DISABILITY LAW
"What To Do When a Client or Someone I know becomes Disabled"

Greg Reed
Bemis Roach and Reed
4100 Duval Road, Bldg. I, Suite 200
Austin, Texas 78759
(512) 454-4000
greg@brrlaw.com

CAPITAL AREA PARALEGAL ASSOCIATION
April 27, 2016
Austin, Texas

Greg Reed
Bemis Roach and Reed
4100 Duval Road, Bldg. I, Suite 200
Austin, Texas 78759
(512) 454-4000
Fax: (512) 453-6335
greg@brrlaw.com

Greg Reed is a partner in the Austin law firm of Bemis, Roach & Reed. He received his law degree in 1991 from the University of Texas at Austin. He is Board Certified in Personal Injury Trial Law by the Texas Board of Legal Specialization and AV rated by Martindale-Hubbell. He has been named a "Super Lawyer" 2011 through present. Mr. Reed is admitted to every federal district in Texas and specializes in representing claimants with Long Term Disability and Social Security Disability claims.

Acknowledgement

My law partner, Lonnie Roach, researched and wrote the section of this paper related to ERISA disability. Lonnie Roach is a partner in the Austin law firm of Bemis, Roach & Reed. He received his law degree in 1991 from the University of Texas at Austin. He is Board Certified in Personal Injury Trial Law by the Texas Board of Legal Specialization and AV rated by Martindale-Hubbell. He has been named a "Super Lawyer" in 2016. Mr. Roach is admitted to every federal district in Texas and specializes in representing claimants with ERISA Long Term Disability claims.

TABLE OF CONTENTS

DISABILITY LAW OVERVIEW

Americans are filing for disability benefits at a startling rate. Since 2003, there has been a 44% increase in disability claims filed by people previously in the workplace. Claims for disability by individuals with little or no work experience increased by 29% over the same time.[1] The conjecture is that a combination of an aging population and a slowing economy caused the growth in disability claims.

Public or Private

Disability benefits come from many different sources and the rules for obtaining benefits change based on the source of the benefit. This paper will discuss the most common public disability benefits, Social Security Disability Insurance and Supplemental Security Income, and will also discuss the most common private disability insurance. It does not address veteran's disability benefits or federal employee disability benefits.

I.
PUBLIC DISABILITY BENEFITS – SSDI AND SSI

The Social Security Administration (SSA) provides two types of disability benefits to qualified individuals. Social Security Disability Insurance (SSDI) is provided under Title II of the Social Security Act. Supplemental Security Income (SSI) is provided under Title XVI of the Act.

A. Definition of Disability

For all individuals applying for disability benefits under Title II, and for adults applying under Title XVI, the definition of disability is the same. The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. SGA means earnings. In 2016, SGA means a person earns at least $1,130 per month. If a person meets the guidelines for blindness, SGA is $1,820 per month.

1. SSDI Non-Disability Qualifications

The Federal Insurance Contributions Act (FICA) is a payroll tax enacted by the federal government to provide money for employees for retirement benefits, Medicare benefits, and disability benefits. In order to qualify for disability benefits under SSDI, a worker must have both recent and sustained work. Eligibility and benefit level are based on age and on the number of "credits" earned in the past. Credits are awarded based on the amount of your earnings. In 2014, a worker receives one credit for each $1,200 of earnings, up to the maximum of four credits per year. There is a misconception that a credit accrues as long as a person works during any quarter of the year. That is not the case. A person can earn all four credits for the year in one day so long as the dollar amount is satisfied. The amount of income needed to qualify for a credit generally goes up slightly every year.

Generally 40 credits are needed, 20 of which were earned in the last 10 years ending with the year the disability began. However, younger workers may qualify with fewer credits.

1 Steve Hargreaves, "Disability Claims Skyrocket: Here's Why", http://money.cnn.com/2013/04/11/news/economy/disability-payments/

The rules are as follows:

- **Before age 24**--You may qualify if you have 6 credits earned in the 3-year period ending when your disability starts.

- **Age 24 to 31**--You may qualify if you have credit for working half the time between age 21 and the time you become disabled. For example, if you become disabled at age 27, you would need credit for 3 years of work (12 credits) out of the past 6 years (between ages 21 and 27).

- **Age 31 or older**--In general, you need to have the number of work credits shown in the chart below and remember that 20 of the credits must be in the 10 years immediately before becoming disabled.

  Unless you are blind, you must have earned at least 20 of the credits in the 10 years immediately before you became disabled.

Born after 1929. Became disabled at:	Credits Needed
31 -42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62 or older	40

Non-working spouse

In very limited circumstances, non-working spouses may qualify for benefits based on the credits earned by the working spouse. If the working spouse is disabled or over 62, the non-working spouse may qualify for benefits at age 62 or at any age if caring for a disabled child under 16. The amount of the benefit is limited to 50% of the benefit of the working spouse.

Former Spouses

A former spouse may be entitled to receive benefits if the following is true:

- The marriage lasted 10 years
- The former spouse is 62 or older
- The former spouse has not remarried
- The former spouse is not personally eligible for disability benefits because of lack of credits OR the amount of the benefit the former spouse is entitled to is less than that of the spouse

Dependents

The dependent, who is an unmarried child of a wage earner who is retired, disabled, or a deceased insured worker is entitled to benefits if he or she is:

- Under age 18
- Under age 19 and a full-time elementary or secondary school student
- Age 18 or older but under a disability which began before age 22

2. SSI Non-Disability Qualifications

SSI is available to individuals who are 65 years of age, blind, or disabled and does not require earned income credits.

Although a claimant may be eligible to receive SSI without any work history, there are very strict

guidelines on the amount of resources one can have before being approved. A single person can have no more than $2,000.00 in resources. If married, the resource cap is $3,000.00 per couple. The following is not counted in the resource total:

- the home you live in and the land it is on;
- household goods and personal effects (e.g., your wedding and engagement rings);
- burial spaces for you or your immediate family;
- burial funds for you and your spouse, each valued at $1,500 or less;
- life insurance policies with a combined face value of $1,500 or less;
- one vehicle, regardless of value, if it is used for transportation for you or a member of your household;
- retroactive SSI or Social Security benefits for up to nine months after you receive them (including payments received in installments);
- grants, scholarships, fellowships, or gifts set aside to pay educational expenses for 9 months after receipt.[2]

B. Disability Determination

If the applicant meets the non-disability criteria (step 1 of a 5 step process), the applicable Social Security field office generally forwards the claim to the disability determination services (DDS) in the State or other office with jurisdiction to make a disability determination. There are DDSs in each of the 50 States, the District of Columbia, and Puerto Rico. In addition to DDSs, SSA has Federal disability processing units that make disability determinations. In Texas, the DDS is the Texas Department of Assistive and Rehabilitative Services (DARS).

Steps 2 through 5 are:

2. Is the condition "severe"? It must interfere with basic work-related activities.
3. Is the condition found on the list of disabling conditions? If it "meets" the listing, it qualifies.
4. Can the applicant perform past relevant work?
5. Can the applicant perform other work? This step factors in age, education, past work, and transferrable skills.

The Listing of Impairments

In order to qualify, the disability must be caused by a physical or mental impairment. The DDS first examines the claim and the associated medical records to determine whether the claim meets a Social Security "listing." The categories are identified in Social Security's Listing of Impairments. Part A of the Listing of Impairments deals with adults. Part B is used for individuals under 18.

The listings in Part A are:

1.0 Musculoskeletal System
2.0 Special Senses and Speech Disorders
3.0 Respiratory System
4.0 Cardiovascular System
5.0 Digestive System Disorders (includes liver)
6.0 Genitourinary Impairments (includes kidney)
7.0 Hematological Disorders
8.0 Skin Disorders
9.0 Endocrine Disorders
10.0 Congenital Disorders that Affect Multiple Body Systems
11.0 Neurological
12.0 Mental Disorders Impairments
13.0 Malignant Neoplastic Diseases
14.0 Immune System Disorders

2 http://www.ssa.gov/ssi/text-resources-ussi.htm, accessed 12 April 2016.

The listings in Part B are:

100.00 Growth Impairment
101.00 Musculoskeletal System
102.00 Special Senses and Speech Disorders
103.00 Respiratory System
104.00 Cardiovascular System
105.00 Digestive System
106.00 Genitourinary Impairments
107.00 Hematological Disorders
108.00 Skin Disorders
109.00 Endocrine Disorders
110.00 Congenital Disorders that Affect Multiple Body Systems
111.00 Neurological
112.00 Mental Disorders
113.00 Malignant Neoplastic Diseases
114.00 Immune System Disorders

Steps 2 and 3 require medical expertise. Steps 4 and 5 require vocational expertise. In every case that makes it past stage 2 (severe impairment), a medical doctor is hired by DDS to assess the claimant's physical or mental residual functional capacity (RFC). If the condition meets a listing, the claim is approved. If it is severe and does not meet a listing, the vocational expert takes the RFC and uses the limitations identified to determine whether the claimant can perform past relevant work or any other work. If the answer is no, the claim is approved.

C. Appeal Process

A Social Security Disability claim has five basic levels:

1. Initial application
2. Reconsideration
3. Hearing before administrative law judge
4. Appeals Council
5. Appeal to federal court

The time it takes to get a decision on your disability application can vary depending on:

- The nature of your disability;
- How quickly we can get your medical evidence from your doctor or other medical source;
- Whether it is necessary to send you for a medical examination; and
- Whether we review your application for quality purposes.

The real waiting commences when the claimant requests a hearing before an administrative law judge. As of March 9, 2016, the wait times in Texas were:

- Dallas Downtown – 14 months
- Dallas North – 14 months
- Fort Worth – 11.5 months
- Houston North – 11.5 months
- Houston Bissonnet – 15.5 months
- Rio Grande Valley – 18 months
- San Antonio – 16 months

Decisions by the Appeals Council frequently take longer than 12 months. In general, a favorable Appeals Council decision remands the case for another ALJ hearing with instructions to the judge on how to proceed.

60 Day Appeal Window

Every appeal must be made within 60 days of receipt of the adverse determination. Social Security will assume that the claimant received the determination no later than five days from the date on the decision. It is the claimant's burden to prove otherwise.

All steps in the appeal process are mandatory in order to take the case to federal court.

II.
PRIVATE DISABILITY - CLAIMS AGAINST DISABILITY INSURERS

Insurance is intended to provide protection against the risks insureds face in life. Some risks, such as the risk of injury or illness, loss of the ability to work, or loss of life itself are so severe and life-altering, that employers and trade organizations want to protect their employees or members from these risks and deliver vital coverage by means of affordable, group rates, or as an employee benefit to supplement salaries. When an employee obtains his coverage in this way, there is a good chance the coverage delivered is more than simple insurance—it is an ERISA plan. **It is important to understand the distinction between ERISA coverage and insurance when a dispute arises over the denial of benefits.**

The Employee Retirement Income Security Act of 1974, better known as ERISA, was enacted to ensure that employees receive the pension and other benefits promised by their employers and to encourage employers to provide benefits to their employees. Most Americans today receive their health benefits through "welfare benefit plans," that are governed by ERISA. Death and Long Term Disability benefits are also commonly provided as employee benefits under ERISA plans and thus subject to its governance. Oftentimes employers provide these benefits through the purchase of insurance covering their employees. When evaluating a dispute between a claimant and a plan, the most important question to ask is perhaps: "Who purchased the coverage?" If the answer is the claimant's employer, then in all likelihood the dispute is governed by ERISA. This is a crucial determination to make because the laws and regulations impacting the claim vary considerably, and not necessarily intuitively, from those governing traditional insurance and contracts.

A. What is an ERISA plan?

"The terms 'employee welfare benefit plan' and 'welfare plan' mean any plan, fund, or program which was . . . established or maintained by an employer or by an employee organization . . . to the extent that such plan, fund, or program was established . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) [holiday benefits, among others] of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B) [relating to severance pay arrangements and supplemental retirement income payments], the terms 'employee pension benefit plan' and 'pension plan' mean any plan, fund, or program which was . . . established . . . by an employer or by an employee organization . . . to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program - (i) provides retirement income to employees, or (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond, regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan."
29 U.S.C. § 1002(1) (emphasis supplied)

B. Should be in writing.

Every employee benefit plan should be established and maintained pursuant to a written instrument. The written instrument "shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan." 29 U.S.C. § 1102(a)(1).

C. What minimum indicia can define a plan - insurance policy, criterion/critical factors?

(1) A plan, fund or program, (2) established or maintained, (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, pre-paid legal services or severance benefits, (5) to participants or their beneficiaries. *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (*en banc*). In discussing the statutory elements, *Donovan* held that a "plan fund, or program under ERISA implies the existence of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits." *Id*. at 1372.

An ERISA plan can be held to exist in the absence of a written plan document or compliance with other ERISA requirements. *Id.* The test is whether a reasonable person could ascertain from the surrounding circumstances: (1) intended benefits, (2) intended beneficiaries, (3) a source of financing, and (4) a procedure for obtaining benefits. *Id.*

An ERISA plan can be established without a name or without formal documentation.

D. Some plans fall within the Safe Harbor provision.

Not all employer-provided plans are governed by ERISA. Federal regulations set out how an employer might establish a plan to be paid for with payroll deductions but still fall within the "Safe Harbor" and not subject to ERISA:

1. no contributions by employer or union;
2. participation by the employee is voluntary;
3. no endorsement by employer or union; and
4. no compensation to employer or union except for reasonable compensation for payroll deduction. 29 C.F.R. § 2510.3-1(j).

E. What is not an ERISA plan?

Some employee benefit plans are exempted from ERISA solely due to the nature of the employer. ERISA provides that it shall not apply to any employee benefit plan if -

1. such plan is a governmental plan (as defined in section 1002(32) of the title);
2. such plan is a church plan (as defined in section 1002(33) of the title) with respect to which no election has been made under section 410(d) of title 26;
3. such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;
4. such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or
5. such plan is an excess benefit plan (as defined in section 1002(36) of the title) and is unfunded.

29 U.S.C. § 1003(b).

F. Who are the plan principals?

"The term 'employer' means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity. " 29 U.S.C. § 1002(5).

"The term 'employee' means any individual employed by an employer." 29 U.S.C. § 1002(6).

"The term 'participant' means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit." 29 U.S.C. § 1002(7).

"The term 'beneficiary' means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

"The term 'administrator' means (i) the person specifically designated by the terms of the instrument under which the plan is operated." 29 U.S.C. § 1002(16)(A). The statutory definition makes clear that an employer can be a plan administrator. 29 U.S.C. § 1002(16)(A)(ii). ERISA defines [plan] administrator as: "(i) the person specifically so designated by the terms of the instrument under which the plan is operated; and (ii) if an administrator is not so designated,. . ." (29 U.S.C. § 1002(16)(A) the administrator by default would be the plan sponsor.

"The term 'plan sponsor' means the employer in the case of an employee benefit plan established or maintained by a single employer." 29 U.S.C. § 1002 (16)(B)(i).

G. Who are fiduciaries?

A named fiduciary is [1] "a fiduciary who is named in the plan instrument, or [2] who, pursuant to a procedure specified in the plan, is identified as a fiduciary." 29 U.S.C. § 1102(a)(2).

A plan may allocate fiduciary responsibilities. A plan document may expressly provide for procedures for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries. U.S.C. § 1105(c)(1)(A).

A plan document may expressly provide for procedures for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities. 29 U.S.C. § 1105(c)(1)(B).

ERISA requires that any procedures for allocating responsibilities for the operation and administration of a plan must be described under the plan. 29 U.S.C. § 1102(b)(2).

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title. 29 U.S.C. § 1002 (21)(A).

H. What is the obligation of a fiduciary?

1. Prudent man standard of care.
   a. Subject to sections 1103(c) and (d), 1342, and 1344 of the title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –
      (1) for the exclusive purpose of:
      (2) providing benefits to participants and their beneficiaries; and
      (3) defraying reasonable expenses of administering the plan;
2. with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
3. by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
4. in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.
   29 U.S.C. § 1104.

III.

CONSIDERATIONS WHEN EVALUATING AN ERISA CLAIM:

A. Time Limits: Notice of Claim/Proof of Loss/Statute of Limitations

1. Notice of Claim/Proof of Loss

Most benefits plans have requirements regarding the timing of both the claimant's *notice of claim* and the more formal *proof of loss*. These requirements are found within the terms of the plan which may be either in the summary plan description (SPD) or the insurance policy if such exists. The *notice of claim* is generally described as the initial notice to the administrator or the insurance carrier that a participant is claiming, or is intending to claim, certain benefits under the Plan. In contrast, the *proof of loss* is the statement of facts, usually along with supporting documentation that proves facts supporting the claim and the triggering of benefits afforded by the Plan.

Both the notice of claim and proof of loss are generally required to be submitted by the participant to the proper administrator or fiduciary within certain prescribed periods of time. The notice of claim is often within thirty (30) days of the event triggering the initiation of a claim. Proof of loss generally required to be given no later than one year after the notice of claim or benefit-triggering event.

Sometimes the claimant does not or cannot give either timely notice or timely proof of loss or both. What is the effect of a claimant's failure to give timely notice of claim or proof of claim? In Texas and most other state jurisdictions, the notice-prejudice rule has been adopted for insured claims. *PAJ, Inc. v. Hanover Insurance Co.*, 243 S.W.3d 630, 634 (Tex. 2008). This rule requires that the administrator first prove that it has suffered actual prejudice as a result of the late notice or filing in order to raise a claim forfeiture defense. Although a state law, the doctrine is not preempted under ERISA due to its direct regulatory effect on the business of insurance. *UNUM Life Insurance Co. v. Ward*, 119 S.Ct. 1380, 1386-1387 (1999).

2. Statute of Limitations

- **a. Claim for benefits** - 4 years. ERISA contains no distinct statute of limitations for claims for benefits brought under § 502(a)(1). For these cases, the circuits agree that the state-law statutes of limitations for breach of contract should be applied. *See e.g. Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992). In Texas, the 4 year period found in Tex. Civ. Prac. & Rem. Code § 16.004 is used unless the Plan establishes a different period.
- **b. Interference with ERISA rights** - 2 years. Claims brought under § 510 of ERISA, typically for retaliation for exercising ERISA rights, are viewed by the Fifth Circuit as most analogous to state-law tort claims and therefore do not use the same statute of limitations as do claims for benefits. In Texas, the two year period, found in Tex. Civ. Prac. & Rem. Code § 16.003, is applied. *McClure v. Zoecon, Inc.*, 936 F.2d 777 (5th Cir. 1991).
- **c. Breach of Fiduciary Duty** - 3 years (could be as long as 6 years by ERISA statute § 413).

Individualized claims for breach of fiduciary duty were recognized by the U.S. Supreme Court in *Varity v. Howe*, 516 U.S. 489, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996). These claims, brought under § 502(a)(3) are subject to the only statute of limitations actually found in ERISA. Section 413 provides:

No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of: (1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or (2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation; except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

The Fifth Circuit has held that § 413 is actually a statute of repose which establishes "an outside limit of six years in which to file suit, and tolling does not apply" *Radford v. General Dynamics Corp*., 151 F.3d 396, 400 (5th Cir. 1998). This appears to be true even though Fifth Circuit precedent may require a claimant to exhaust administrative remedies before filing a breach of fiduciary duty claim. *See, Simmons v. Willcox*, 911 F.2d 1077 (5th Cir. 1990).

3. Exceptions to general rule.

a. Different time limitation in the Plan

Many (if not most) plans contractually modify the period for limitations by inserting a different period of time in which to bring a cause of action. These contractual modifications of a claimant's statute of limitations are enforced so long as they are found to be reasonable. *Harris Methodist Forth Worth v. Sales Support Servs. Inc. Employee Health Care Plan*, 426 F.3d 330 (5th Cir. 2005). Reasonableness, however, is in the eye of the beholder. The Fifth Circuit has found a limitations period of 120 days to be reasonable in the context of a disability benefit claim under § 502(a)(1). See, *Dye v. Associates First Capital Corp. Long-Term Disability Plan 504*, 243 Fed.Appx. 808 (5th Cir. 2007) (Not pub.). Moreover, in *Dye*, the court acknowledged decisions from other circuits finding limitations periods as short as 45 days to be reasonable and gives no indication that this time frame would be found unreasonable in the Fifth Circuit.

Although the Fifth Circuit ostensibly looks to state-law for guidance in limitations cases, it refused to do so with respect to an important safety net Texas provides. Texas Civ. Prac. & Rem. Code 16.070(a) provides:

> ...a person may not enter a stipulation, contract, or agreement that purports to limit the time in which to bring suit on the stipulation, contract, or agreement to a period shorter than two years. A stipulation, contract or agreement that establishes a limitations period that is shorter than two years is void in this state.

Despite the clear policy evidenced by this statute, the Court in *Dye* summarily dismissed an argument that it provided an analogous state period of limitations citing only a Texas court of appeals case that held § 16.070(a) is not binding on ERISA claims. *See, Hand v. Stevens Trans. Inc. Employee Benefit Plan*, 83 S.w.3d 286 (Tex.App. Dallas 2002).

b. Limitations tolled during administrative appeal?

In light of the requirement that a claimant exhaust administrative remedies before filing suit, it would seem to follow that limitations are tolled while those administrative remedies are pursued. This is not necessarily true, however. As stated above, the Fifth Circuit in *Radford* expressly rejected the notion that limitations are tolled while mandatory administrative appeals are pursued in breach of fiduciary duty claims. The Fifth Circuit has yet to expressly decide whether pursuit of administrative remedies tolls limitations for claims for benefits cases.

At least one District court has, however. In *Buckley v. Hartford Life and Accident Ins. Co.*, 2007 WL 2701397, the District court examined this issue and

found that it would be unfair to allow limitations to run while simultaneously requiring a claimant to exhaust administrative remedies.

B. Claim Process

1. Application for Benefits

a. written claim form or verbal claim - sometimes referred to as a "proof of loss."
b. employee portion of written proof of loss - biographical information, reason for disability or other loss, restrictions and limitations, etc.

c. employer portion of written proof of claim - biographical information, job description, monthly pay and miscellaneous questions.
d. physician portion of written proof of claim - period of treatment, restrictions and limitations, perhaps diagnosis (postage stamp space for answers), and treatment records.

2. Deadlines

a. deadlines in the Plan

Most ERISA plans incorporate the deadlines for claims procedure found in the regulations published by the U.S. Department of Labor. These deadlines can however change from time to time and there is often considerable lag time before a particular plan is updated. Some claimants who have been receiving benefits for a long period of time, such as in long term disability cases, may be operating under plan terms that are substantially different than those found in the federal code. The careful practitioner will review each plan for deadlines and compare with the federal regulations so that any departures from the current regulations are noted. It is not safe to assume that a plan deadline that differs from the appropriate deadline in the regulations is void. The Fifth Circuit has held that technical noncompliance with ERISA procedures will be excused so long as the claimant is not denied a full and fair review. *Robinson v. Aetna*, 443 F.3d 389, 393 (5th Cir. 2006).

b. deadlines in the federal code

The Code of Federal Regulations, at 29 C.F.R. 2560.503-1, lists the chronological deadlines each plan is required to adopt if it is to be determined to provide a "full and fair" review of denied claims as required by ERISA § 503. The deadlines vary depending on the nature of the claim.

(1) Health claims (non urgent)

90 days from receipt of claim Plan must notify claimant of initial adverse benefit determination. May be extended up to an additional 90 days should circumstances require.

180 days from receipt of adverse benefit determination: Claimant must appeal adverse benefit determination.
60 days from receipt of appeal (Post service claims only)
Plan must notify claimant of decision on appeal.

(2) Disability claims

45 days from receipt of claim Plan must notify claimant of initial adverse benefit determination. May be extended up to an additional 60 days should circumstances require.

180 days from receipt of adverse benefit determination: Claimant must appeal adverse benefit determination.

45 days from receipt of appeal Plan must notify claimant of decision on appeal. May be extended an additional 45 days if circumstances require.

(3) Other claims

90 days from receipt of claim Plan must notify claimant of initial adverse benefit determination. May be extended up to an additional 90 days should circumstances require.

60 days from receipt of adverse benefit determination: Claimant must appeal adverse benefit determination.

60 days from receipt of appeal Plan must notify claimant of decision on appeal. May be extended an additional 60 days if circumstances require.

3. Obtaining Documents By Which The Plan Is Operated

ERISA plans are typically governed by a written document. In most situations, the employee would be provided with a summary plan description (SPD), a much shorter and easier to read document, in lieu of the formal plan document. If an employee needs to make a claim under the employee benefit plan, that employee would most likely start with the SPD. The plan and summary plan description provide the employee with the description of the benefits of the plan and how to make a claim.

The SPD, or for that matter the plan document may instead refer to a particular insurance policy which sets out the benefits and/or the claim procedure. If the employee does not have the SPD or insurance policy, he/she may request it. Similarly, the employee may request a copy of relevant documents pertaining to the denial of the claim. The plan is required to produce relevant documents upon receipt of a proper, written request.

Request relevant documents - definition of relevant, 29 C.F.R. § 2560.503-1(m)(8), from the plan:

1. relied on in making benefit determination;
2. submitted, considered or generated in the course of making benefit determination, regardless of whether relied on;
3. demonstrates compliance with administrative procedures in making benefit determination in accordance with plan documents; and
4. in case of group health or disability benefits, constitutes a statement of policy with concerning the denied treatment, regardless of whether relied on in making benefit determination. 29 C.F.R. § 2650.503-1(m).

Upon receipt of a proper request, a plan is required to provide requested documents within 30 days. Failure of the plan to do so is actionable under 29 U.S.C. § 1132(c). ERISA provides for a penalty of up to $110.00 per day for failure to provide documents in response to a request.

4. Denial Letter

The denial letter must provide the information required by ERISA (29 U.S.C. § 1133) and ERISA regulations (29 C.F.R. § 2560.503-1(f)) *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154 (4th Cir. 1993) (Non-compliance with §1133(1) was evidence of abuse of discretion but did not require a heightened standard of review.)

ERISA regulations list the requirements of a proper, adverse benefit determination:

> (g) Manner and content of notification of benefit determination.
>
> (1) Except as provided in paragraph (g)(2) of this section, 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;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits, (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other with the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request. . . .

29 C.F.R. § 2560.503-1 (g).

5. Administrative Record

The administrative record consists of the documents available, reviewed or relied on by the administrator of the plan to evaluate a particular claim. It necessarily includes the plan document governing the claim (usually the Summary Plan Description or insurance policy) and the entire claim file that was compiled during the claim and appeal process. It is the responsibility of the plan administrator to identify the matters to include in the administrative record and the claimant can thereafter object to the completeness of the record. *See e.g. Barhan v. Ry-Ron Inc.* 121 F. 3d 198, 201-202 (5th Cir. 1997). Once the administrative record is complete, a district court reviewing a decision of the administrator is constrained to the factual evidence before the administrator. *Robinson v. Aetna*, 443 F. 3d 389, 394 (5th Cir. 2006).

C. Appeal Process

ERISA, § 503 provides:

Sec. 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall--

1. provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
2. afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

A claimant who receives an adverse benefit determination must be afforded an opportunity for a "full and fair" review. This review, directed to the appropriate fiduciary, is the administrative appeal. It can be made with or without supporting documentation. Since the ERISA administrator is required to give its specific reasons for the denial of the claim, the administrative appeal need only be directed at those specific reasons, not the termination of benefits generally. *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 393 (5th Cir. 2006). This means the administrator must state all the grounds on which it ultimately relies in the original denial letter. *Id. Citing McCartha v. Nat's City Corp.*, 419 F.3d 437, 446 (6th Cir. 2005). The requirement that the administrator disclose the basis for its decision is necessary so that the beneficiary can adequately prepare for any further administrative review. *Schadler v. Anthem Life Ins.*, 147 F.3d 388, 394 (5th Cir. 1998).

The most obvious reason for filing an administrative appeal is the hope that the plan administrator will reconsider the adverse benefit determination and award or restore benefits. Pursuing all required administrative appeals is also a necessary prerequisite for filing suit. Although a plan may allow for unlimited administrative appeals, it may require no more than two for health and disability claims. 29 C.F.R. 2560.503-1(c)(2).

The administrative appeal, along with any supporting documentation, becomes part of the administrative record. At the conclusion of the appeal process, the administrative record closes. Once the administrative record is determined, the Court is precluded from receiving evidence to resolve disputed material facts. *Vega v. National Life Ins. Services Co.*, 188 F.3d 287, 299 (5th Cir. 1999 (*en banc*)). For this reason, it is imperative that all necessary evidence a party requires to successfully litigate a case be included in the record at the time of appeal or submitted along with the appeal.

D. Exhaustion of Remedies

ERISA contains no specific requirement that a claimant exhaust administrative remedies before filing suit in benefits cases in federal court. Virtually every circuit, however requires this. *See e.g. Lacy v. Fulbright & Jaworski*, 405 F.3d 254 (5th Cir. 2005). As a general rule, a claimant should always exhaust administrative remedies prior to filing suit. As a judicially created doctrine, however, the district court does have discretion to waive the requirement that a claimant exhaust administrative remedies if the claimant can show exhaustion of administrative remedies would be futile. *Denton v. First Nat'l Bank of Waco, Tex.*, 765 F.2d 1295 (5th Cir. 1985).

Should a claimant file suit before exhausting administrative remedies, the suit is subject to dismissal, typically without prejudice. *See e.g. Galvan v. SBC Pension Benefit Plan*, 204 Fed.Appx. 335 (5th Cir. 2006).

In breach of fiduciary duty cases, there is conflicting Fifth Circuit precedent on whether exhaustion of administrative remedies is required. *Compare*, *Simmons v. Willcox*, 911 F.2d 1077 (5th Cir. 1990) and *Galvan, supra*. The distinction appears to rest on whether the breach of fiduciary duty claim is predicated on a claim for benefits. If so, then a claimant must exhaust administrative remedies. If not, then exhaustion is not required.

E. Lawsuit For Benefits

1. Claim for Benefits

Plaintiff has a claim against the plan for the recovery of plan benefits owed and is brought pursuant to the ERISA civil enforcement provision which provides "A civil action may be brought . . . (1) by a participant or by a beneficiary . . . (B) 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 rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

2. Civil Interference with rights to receive benefits.

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, section 1201 of this title, or the Welfare and Pension Plans Disclosure Act (29 U.S.C. §301 *et seq*.), or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act. It shall be unlawful for any person to discharge, fine,

suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to this chapter or the Welfare and Pension Plans Disclosure Act. The provisions of section 1132 of this title shall be applicable in the enforcement of this section. 29 U.S.C. § 1140.

3. Jurisdiction/Venue

With rare exception, ERISA cases are litigated in federal court. ERISA contains a specific jurisdictional provision at 29 U.S.C. § 1132(e) granting exclusive jurisdiction of breach of fiduciary duty claims (29 U.S.C. § 1109) and interference with the right to receive benefits claims (29 U.S.C. § 1140) to federal district court. ERISA grants concurrent jurisdiction of claim for benefits cases (29 U.S.C. § 1132(a)(1)(B)) to federal district court and "State courts of competent jurisdiction." These cases are typically removed to federal court, however if filed in state court.

ERISA provides a choice of venue for cases filed in federal court allowing them to be brought: "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found." 29 U.S.C. § 1132(e).

4. Preemption

In order to provide a uniform system of regulating employee benefits, ERISA preempts most state laws and regulations that would otherwise govern employer provided benefits. While this increases efficiency for multi-state employers and ERISA plans by not subjecting them to differing states' regulations for the same plans, it unfortunately leaves little in the way of regulation for most of these plans. ERISA was never intended to provide the regulatory framework for day to day issues such as administering a claimant's health insurance claim; that job was traditionally done by the states. In the years since its adoption however, most courts have ruled that state regulations, such as the Texas Insurance Code and states' common law simply do not apply to ERISA plans.

Most state laws which "relate to" employee benefit plans are preempted by ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (concerning a broadly-based Mississippi bad faith rule.) The conventional analysis is that ERISA provides, with certain narrow exceptions, that the rights, regulations, and remedies afforded by that statute "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). For purposes of preemption, "[t]he term 'State law' includes all laws, decisions, rules, regulations, or other State action having effect of law, of any State." 29 U.S.C. § 1144(c)(1).

ERISA contains two clauses dealing with the scope of preemption. The preemption clause and the savings clause. The preemption clause provides that, "except as provided in [the savings clause] the provisions of this title . . . shall supersede any and all State laws insofar as they may or now or hereafter relate to any employee benefit plan." ERISA § 514(a) codified at 29 U.S.C. § 1144(a). The savings clause provides that ". . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ." ERISA § 514(b)(2)(A) codified at 29 U.S.C. § 1144(b)(2)(A).

F. Standard of Review

ERISA provides federal courts with jurisdiction to review benefit determinations. *See* 29 U.S.C. § 1132(a)(1)(B); *Baker v. Metro. Life Ins. Co.*, 364 F.3d 624, 629 (5th Cir. 2004). An administrator's denial of benefits under an ERISA plan is reviewed by the district court under a *de novo* standard unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits or to

construe the terms of the plan. *Firestone Tire and Rubber Co. v. Bruch* 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). When the plan fiduciary is vested with the discretionary authority to determine disability claims under the plan, a district court may reverse the decision regarding a denial of benefits if the decision is arbitrary and capricious. *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 395 (5th Cir. 2006). A decision is arbitrary and capricious if made without a rational connection between the known facts and the decision, or between the found facts and the evidence. *Bellaire Gen. Hosp. V. Blue Cross Blue Shield of Mich*., 97 F.3d 822, 828 (5th Cir. 1996). An administrator's decision to deny benefits must be "based on evidence, even if disputable, that clearly supports the basis for its denial." *Vega v. Nat'l Life Ins. Servs., Inc*., 188 F. 3d 287, 299. Without some *concrete evidence* in the administrative record that supports the denial of the claim, the Court must find the administrator abused its discretion. *Id*. An administrator cannot unreasonably rely on statements contained in the record without considering them in the context of all the relevant facts and evidence presented. *See e.g. Lain v. UNUM Life Insurance Company of America* 279, F. 3d 337, 346 (5th Cir. 2002).

Upon electing to deny a claim, administrators are required by ERISA, 29 U.S.C. § 1133 to:
1. provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
2. afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Subsection (1)'s mandate that the claimant be specifically notified of the reasons for an administrator's decision suggests that it is those "specific reasons" rather than the termination of benefits generally that must be reviewed under subsection (2). *Robinson*, 443 F.3d at 393.

The standard of review for an administrator's actions is *de novo* or abuse of discretion based on the determination of whether the administrator has the discretion to determine eligibility for benefits or to construe the terms of the plan. If the administrator does not have this discretion, the district court should apply the *de novo* standard of review for the law aspects of the decision by the administrator. However, in the Fifth Circuit the factual aspects of the decision by the administrator are nevertheless, always reviewed for abuse of discretion. *Estate of Bratton v. Nat.'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 215 F. 3d. 516, 522 (5th Cir. 2000). *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 946, 103 L. Ed. 2d 80 (1989).

On the other hand, if the plan administrator is determined to have discretionary authority to determine eligibility for benefits or to construe the terms of the plan, in the Fifth Circuit, the review of both the administrators' law and factual aspects of the decision is based on abuse of discretion.

Oftentimes, an ERISA administrator both determines eligibility benefits and pays benefits out of its own pocket. This is typical with fully insured ERISA plans. In this circumstance, the ERISA administrator operates under a conflict of interest. *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2348, 76 USLW 4495, 171 L.Ed.2d 299 (2008). This conflict must be weighed as a factor in determining whether there is an abuse of discretion. *Id.* The fact that an ERISA administrator reached its decision to deny while burdened by a conflict of interest can serve as a tiebreaker should the Court find other factors are closely balanced. *Glenn*, at 2351.

A reviewing court may give more weight to a conflict of interest, where the circumstances surrounding the plan administrator's decision suggest "procedural

unreasonableness." *Schexnayder v. Hartford Life & Accident Ins. Co.*, 600 F.3d 465, 469 (5th Cir. 2010). A decision demonstrates procedural unreasonableness where, for example, an administrator takes positions that are financially advantageous by emphasizing evidence which supports denial of benefits and deemphasizing other evidence. *Glenn*, 554 U.S. 118, 128 S.Ct. at 2352.

> In *Glenn*, Court held:
> Often the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket. We here decide [1] that this dual role creates a conflict of interest; [2] that a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and [3] that the significance of the factor will depend upon the circumstances of the particular case.

In so holding, the Court reconfirmed several of the principles in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, (1989) where it stated:

> (1) In "determining the appropriate standard of review," a court should be "guided by principles of trust law"; in doing so, it should analogize a plan administrator to the trustee of a common-law trust; and it should consider a benefit determination to be a fiduciary act (i.e., an act in which the administrator owes a special duty of loyalty to the plan beneficiaries). [*11] Id., at 111-113, 109 S. Ct. 948, 103 L. Ed. 2d 80. See also Aetna Health Inc. v. Davila, 542 U.S. 200, 218, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004); Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 570, 105 S. Ct. 2833, 86 L. Ed. 2d 447 (1985).
> . . .
> (4) If "a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" Firestone, supra, at 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (quoting Restatement § 187, Comment d; emphasis added; alteration omitted).

The Court stated that the payor/determiner conflict is one of the types of conflicts that must be taken into account by the reviewing court. The Court stated:

> The employer's fiduciary interest may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary. Thus, the employer has an "interest . . . conflicting with that of the beneficiaries," the type of conflict that judges must take into account when they review the discretionary acts of a trustee of a common-law trust. . . . cf. Black's Law Dictionary 319 (8th ed. 2004) ("conflict of interest" is a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties").

Id. at *12-*13.

The Court reasoned that the dual role of payor/determiner created a conflict because:

> … ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of

> the plan, § 1104(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators "provide a 'full and fair review' of claim denials," *Firestone*, 489 U.S., at 113, 109 S. Ct. 948, 103 L. Ed. 2d 80 (quoting § 1133(2)); and it supplements marketplace and regulatory controls with judicial review of individual claim denials, *see* § 1132(a)(1)(B).

Id. at, *17 (emphasis supplied).

The Court reiterates that the conflict must be taken into account. "Trust law continues to apply a deferential standard of review to the discretionary decision making of a conflicted trustee, while at the same time requiring the reviewing judge to take account of the conflict when determining whether the trustee, substantively or procedurally, has abused his discretion." *Id.* at *18 (emphasis supplied). The reviewing judge must determine the lawfulness of the benefits denial by taking into account several factors, including conflict, reaching a result by weighing all together. The Court has fashioned a facts-and-circumstances reasonableness test to administrative decisions.

The reviewing court must also determine the inherent or case-specific importance of the conflict factor based on the likelihood that it affected the claim decision. The Court stated, "The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision. . ." *Id.* at *21. The Court also noted that certain conduct by the administrator may give weight to the conflict. "This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court in giving more weight to the conflict (because MetLife's seemingly inconsistent positions were both financially advantageous)." *Id.* at *23.

Where, at the opposite end, the factor may be less important based on precautions taken by the administrator. "It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits." *Id.* at *21-*22.

The Supreme Court approved of the Sixth Court of Appeals' weighing of the factors in performing the combination-of-factors method of review. The Court stated:

> The Court of Appeals' opinion in the present case illustrates the combination-of-factors method of review. The record says little about MetLife's efforts to assure accurate claims assessment. The Court of Appeals gave the conflict weight to some degree; its opinion suggests that, in context, the court would not have found the conflict alone determinative. *See* 461 F.3d at 666, 674. The court instead focused more heavily on other factors. In particular, the court found questionable the fact that MetLife had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then ignored the agency's finding in concluding that Glenn could in fact do sedentary work. *See id*., at 666-669. This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court in giving more weight to the conflict (because MetLife's seemingly inconsistent positions were

> both financially advantageous). And the court furthermore observed that MetLife had emphasized a certain medical report that favored a denial of benefits, had de-emphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence. *See id.*, at 669-674. All these serious concerns, taken together with some degree of conflicting interests on MetLife's part, led the court to set aside MetLife's discretionary decision. *See id.*, at 674-675. We can find nothing improper in the way in which the court conducted its review.

Id. at *22-*24.

G. Discovery

Except for the production and determination of the administrative record, there is no discovery on the fact resolution of the plan's/insurance company's decision. On some issues however, discovery is allowable.

In *Glenn*, the Court's opinion appears to make it clear that discovery is appropriate and proper regarding the existence of various areas of conflict. It is even clearer that discovery is necessary to show the "case-specific" importance of the conflict as a factor. The Court stated "The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision,. . ." *Metropolitan Life Ins. Co.* at *21. Discovery is appropriate to show that the areas of conflict affected the decision.

The Court envisioned that a claimant would have discovery with respect to the payor/determiner conflict as well as conflicts of that type and whether those conflicts affected the benefit determination. Without such discovery, it would be difficult for a claimant to convince a court that a conflict existed or to demonstrate the importance of that conflict as a factor, if the claimant is not given an opportunity for discovery regarding those issues.

Prior to its adoption of the combination of factors review standard post *Glenn*, the Fifth Circuit recognized that discovery is appropriate in matters related to the degree of deference that should be accorded to an administrator's decision: "[T]he arbitrary and capricious standard may be a range, not a point. There may be in effect a sliding scale of judicial review of trustees' decisions-more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is ...." *Vega v. Nat'l Life Ins. Services, Inc.*, 188 F.3d 287, 296 (5th Cir. 1999) *en banc*, citing Wildbur *v. ARCO Chemical Co.*, 974 F.2d 631, 638 (5th Cir. 1992); This is based on the Court's statement that "[t]he greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be." *Lain v. UNUM Life Ins. Co. of America*, 279 F.3d at 343, citing *Vega v. Nat'l Life Ins. Services, Inc.*, 188 F.3d at 297.*Wildbur v. ARCO Chemical Co.*,974 F.2d 631, 638 (5th Cir. 1992), states "[It is] obvious that some evidence other than that contained in the administrative record may be relevant at both steps of this process of judicial review."

While the sliding scale standard of review is no longer used in the Fifth Circuit, there is no reason why the same type of discovery related to the extent of a conflict of interest would not be allowed in support of the combination of factors approach.

H. Remedy

Upon finding that an ERISA administrator abused it's discretion, the Court should award damages, including prejudgment interest and attorney fees. *Vega v. Natl. Life Ins. Services Inc., 188 F.3d 287,302 & n. 13 (5th Cir. 1999).*

1. Benefits

Damages include benefits wrongfully withheld as a result of the denial. In addition to past monetary benefits, such as in the case of life or disability insurance, benefits can include precertification of health benefits or an order that certain benefits be provided (clarification of the right to receive future benefits, §502(a)(1)(B)).

2. Prejudgment Interest

A successful claimant is entitled to prejudgment interest. *Vega, supra*. When awarding prejudgment interest in an action brought under ERISA, it is appropriate for the District Court to look to state law for guidance in determining the rate of interest. *Hansen v. Continental Insurance Co.,* 940 *F.2d 971, 984 (5th Cir. 1991).* According to the Court in *Hansen*, the district court has the option of using the Texas statutory rate for contract actions, V.A.T.S. Finance Code, § 302.002 (6% *per annum* compounding from date payment due on stream of benefits analysis) or the Texas statutory rate for other actions, V.A.T.S. Finance Code, § 304.103 (7.75% simple interest on entire judgment). After *Hansen* was decided, the Texas Supreme Court held that all prejudgment interest calculations, including those for contract actions, should be decided in accordance with the prejudgment interest statute. See Johnson & Higgins of Texas, Inc. v. Kenneco Energy Inc. 962 S.W. 2d 507, 532 (Tex. 1998).

3. Discretionary Attorney's Fees

ERISA, in 29 U.S.C. § 1132 (g)(1), provides for an award of reasonable attorneys fees and costs to either party at the Court's discretion. The 5th Circuit in Vega v. Nat'l Life Ins. Servs., Inc., 188 F. 3d 287, 302 (5th Cir. 1999), held that the Court should award attorneys fees upon a finding that an ERISA administrator abused it's discretion.

Attorney fees awards in ERISA cases are typically made using the Lodestar approach. In the Fifth Circuit, a claimant must establish the reasonableness of the fees sought based on the factors set out in Johnson v. Georgia Highway Exp., Inc. 488 F.2d 714 (5th Cir. 1974) (the Johnson factors). These include: (1) the time and labor required, (2) the novelty and difficulty of the questions, (3) the skills necessary to perform the legal services properly, (4) the preclusion of other employment by the attorney due to the acceptance of the case, (5) the customary fee, (6) whether the fee is fixed or contingent, (7) time limitations imposed by the client or other circumstances, (8) the amount of money involved and the results obtained, (9) the experience, reputation and ability of the attorney, (10) the undesirability of the case, (11) the nature and length of the professional relationship with the client and (12) awards in similar cases.

a. pre-lawsuit - in the Fifth Circuit there are no attorney's fees allowed for attorney work in the claim process.

b. lawsuit - attorney's fees and cost of the action are discretionary with the district court.

c. what are reasonable and necessary attorney's fees.

(1) discretion of the court 29 U.S.C. § 1132(g)(1); and
(2) five factors in the Fifth Circuit:
  (a) degree of opposing party's culpability,
  (b) ability of opposing party to satisfy award of attorney's fees,
  (c) deterrent effect of award on other persons,
  (d) whether party requesting fees sought to benefit all participants in the plan or to resolve a significant legal question regarding ERISA, and
  (e) relative merits of the party's position.

CONCLUSION

ERISA plans typically confer a level of deference on a claim decider, often an insurance company, which is not seen in most other insurance claims. Traditional protections, such as the duty of good faith and fair dealing, the protections enumerated in the Texas Insurance Code, and even the right to trial by jury for an aggrieved claimant are notably absent. This does not mean that there are no protections, however.

The ERISA statute provides a clear outline of rights available under law. Federal regulations provide a comprehensive framework for enforcing those rights, detailing the steps necessary to provide a claimant a fair determination of his claim.

Finally, an increasing awareness of the challenges administrators face when they determine claims while burdened by an inherent conflict of interest is leading the federal courts to more closely scrutinize those instances where it appears the administrator was influenced more by its bottom line, than by its duty to fairly determine a claim.

While these protections are different than those that might be available in traditional insurance matters, they can be powerful. When used with skill, they help level the playing field for those with claims against health, disability, and life insurers governed by ERISA.