Benefit Claims

2019 ABA EBC Midwinter Meeting
Nashville, Tennessee

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Tipping the scales?

- Are the tides turning such that it is more difficult for the defendant plan/insurer to prevail?
  - De novo review
  - Changes in regulations applicable to disability claims
Changes to Claims Regulations

- Effective for claims filed on and after April 1, 2018
- Main focus on long-term disability claims
- Plan sponsors need to determine whether:
  - other benefits are conditioned on a finding of disability
  - the plan administrator has any discretion in making the determination that the claimant is disabled
- If so, new regulations apply
• Applicable to claims filed before 4/1/2018 but that are denied after that date?
  • Regs state: “shall apply to claims for disability benefits filed under a plan after April 1, 2018.” 29 C.F.R. Sec. 2560.503-1 (p)
  • But – to have a full and fair review there must be compliance with the new regs.

• Is the best practice to comply regardless of original date of disability?
  • Recall same issues with 2002 regs.
Greatest Areas of Change with New Regulations

- Provision of medical reviews prior to a final decision
- Opportunity to review and respond to new information
- Requirement to explain “why” evidence is insufficient
- Notice of Statute of Limitations
- Applies to more than just disability plans; any time a claims adjudicator must make a determination of disability in order to decide a claim, must follow the regulations
Evidence

• Evidence to prevail on de novo review?
  • New evidence?
    • Medical?
    • Discovery?

• Evidence to prevail on abuse of discretion review?
Standard of Review

- **Gordon v. Metropolitan Life Ins. Co.,** No. 17-16821, ____ Fed. Appx. ____, 2019 WL 102403 (9th Cir. Jan. 4, 2019) (reversing and remanding lower court’s decision in favor of insurer, finding that *de novo*, not abuse of discretion, review applied based upon insurer’s years-late determination on appeal)

- **Hoffman v. Screen Actors Guild Pension Plan,** No. 16-56663, ____ Fed. Appx. ____, 2019 WL 103895 (9th Cir. Jan. 4, 2019) (reversing and remanding the lower court’s decision in favor of pension plan, finding that lower court relied on the plan’s finding of facts and did not consider any of the alleged procedural defects)
Remands

• Are remands the new normal?
  • *Hennen v. MetLife*, ---F.3d---, 2018 WL 4376994 (7th Cir. Sept. 14, 2018) (remanding, as “[t]he fact that MetLife acted arbitrarily ‘does not mean that the claimant is automatically entitled to benefits.’”)
  • *But see Gross v. Sun Life*, 880 F.3d 1 (1st Cir. 2018) (upholding award of benefits after initial appellate decision four years prior remanding the decision resulted in a second adverse benefit determination)
Remands

- Why are remands favored?
- Do courts HAVE to remand?
- Judicial instructions on remand?
- What happens on a remand?
- Defendants beware: remand could lead to an award of attorneys’ fees to plaintiff
Attorneys’ Fees

• **Quality of Lawyering**

• **Rates, Hours, and Reductions**
  - *Gross, 880 F.3d 1* (1st Cir. 2018) (rates, hours, blanket reductions)

Would you have reduced the hours?
Would you have reduced the rate?
Attorneys’ Fees

• **Defendant Insurer Ordered to Pay Defendant Plan’s Fees**
  - *Micha v. Sun Life*, 874 F.3d 1052 (9th Cir. 2018) (defendant insurer must pay defendant plan’s fees and costs where insurer settled with plaintiff).

• **Survey on Fee Awards in Disability Cases**
  - [https://www.americanbar.org/content/dam/aba/publications/labor_employment_law_news/EBC%20Newsletter/a_survey_of_fee_awards.html](https://www.americanbar.org/content/dam/aba/publications/labor_employment_law_news/EBC%20Newsletter/a_survey_of_fee_awards.html)
  • Question regarding ambiguity in pension plan provision regarding application of early retirement reduction factors
  • District court applied *contra proferentem* doctrine and found for retirees
  • Sixth Circuit determined that *contra proferentem* cannot be used where *Firestone* deference would apply
  • *Contra proferentem* doctrine also cannot be used to determine whether there is an abuse of discretion that would alter the standard of review, unless it can be shown that the plan administrator deliberately made the plan ambiguous
• **Munro v. University of Southern California, et al., No. 17-5550, 2018 WL 3542996 (9th Cir. July 24, 2018)**
  - Plaintiffs sought to represent a class of participants in two ERISA-governed defined contribution plans sponsored by the University of Southern California, alleging multiple breaches of fiduciary duty stemming from the administration of those plans.
  - Plaintiffs sought equitable relief on behalf of the plans under ERISA Section 502(a)(2) in the form of monetary relief, removal of the breaching fiduciaries, a full accounting of losses, reformation of the plans, and an order regarding appropriate future investments.
  - An ERISA Section 502(a)(2) breach of fiduciary duty claim is brought on behalf of an ERISA plan by its participants, so individual agreements to arbitrate don’t apply to claims brought on behalf of the plan.
  - Ninth Circuit specifically declined to rule that an agreement to arbitrate ERISA claims is always unenforceable. The Court suggested that it might disagree in a future case with its 1984 decision in **Amaro v. Continental Can Co., 724 F.2d 747 (9th Cir. 1984)**, which it held that ERISA’s “equitable character” could not be satisfied in an arbitral proceeding.
Assignments

- *Eden Surgical Center v. Cognizant Technology Solutions Corp.*, No. 16-56422 (9th Cir. April 26, 2018)
  - Ninth Circuit affirmed district court’s grant of summary judgment in favor of the defendant plan administrator and against a healthcare provider purporting to bring claims for ERISA benefits as an assignee of the provider’s patients.
  - Court held that ERISA plan’s anti-assignment provision bars a provider’s suit even where the plan mistakenly told the provider that no such anti-assignment provision exists.
  - Anti-assignment provisions in ERISA plans continue to preclude providers from suing the plans as assignees.
MNAD
Limitations

  • Third Circuit affirmed holding that the plaintiff’s disability was limited to the plan’s 24 month period for mental/nervous conditions.
  • The plan at issue limited benefits “caused by or contributed to by mental or nervous disorders” to 24 months.
  • The plaintiff stopped working in May 2010 due to physical complaints (back pain and tremors). Reliance Standard, the plan’s insurer and claims administrator, paid benefits for four years, and then requested that the plaintiff submit to an in-person independent medical examination. The examining physician concluded that the plaintiff’s tremors were psychological, not physical, in nature. The plaintiff’s medical records also showed that she suffered from depression and anxiety. Accordingly, Reliance Standard terminated the claim, asserting that it was subject to the 24 month limitation for mental/nervous disorders.
  • Court held that the plan’s language made clear that to remain eligible for benefits beyond 24 months, it was the plaintiff’s burden to “prove she was totally disabled from any occupation solely due to a physical condition” and that ‘caused or contributed to by’ in a mental disorders limitations clause” means “that benefits may be terminated when physical disability alone is insufficient to render a claimant totally disabled.” Accordingly, because the record reflected that the plaintiff was capable of performing sedentary work even with her physical condition, the Court found that Reliance Standard did not abuse its discretion in concluding that the mental/nervous limitation applied.
Statute of Limitations

Background:

- **Heimeshoff v. Hartford Life & Acc. Ins. Co.,** 571 U.S. 99, 134 S. Ct. 604, 187 L. Ed. 2d 529 (2013) (contractual SOLs are enforceable so long as they are not “unreasonably short.”)

- **Proof of Loss:** Often a statutory requirement to include when “proof of loss” is due and within how many years after “proof of loss” is due one can file suit. E.g., Cal. Ins. Code Secs. 10350.11 and 10350.7.
Statute of Limitations

Hypo:

- Plaintiff files a claim for partial disability benefits in April 2014. It is approved from April 2014-April 2015, but denied thereafter.

- After submitting a request for review, the denial is upheld ultimately in April 2016.

- Plaintiff continues working part time and does not file suit, but never regains her “actively at work” status.

- In November 2018, she needs to stop working altogether.
Statute of Limitations

The Plan has a Proof of Loss Provision
“Written Proof of Loss must be furnished to Us within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss.”

The Plan has Contractual SOL Provision
“Legal action cannot be take against us more than 3 years after the date Proof of Loss is required to be given according to the terms of the Policy.”
Can she sue under the original claim?

- 90 days after liability is accepted is August 2015.
  3 years later is August 2018

- But 3 years after final denial letter is April 2019.
Statute of Limitations

Does this Change Your Mind?

- *Wetzel*, 2001 WL 36961605 (C.D. Cal. 2001) (following 9th Cir. remand, held that “period for which insurer is liable” refers to a date when disability ended as a medical fact, not when the insurer declines liability)

- *Gray v. United of Omaha*, 251 F. Supp. 3d 1317, 1324 (C.D. Cal. 2017) (“period for which the insurer is liable” refers to “the entire period of disability, and proof of loss is not required until that period ends.”)
Can a SOL defense always be resolved at the Motion to Dismiss Stage given the factual considerations?
Thank you and have a safe trip home!

-Ada, Cassie, & Lisa