurance disputes. Insurance provided through a person's employer, with some notable exceptions, is generally governed by the Employee Retirement Income Security Act of 1974 (ERISA), which has been interpreted by the courts to pre-empt nearly all state law rights and remedies.

Congress enacted ERISA in 1974 to protect retirees and pensioners whose employer-sponsored pensions were being mismanaged, or even looted, by the fiduciaries responsible for managing them. The stated purpose of ERISA was to protect, "the continued well-being and security of millions of employees and their dependents" through the regulation of pension funds maintained by employers. See 29 USC Section 1001.

Despite these laudable goals, the courts have interpreted ERISA to effectively deregulate the insurance industry, severely limiting substantive and procedural remedies available to wrongfully denied insurance claimants under even the most outrageous circumstances.

ERISA governs employer-provided benefit plans, including health, accident, disability, long-term care and short and long term disability benefits. ERISA does not apply to private, individual policies purchased from an insurance company by the insured. Nor does it apply to plans issued to government employees, employees of certain religious organizations, business owners, or certain employees who voluntarily enroll in a plan in which they pay the premiums.

One of the most harmful developments in ERISA jurisprudence is the imposition of the arbitrary and capricious standard of review for legal challenges to adverse benefit claims decisions at the district court level. In 1989, the U.S. Supreme Court held that when an ERISA insurance provider includes policy language granting *itself* "discretion" to both interpret the plan's terms and to make benefits determinations, the claimant must demonstrate that the decision was arbitrary and capricious to overturn a denial. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). In other words, a court may find that the insurer was wrong, that the plaintiff is disabled, and the company can still win. Nearly all insurers now place so-called "discretionary clauses" in policies.

In 2008, in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), the Supreme Court provided a small dose of relief when it held that benefit denials were entitled to less deference where the insurer acted under a conflict of interest as the decision-maker with respect to benefits as well as the funder of those benefits. With the relief has come even greater confusion regarding what evidence supports (or undermines) the inference of a conflict and the appropriate level of skepticism of an adverse benefit decision by a conflicted fiduciary.

In response to the abuses many insureds have suffered as a result of this untenably high bar for ERISA plaintiffs, several states have banned these discretionary clauses. Last month the state Legislature overwhelmingly passed AB 1868, which would have banned discretionary clauses in life and disability insurance policies. Gov. Arnold Schwarzenegger vetoed the legislation.

Despite ERISA's express purpose to provide "appropriate remedies, sanctions, and ready access to the federal courts," courts have uniformly held that ERISA litigants may not have a jury trial. An ERISA plaintiff is often limited to a judicial review of the cold "administrative record," which is the claim file created by the insurance company. There is no witness testimony, no cross-examination and no face-to-face credibility determinations.

Discovery in ERISA is narrow to non-existent and, when permitted, is often limited to the question of whether the insurer's decision was infected by a conflict of interest, with many courts holding that all discovery into the merits of the claim is off limits.

A fundamental injustice perpetuated by ERISA is that it has no teeth. ERISA preempts the usual panoply of remedies for unreasonable insurance denials, including accelerated future benefits, consequential damages, emotional distress damages and, even in the most outrageous and fraudulent cases, punitive damages.

An ERISA plaintiff must get through the mandatory administrative appeal (which can take over a year) during which time they are not receiving benefits. Assuming the insurance company still refuses to pay, the claimant must file a lawsuit. Finally, the claimant must show, often without any meaningful discovery or the right to submit additional evidence, that the defendant insurance company acted arbitrarily and capriciously.

After overcoming all of these hurdles, the prevailing claimant is entitled to back benefits. Period.

This virtual immunity creates a powerful economic incentive for insurance companies to deny millions of dollars worth legitimate claims. This bottom line boondoggle dwarfs the administrative expenses of defending infrequent and low-stakes ERISA litigation.

ERISA's procedural and substantive limitations create traps for the unwary. Here are some tips for those who wish to challenge an adverse benefit decision:

Get Your Claim File: After receiving a denial or termination letter, immediately request your claim file in writing. ERISA regulations require insurers to provide to claimants "all relevant information" to the claim. This includes all documents received, created or relied upon pertaining to the claim, including policies, procedures and guidelines, internal communications, medical records, surveillance reports, and medical and/or vocational reviews done by in-house consultants. 29 Code of Federal Regulations 2560.503-1 (h)-(g).

Get Your Insurance Policy: You have an absolute right to the applicable insurance policy, which is typically comprised of a summary plan description, the booklet provided to employees describing the coverage, along with a more comprehensive master policy. Claimants should request all policies from both the insurance provider as well as the employer.

The Administrative Appeal: After a claim denial, claimants are given the right to "appeal." What most claimants do not know is that the record that a court ultimately considers is often limited to those documents created by the insurer and submitted by the claimant during the administrative appeal. In most cases, an appeal is mandatory before filing suit for benefits.

Marshall the Evidence: The administrative appeal is the first, and possibly only, opportunity to make the case for disability and rebut the insurance company's conclusions. Appealing claimants should review the claim file for every inaccuracy, over-statement, omission and example of cherry-picking. An appeal should include a detailed summary of the evidence supporting the benefits claim and rebutting any inaccurate facts or unfounded conclusions. Claimants should provide detailed evidence supporting disability, including all relevant medical records, statements from treating physicians and/or other helpful witnesses. In some cases, it may be appropriate to retain a medical specialist, a vocational counselor or a functional capacity evaluator who can describe why the claimant can no longer perform their former occupational duties.

Document Communications in Writing: Telephonic communications with insurance companies is common. Beware! You will be relying on a claims administrator to document the substance of unwritten communications in the all-important claim file. Any important communication, including requests for documents, should be memorialized in writing by the claimant and sent to the insurance company.

The perversion of a federal statute enacted to protect workers into a virtual shield for insurance company malfeasance has led several judges to describe ERISA as "Everything Ridiculous Imagined Since Adam." Practitioners and claimants alike should use all the tools available to exercise and expand ERISA's limited remedies.

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