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ERISA Long-Term Disability Claims: Attorney Fees and Other Issues

BY STEPHEN ROGER BOSIN

In *Hardt v. Reliance Standard Life Insurance Company*, No. 09-448 (May 24, 2010), the Supreme Court made it easier to recover attorney's fees in an ERISA action. In this case the court found compelling evidence in the record that the claimant was totally disabled and that it was inclined to rule in her favor but concluded that it would be unwise without giving the carrier 30 days to consider all the evidence and that if it failed to do so, that it would enter judgment in favor of the claimant. Having been so persuaded, the carrier awarded benefits. When an application was then made for attorney's fees it argued that, as there was no judgment in claimant's favor, it could not be a prevailing party.

The Court ruled that the applicant need not be the "prevailing party" to request attorney's fees and noted that there is no such requirement in Section1132 (g)(1) and held that a court may award attorney's fees and costs under this section as long as the clamant has achieved "some degree of success on the merits." This is a departure from the rule in this circuit which requires even more than prevailing party to recover attorney's fees. In *Ursic v. Bethlehem Mines*, 719 F.3d 670 (3d Cir. 1983), the court had laid down five policy factors in determining whether to make any award of fees under ERISA. They are: (1) the offending parties' culpability or bad faith; (2) the ability of the offending parties to satisfy an award of attorneys' fees; (3) the deterrent effect of an award of attorneys' fees against the offending parties; (4) the benefit conferred on members of the pension plan as a whole; and (5) the relative merits of the parties' position. Since the Supreme Court has stated that one need only have achieved some degree of success on the merits, a strong argument can be made that lower courts cannot impose more onerous standards. Keep in mind, however, that even if attorney's fees are awarded, it only applies to services rendered in litigating the claim and not rendered in exhausting one's administrative remedies, which here means attempting to persuade the plan administrator to reverse the decision made by the claims department. This is a time-consuming process in which the claimant has typically 180 days to obtain additional information to persuade the claim reviewer that an error had been made.

Handling an ERISA-covered claim for long-term disability benefits is always a battle played on an uneven playing field. The plan administrator has access to more resources. Not only do they have an in-house medical staff, they also have access to an almost unlimited pool of medical and vocational experts who are knowledgeable in their respective fields and sophisticated in expressing their opinions. In addition, the attorneys that represent them have become proficient over time in their specialty.

In order to reach the point where you are the prevailing party, there are many obstacles along the way.

The Arbitrary and Capricious Standard: Aside from these structural advantages in having more resources, the ERISA plan administrator is also shielded by the arbitrary and capricious standard. This means that the trier of fact need only find that there was a rational basis to support the plan administrator's decision to deny coverage, not whether its decision was right or wrong. See, *Abnathya v. Hoffmann-La Roche, Inc*. 2 F.3d 40 (3d Cir.).The case law is replete with the statement that courts are not to second guess plan administrators.

There are certain defenses. The plan must contain language finding that the plan administrator was given discretionary authority. This is a difficult point to win as courts tend to

Bosin is an attorney with the Law Offices of Stephen Roger Bosin in River Edge.

construe the plan language to find discretionary authority even in the absence of an express delegation. New Jersey has provided help to litigants. Pursuant to N.J.A.C § 11:4-58.2 published September 9, 2009, discretionary clauses in health and disability insurance contracts are no longer permitted.

Offsets & Limitations: The amount paid to the claimant may be subject to a variety of deductions. Almost all policies provide that the amount received is subject to reduction in the amount received for Social Security benefits, or other forms of disability compensation such as workers compensation or amounts received in settlement of a personal injury action.

Plans also attempt to limit payment for certain types of chronic conditions. Newer plans limit the payment for mental illness or chronic fatigue to only 24 months.

Pre-Existing Conditions: The plan administrator will look at all the medical information that was provided in support of the claim to find some evidence of a pre-existing condition to deny coverage. If the condition was not diagnosed nor suspected in the pre-existing condition period, it has been held not to be a pre-existing condition. See, *McLeod v. Hartford Life & Acc. Ins. Co.*, 372 F.3d 618, 628 (3d Cir. 2004).

The significance of the Social Security decision: Long-erm disability plans usually require the claimant apply for Social Security disability benefits, and even provide counsel at no cost. The purpose of this generosity is to have benefits paid be used to reduce the award. The decision of the Social Security finding disability is not, however, binding on the plan administrator. Failure to consider the decision of the Social Security Administration may, however be used as evidence of an abuse of discretion.

The statute of limitation: ERISA does not contain an express statute of limitations for benefits claimed under Section 1132(a)(1)(B). The governing time period is, however, contained in the plan which specifies the period of limitations for the commencement of legal action. Courts have determined that a three-year period provided in an ERISA plan is reasonable. *Grasselino v. First Unum Life Ins. Co.*, 2008 WL 5416403 (D.N.J. Dec. 22, 2008).

Discovery: Claimants want to know how their claim could possibly have been denied and their counsel wants to depose the claims manager, medical experts and the vocational experts. As a matter of case law, not statute, discovery has been limited to the administrative record. This usually consists of the information supplied by the claimant, the company's internal claims handling information, expert reports and the long-term disability policy.

Discovery is now permitted with respect to the existence of any conflict of interest. The conflict arises where the plan administrator is not only administering the claim, but paying the claim from its own funds. If there is a conflict of interest, this is a factor that you can ask the court to consider in determining whether there was an abuse of discretion in denying the claim for benefits.

There is another issue with respect to a conflict of interest which pertains to the third-party claims reviewers. ERISA law and regulations require that each claim be given a full and fair review. What is the likelihood of that occurring when the physician or medical reviewing group virtually always finds a reason to deny the claim? Courts in New York and Texas have allowed discovery on this issue, See, *Burgio v. Prudential Life Insurance Company of America*, 2008 WL 4376241 (E.D.N.Y. 2008), where the court permitted discovery with third-party vendors to determine if they were hired as a result of a belief that they would espouse a particular point of view. The District Court in Texas in *Copus v. Life Ins. Co. of North America,*, 2008 WL 2794807 (N.D. Tex. July 18, 2008), similarly held that the manner and retention of internal and outside reviewers was discoverable, as it may be reflective of institutional bias. This has yet to happen in this state. As of now, before discovery is permitted a plaintiff presents a good-aith basis for alleging some bias or that a conflict infected the administrator's determination. *Delso v. Trustee of the Retirement Plan for the Hourly Employee of Merck & Co., Inc.*, 2006 WL 3000199 (D. N.J. Oct. 20, 2006).

Defenses to the Claim: The following is not exhaustive but it is illustrative of the issues to be dealt with in handling an appeal. Plan administrators will deny claims based on video surveillance, functional capacity assessments, vocational expert reports, IME reports, deficiency in medical information supplied by the claimant or even claimant's own statements. Each of these areas has been litigated and there is case law on the subject. Given the fact that anyone of these defenses if raised must be overcome by the arbitrary and capricious standard, it is almost always difficult to prevail. The claim file is voluminous and must be read with care to find the key facts that will persuade the court to act in your favor.■