# *Disability Insurance under ERISA: Its Not Your Ordinary State Contract Claim*

By: Kevin Schlosser

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Disability insurance is one of those precious protections that is intended to be available at those times when life throws us a curve ball that could jeopardize our ability to provide for ourselves, our family and our loved ones. Many disability insurance companies, however, are becoming increasingly more aggressive in denying claims, forcing insureds to enforce their legal rights in formal litigation. Indeed, there has been an explosion in recent years of reported decisions concerning disability insurance claims. Lawyers that intend to assert and enforce such claims should be aware, however, that enforcing a disability insurance policy may not be as straightforward as it seems. If, for example, the disability insurance arises from an employer-sponsored plan, the insured's rights are likely to be governed by the Employee Retirement Income Security Act of 1974, commonly known as "ERISA."[1]

If the disability insurance is governed by ERISA, there is a broad body of law -- statutory, regulatory and decisional -- that must be followed, even though the insurance policy itself may not contain a single word about that body of law. This article will review some of the more important issues facing the practitioner seeking to enforce a client's rights under an employer-sponsored ERISA plan providing for disability insurance.

**1. Federal Preemption**

Based upon the number of reported decisions, it appears that many practitioners do not know that if their client has received disability insurance coverage through an employer-sponsored plan governed by ERISA, the disability claim is governed strictly by federal law and all state law claims are preempted.[2]

The term "employee benefits plan" is defined in ERISA as "an employee welfare benefit plan or an employee pension plan," and an employee benefit plan "includes any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . benefits in the event of sickness [or] disability . . . ."[3] ERISA specifically empowers a claimant, or insured, to maintain a private action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his right to future benefits under the terms of the plan."[4] ERISA preempts any and all state laws "insofar as they may now or hereafter relate to any employee benefit plan"[5] and such state laws encompass "all laws, decisions, rules, regulations, or other state actions having the affect of law, of any State"[6] and include statutory provisions and common law claims

as well.[7] Thus, any attempt to enforce rights under an employer-sponsored disability insurance policy covered by ERISA is likely to be governed exclusively by ERISA.

Keep in mind, however, that even if disability insurance was initially obtained through an employer-sponsored plan explicitly covered by ERISA, that does not necessarily mean that ERISA always applies to that insurance. For example, if the disability policy was converted to an individual policy after employment terminated, the disability claim under the converted policy will not be covered by ERISA.[8]

Once governed by ERISA, the claim for disability insurance takes on a different life with different rules and procedures than under typical state law contract claims.

**2. No Trial By Jury**

Unlike in state court when a party is seeking damages for breach of a contractual obligation to provide insurance, where a trial by jury would be appropriate, under ERISA the insured is unlikely to have the right to a trial by jury when enforcing rights to disability insurance. Courts have struggled with the issue as to whether ERISA provides "legal" and/or "equitable" remedies for the purposes of granting the right to trial by jury. Although the issue is far from clear, the Second Circuit has decided not to allow a jury in cases seeking to enforce disability benefits under ERISA. After surveying law from other circuits, for example, the Second Circuit in Sullivan v. LTV Aerospace and Defense Co., ruled that a plan beneficiary is not entitled to a jury in a case enforcing his or her rights to ERISA benefits.[9]

**3. Standards of Review**

If an employee's claim for disability benefits is denied, and that denial is upheld after the employee resorts to the administrative appeal process afforded by ERISA, the employee still has a right to challenge the denial in court — notwithstanding any contrary language in the insurance policy. The standard that the courts use to review the denial determination is obviously quite important. There are basically two standards for review — a de novo standard by which the court stands in the shoes of the plan administrator who made the determination and considers the decision anew — and the more restricted "arbitrary and capricious standard."

In the leading case of Firestone Tire & Rubber Co. v. Bruch, the United States Supreme Court made it clear that a denial of disability insurance benefits must be reviewed by the court under a de novo standard "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[10] The Second Circuit has recognized that the Supreme Court in Firestone "did not set forth any talismans by which a plan could trigger the highly differential ''arbitrary and capricious' standard of review."[11] Courts do, however, generally look to the explicit language of the policy or ERISA plan to determine whether the administrator or fiduciary has been granted discretionary authority to determine benefits and, therefore, to apply the arbitrary and capricious standard.[12] Nevertheless, "[d]iscretion is not found ''merely because the administrator has the power to deny a claim.'"[13]

If a court finds that the arbitrary and capricious standard of review applies, it may overturn the decision to deny benefits if that decision was "without reason, unsupported by substantial evidence or erroneous as a matter of law."[14] Accordingly, the court "may not upset a reasonable interpretation by the administrator."[15]

Nevertheless, even if the court finds that the plan or policy explicitly affords the administrator or fiduciary ultimate discretion to deny benefits, the court may consider other factors (beyond the strict arbitrary and capricious standard) in determining whether to overturn the decision. For example, courts consider whether the plan administrator or fiduciary is operating under a "conflict of interest" in determining plan benefits. One readily recognized conflict of interest is where the same plan administrator or fiduciary both determines eligibility for benefits and pays those benefits — such as where the disability insurance company that is responsible for paying the benefits is granted discretion to review and determine those benefits. There is a split in the circuits as to how precisely to deal with this situation. The Eleventh Circuit, for example, has authorized the courts to apply greater scrutiny over decisions denying benefits where such a conflict of interest exists.[16]

The Second Circuit has rejected the Eleventh Circuit's approach in these cases where a conflict of interest is present, applying a slightly different analysis and review process over decisions to deny benefits.[17] The Second Circuit has held that in cases where the plan administrator is shown to have a conflict of interest, the test for determining whether the administrator's interpretation of the plan is arbitrary and capricious is as follows: Two inquiries are pertinent. First, whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan; second, whether the evidence shows that the administrator was in fact influenced by such conflict. If the court finds that the administrator was in fact influenced by the conflict of interest, the deference otherwise accorded the administrator's decision drops away and the court interprets the plan de novo.[18]

We may not have heard the last word from the Second Circuit on this issue, however, because it appears that there are differing views of how to treat a conflict of interest, even within the Second Circuit itself. For example, in an enlightening footnote, Judge Oakes wrote for an unanimous Second Circuit panel that the court had "numerous concerns" with the manner in which the Second Circuit had previously dealt with the conflict of interest issue, believing that it may have set up an insurmountable obstacle to proving that the conflict of interest actually affected the decision making process: "One would not expect to find the decision-makers saying, "In view of our conflict, we find the Plan's construction to be reasonable'."[19] In the case before the Second Circuit at that time, however, Judge Oakes did not need to address the issues further because the de novo standard of review clearly applied in that case.[20]

Whether the de novo or arbitrary and capricious standard applies, another issue that has generated a great deal of litigation is what type of evidence the district court can consider in reviewing the denial of benefits. For example, once the plan administrator denies

the employee disability insurance benefits, the employee has a right to appeal that determination within the insurance company. The information and materials that the insurance company considers in reviewing and later determining an appeal of such disability claims is generally known as the administrative record. This record usually consists of the employee's claim for benefits, correspondence concerning the claim, reports from physicians and other consultants upon whom the insurance company relied as well as other materials sought to be included by the employee. The insurance companies often argue that the district court has no right to consider any evidence outside of the administrative record, while the employees frequently assert that other evidence is relevant whether the de novo or arbitrary and capricious standard applies.

The Second Circuit has reviewed the manner in which other courts have resolved these issues as follows: Courts presented with this issue have reached varied results. The Sixth Circuit has held that no evidence beyond the administrative record is permissible, on the grounds that district courts ought not to become "substitute plan administrators.' Perry v. Simplicity Eng'g, 900F.2d 963, 966-67 (6th Cir. 1990). While the Eleventh Circuit seems comfortable allowing district courts to rely upon entirely new evidence without restriction, Moon v. American Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989), other courts, including the Eighth Circuit have permitted some additional evidence where the administrative record is inadequate to conduct a proper review of the administrative decision. Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993) (decision within discretion of trial court, which should not be exercised absent good cause); Quesinberry v. Life Ins. Co. of N. Amer., 987 F.2d 1017, 1021-27 (4th Cir. 1993) (en banc); cf. Luby v. Teamsters Health, Welfare, and Pension Trust Funds, 944 F.2d 1176, 1184-85 (3d Cir. 1991) (where record is sufficiently developed, court may limit review to that evidence even upon de novo review).[21]

After reviewing the cases from other circuits and its own prior decisions, the Second Circuit held that "the decision whether to admit additional evidence is one which is discretionary with the district court, but which discretion ought not to be exercised in the absence of good cause."[22] In particular, the Second Circuit has ruled that such "good cause" is shown where the plan administrator was not "disinterested" or had some type of conflict of interest in rendering a determination on the disability claim, such as the conflict discussed above.[23]

**4. Discovery in ERISA Disability Cases**

It is not surprising that in view of the lively debate on the type of standard of review, issues have also been raised as to the scope of discovery in ERISA disability cases. The insurance companies often claim that discovery should be limited strictly to the administrative record. However, this approach has clearly been rejected by the courts. In Nagele v. Electronic Data Systems Corp.,[24] Magistrate Judge Foschio carefully reviewed the applicable law and approved of comprehensive discovery requests in the form of interrogatories seeking broad information about the disability claim at issue and the policies and procedures of the defendant insurance company. Other courts have

authorized various forms of discovery, including depositions of the insurance company representatives involved in the decision-making process.[25]

### 5. Attorneys Fees

Finally, the award of attorneys fees is explicitly addressed in ERISA unlike the ordinary state law claim for disability benefits. Under ERISA, the district court has discretion to "allow a reasonable attorney's fee and costs of action to either party."[26] In determining whether to make such an award, the court is ordinarily to consider "five factors: (1) the degree of the offending party's culpability or bad faith, (2) the ability of the offending party to satisfy an award of attorney's fees, (3) whether an award of fees would deter other persons from acting similarly under like circumstances, (4) the relative merits of the partys' positions, and (5) whether the action conferred a common benefit on a group of pension plan participants."[27] A party need not establish each and every one of the factors in order to be entitled to attorneys fees. While the district court is left with discretion as whether to award attorneys fees, it must articulate reasons for its decision to grant or deny the fees.[28] When the district court does not state the reasons for granting or denying fees, and an appeal follows, the Second Circuit will remand the matter for appropriate and informative findings.[29] The Second Circuit has ruled that a party may not recover attorneys' fees incurred for representation during the administrative review process: "Thus, fees incurred in administrative proceedings prior to filing suit in the district court are unavailable, but fees incurred during an administrative remand ordered by the district court and over which the court retains jurisdiction are authorized by the statute."[30] The district court also has discretion to grant prejudgment interest.[31]

### Conclusion

As should be clear by now, any practitioner seeking to enforce a client's claim to disability insurance benefits must be aware of the applicable law before proceeding. If the disability insurance is governed by ERISA, a long-standing body of law will apply — even though the insurance policy may not say a word about ERISA. Counsel should make sure that they are thoroughly familiar with all of the applicable legal issues, many of which are outlined above.

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[1] 29 U.S.C. §§ 1001 et. seq.

[2] See, e.g., Barnable v. First Fortis Life Ins. Co., 44 F.Supp. 2d. 196 (E.D.N.Y. 1999).

[3] See, 29 U.S.C. §§§§1002(3) & 1002(1).

[4] 29 U.S.C. §§ 1132(a)(1)(B).

[5] 29 U.S.C. §§ 1144(a).

[6] 29 U.S.C. §§ 1144(c)(1).

[7] See, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48 (1987).

[8] Arancio v. the Prudential Insurance Co. of America (S.D.N.Y.), N.Y.L.J., Aug. 22, 2002.

[9] 82 F.3d 1251, 1257-1259 (2d Cir. 1996).

[10] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

[11] Jordan v. Retirement Comm. of Rensselaer Polytechnic Inst., 46 F.3d 1264, 1267 (2d Cir. 1995); Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995).

[12] Barnable v. First Fortis Life Ins. Co., 44 F. Supp.2d 196, 201 (E.D.N.Y. 1999).

[13] Id.

[14] Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995).

[15] Jordan v. Retirement Comm. of Rensselaer Polytechnic Inst., 46 F.3d 1264, 1271 (2d Cir. 1995).

[16] See Brown v. Blue Cross and Blue Shield, 898 F.2d 1556, 1561 (11th Cir. 1990), cert. denied, 498 U.S. 1040 (1991). For a review of the manner in which various circuits have considered and analyzed how the conflict of interest effects the level of scrutiny and the standard of review that the courts will impose upon the denial of benefits, see the district court opinion in Whitney v. Empire Blue Cross and Blue Shield, 920 F. Supp. 477 (S.D.N.Y. 1996), rev'd, 106 F.3d 475 (2d Cir. 1997). While the district court was reversed by the Second Circuit, the lower court decision is useful in understanding how the courts of the various other circuits have treated this important issue.

[17] Whitney v. Empire Blue Cross and Blue Shield, 106 F.3d 475, 477 (2d Cir. 1997); Sullivan v. LTV Aerospace and Defense Co., 82 F.3d 1251 (2d Cir. 1996).

[18] Sullivan v. LTV Aerospace & Defense Co., 82 F.3d 1251, 1255-56 (2d Cir. 1996).

[19] DeFelice v. American International Life Assurance Company of New York, 112 F.3d 61, 66 n.3 (2d Cir. 1997).

[20] Id.

[21] DeFelice v. American International Life Assurance Company of New York, 112 F.3d 61, 65 (2d Cir. 1997).

[22] Id. at 66.

[23] Id.

[24] 193 F.R.D. 94 (W.D.N.Y. 2000).

[25] Sheehan v. Metropolitan Life Insurance Co., 2002 WL 1424592 (S.D.N.Y.) (Haight, J.); see also, Turay v. Aetna U.S. Healthcare, 160 F. Supp. 2d 557 (S.D.N.Y. 2001) (considering depositions of physicians and parties).

[26] 29 U.S.C. §§ 1132(g)(1); Miller v. United Welfare Fund, 72 F.3d 1066, 1074 (2d. Cir. 1995).

[27] Chambless v. Masters, Mates and Pilots Pension Plan, 815 F.2d 869, 871 (2d. Cir. 1997), cert. denied, 496 U.S. 905 (1990).

[28] Jones v. UNUM Life Ins. Co. of AM, 223 F.3d 130, 139 (2d. Cir. 2000).

[29] Id. at 138.

[30] Peterson v. Continental Casualty Co. (2d Cir.), N.Y.L.J., Feb. 19, 2002.

[31] Id. at 140.