

# DISABILITY BENEFITS LITIGATION: A PRIMER UNDER ERISA

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## DISABILITY CLAIMS LITIGATION UNDER ERISA

### I. INTRODUCTION

This paper is meant to act only as a primer to lead the general practitioners into the maze of managing and litigating disability claims arising under the Employment Retirement Income Security Act (“ERISA”), 29 U.S.C. 1001, et seq. The focus is to help the general practitioner spot and avoid some of the pitfalls arising in the litigation of these claims.

Although ERISA was enacted to protect the rights of persons with respect to welfare and benefit plans, there remains very little left to the claimant since the statute virtually pre-empts all other related laws, and the courts have carved up and interpreted the statute to the benefit of the employers and the insurance companies. As so aptly put by our own Judge Becker in his concurrence in DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442 (3d Cir. 2003), the price of trying to maintain some equity in the face of the expansive ERISA pre-emption doctrine is like “a descent into a Serbonian bog wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases.”

I can by no means pull anyone out of the bog, but offer a few insights into this complex area of the law.

### II. BACKGROUND INFORMATION

Due to the demographics the baby-boom bubble, our workforce is aging. As our workforce ages, employers will feel the impact of the changing cohort of the workforce and the costs associated with the employment of older workers. Employers will continue to look for ways to manage rising health care and benefits costs associated with their businesses. According to research performed by Marsh Risk Consulting in a 2003 survey, employers’ top concerns are 1) trying to manage the increased costs of time-off and disability programs, and 2) finding ways to effectively manage the impact of employee absences from work, which includes a reported rise in the incidence of disability claims. [www.marshriskconsulting.com](http://www.marshriskconsulting.com). (Fourth Annual March Mercer Survey of Time Off and Disability Programs).

Four hundred eighty five (485) employers with over one hundred (100) employees responded to the Marsh 2003 survey. Id. Despite reported aggressive management of employee absences, thirty two (32) percent of those surveyed reported that the short term disability incident rates had risen over the previous two years and twenty-two (22) percent reported an increase in long term disability incident rates. Id. According to that survey, the total cost for time off and disability programs averaged 14.9 percent of payroll. Id.

UNUM Provident, the largest insurance company underwriting disability claims (anywhere from thirty to forty percent of the market), has produced data analyzing the

change in the incident of claims across different age cohorts. Although the data from the UNUM Provident Disability Database, 2002-2004, shows that the distribution of STD claims actually drops with age, that data is impacted by the fact that under the age of 40, 51% of the STD claims are filed as maternity claims. Under the age of 40 the claims distribution is reported as follows: accident 11%, sickness 38%, maternity 51%. The claims made for STD over the age of forty broke down as follows: accident 16%, sickness 82%, and maternity 2%. The most frequent impairment reported for individuals over the age of forty was cancer (17% of claims made).

According to data released in 2002/2003 by the Bureau of Labor Statistics, the duration of work related time away from work increases as the population ages, doubling to an average of twelve (12) missed days for workers age 55 and older, from six (6) missed days to workers aged 20-34. 2002/2003 Bureau of Labor Statistics & 2003 Current Population Survey, U.S. Department of Labor.

Additional research conducted by Unum Provident Corporation in 2005, focusing on the aging American workforce concluded the following:

Although workers age 40 and older experience a lower incidence of work injuries, short term disability and unscheduled absences than younger workers, the average amount of time they will miss due to an injury or illness is greater by nearly a third.

Workers older than age 40 account for 50 percent of all short-term disability claims and up to 75 percent of long-term disability claims.

While we might question the accuracy and statistical significance of these different surveys, any increase in the incident rate and/or duration of disability claims brought about by the aging of the American workforce will no doubt be met with aggressive measures to contain those claims. As a result, we should see an increase in litigation over disability claims.

### III. STATISTICAL DATA

#### A. Americans With Disabilities

According to United States Census 2000 Data, out of 72.3 million American families, approximately 20.9 million American families identified themselves as having at least one member with a disability. The questions posed in identifying persons with disabilities were as follows:

Does this person have any of the following long-lasting conditions?

- a. Blindness, deafness or a severe vision or hearing impairment?
- b. A condition which substantially limits one or more basic physical activities such as walking, climbing stairs, reaching lifting or carrying?

Because of a physical, mental or emotional condition lasting 6 months or more, does this person have any difficulty in doing any of the following activities?

- a. Learning, remembering or concentrating?
- b. Dressing, bathing or getting around inside the house?
- c. (Answer this if this person is 16 years or older) Going outside the home alone to shop or visit the doctor's office?
- d. (Answer this if this person is 16 years or older) working in a job or business?

Source: U.S. Census Bureau Questionnaire, Appendix D, located at [www.census.gov/prod/cen2000/doc/sf3.pdf](http://www.census.gov/prod/cen2000/doc/sf3.pdf) . This questionnaire was intended to measure disability in keeping with the definition of disability used under the American With Disabilities Act. Wang, Qi, *Disability and American Families: 2000, Census 2000 Special Reports* (July 2005), p.19.

According to this data, 12.3 million or 17% of families report one or more members who had difficulty working in a job or business. *Disability and American Families: 2000, Census 2000 Special Reports*, p.4. Not surprising, the economic well being of those families with disabilities was substantial less than those families without a member with a disability. Family members with a disability reported a median income of \$39,155, below the overall family median income of \$50,046 and the \$54,515 median income of families without members with a disability. *Id.* at p.6, Table 4.

#### B. Costs of Disability Benefits

According to statistics gathered by the United States Department of Labor, Bureau of Labor Statistics, in June 2006, the average employer costs for employee compensation for all civilian workers per hour worked was computed as follows:

	Cost	Percentage
Total Compensation	\$26.86	100.0
Wages/Salaries	\$18.80	70.0
Total Benefits	\$8.06	30.0
Paid leave (holiday, sick and other)	\$1.88	7.0
Insurance	\$2.19	8.1
Life	.05	.2
Health	2.06	7.7
STD	.05	.2
LTD	.04	.1
Retirement Plans	\$1.15	4.3

Legally required (SSI,  
Medicare, Unemployment) \$2.17 8.1

<http://www.bls.gov/news.release/ecec.t01.htm>.

While according to this survey, the costs associated with disability benefits represent only a small percentage of an employees' compensation, as the work force ages, and the number of disability claims rise, the costs of providing these benefits may constitute an increasing percentage of future costs of employee benefits. With Americans now living longer, and remaining in the workplace longer, age has and will continue to have a profound impact on disabilities. According to the National Association of Health Underwriters, there are 3.74 disabilities per 1,000 people ages 45 to 49. This increases nearly five times more with age, to 15.18 disabilities per 1,000 people ages 60 to 64.

#### IV. DISABILITY PLANS AS A BENEFIT OF EMPLOYMENT

As a benefit associated with employment, many employers offer group short-term disability (STD) and/or long-term disability (LTD) plans. Disability plans are intended to protect the employee from a disruption in his capacity to earn a living while ill, injured or disabled. Employers often offer STD plans that are self insured, or provided out of a company's general assets, while the majority of LTD benefits tend to be purchased as insurance policies.

If a qualified employee is unable to work due to a disability, he will receive a percentage of salary while he remains disabled. Some plans are drafted to protect against the risk that an employee is unable to engage in his "regular or usual occupation," while others only protect against the risk that an employee is able to engage in "any gainful employment for which he is otherwise trained," with standards for recovery similar to the definition under the Social Security Administration. Most disability plans are capped at about 70% of income.

These "group" disability plans usually have an elimination period before benefits become payable. Often employers will dovetail other benefit payments to ensure that there is no gap in coverage for an employee between when the time salary ends and STD and/or LTD benefits begin. Employers may offer paid time off (PTO) during the elimination period. Coverage under the disability plans varies greatly: some plans pay a fixed benefit regardless of whether an individual qualifies for and receives Social Security disability payments, while other plans offset the benefits payable with benefits received from Social Security disability payments and/or other benefit plans.

At present, it is reported that thirty nine (39) percent of employees have access to employer offered STD plans and thirty (30) percent have access to LTD plans. *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2006*, United States Department of Labor.

Since these plans are offered and arise out of an employer-employee relationship, these plans are governed by the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1001, et seq.

#### A. Employer Issued Disability Plans are Welfare Plans under ERISA

Employers are not required by federal law to offer STD/LTD benefits or any other “welfare benefits” to their employees.<sup>1</sup> Once they make a determination to do so however, the Employee Retirement Income Security Act (“ERISA”) 29 U.S.C. § 1001, et seq., delineates how the employer must act in the granting, denial, and termination of these welfare benefits. ERISA contains stringent reporting, recordkeeping and fiduciary requirements as well.

As defined in 29 U.S.C. § 1002, the term welfare plan includes by its very definition disability plans:

(1) The terms “employee welfare benefit plan” and “welfare plan” mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained 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. . .

Certain employer plans, such as governmental or church plans are excluded from coverage. 29 U.S.C. § 1003.

#### B. Employer Reporting /Documentation Requirements

ERISA has extensive requirements regarding filing of reports with the United States Secretary of Labor, providing detailed summary plan descriptions to participants and beneficiaries that define the substance of the benefits offered, maintaining plan documents available for inspection by the plan participant, and other administrative requirements that are beyond the scope of this paper. See generally 29 U.S.C. §§ 1021 – 1029. Failure to comply with these reporting requirements subjects an employer to actions brought by the Secretary of Labor for enforcement and for fines and penalties. See 29 U.S.C. 1132, 29 C.F.R. § 2620.

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<sup>1</sup> Some jurisdictions require employers to pay into state disability plans or to offer disability plans to their employees. As of this writing, California, Hawaii, Rhode Island, New York, New Jersey and Puerto Rico have such laws.

C. ERISA Requires An Administrative Scheme And A Reasonable Claims Review Process

Once an employer grants covered benefits to an employee, ERISA requires that the plan have reasonable claims procedures for the recovery of those benefits, in accordance with regulation carried out by the Secretary of Labor. Under 29 U.S.C. § 1133, 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.

The purpose of the administrative review process is to reduce the number of frivolous claims, to provide a non-adversarial framework for claims review and to reduce the costs of benefit claims disputes. Amato v. Bernand, 618 F.2d 559, 567 (9<sup>th</sup> Cir. 1980).

1. The Claims Review Process Must be Reasonable

The minimum requirements of a reasonable review process are set forth in 29 C.F.R. § 2560.503-I (b).

A claims procedure shall be deemed reasonable if it

- 1) is described in the summary plan description (including the time for filing of the claim and appeal);
- 2) does not contain any provision, and is not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits (i.e., requiring a fee associated with the processing of benefits);
- 3) does not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal; and,
- 4) contains administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

2. Plans Providing Disability Benefits

The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply with the requirements of paragraphs 2650-503-1(b), summarized above, and the following:

(c)(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal . . .

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

### 3. Claim For Benefits Deemed Made

A claim for benefits is deemed filed when made when the claimant or his representative makes a request for a plan benefit or benefits in accordance with a plan's reasonable procedure for filing benefit claims. 29 C.F.R. § 2650.503-1(e). This then necessarily starts the clock for timely review of the claim.

### 4. Notice of Claims Denials

Generally, a notice of claim denial for health and welfare plans generally must be furnished to the claimant within ninety (90) days of receipt of the claim, unless special circumstances would allow for an extension of time for an additional period. The extension of time cannot exceed ninety (90) days. If the plan administrator determines that there are special circumstances requiring an extension, that determination must be provided to the claimant within the original ninety (90) day period, along with the description of the special circumstances identified.

In the case of disability plans the plan administrator must notify the claimant of any adverse benefit determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the plan. This period may be extended by the plan for up to thirty (30) days, provided that the plan administrator determines that such an extension is necessary due to matters beyond the 'control of the plan' and notifies the claimant, prior to the expiration of the initial forty-five (45) day period, of the special circumstances requiring the extension of time and the date by which the plan expects to render a decision.

### 5. Requirements of the Claim Denial

The claim denial must be supplied either in electronic or written form and must provide:

- (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; and
- (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, the decision must cite the rule or reliance on the rule and provide a copy free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the administrator must offer an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

#### D. Time for Appeal

Claimants have one hundred and eighty (180) days to appeal group health and disability claim denials. 29 C.F.R. § 2650.503-1(h)(3)(i), (h)(4).

#### E. Exhaustion of Claims Procedures as a Prerequisite to Filing Suit

ERISA Section 502 sets out the claims procedure for filing suit for a claim to recover benefits. Although ERISA Section 502 is silent as to the exhaustion of remedies, generally the courts will require a claimant or a participant in a plan to exhaust his administrative remedies prior to filing suit.

The courts have waived that requirement when exhaustion would be futile. Berger v. Edgewater Steel Co., 911 F.2d 911, 916 (3d Cir. 1990) ("Although the exhaustion requirement is strictly enforced, courts have recognized an exception when resort to the administrative process would be futile."). It is the Plaintiff's burden to show a "clear and positive showing of futility." Brown v. Cont'l Baking Co., 891 F. Supp. 238, 241 (E.D. Pa. 1995); see also Davenport v. Abrams, Inc., 249 F.3d 130, 133 (2d Cir. 2001) (exhaustion not excused because correspondence with employer did not amount to an "unambiguous application for benefits and a formal or informal administrative decision denying benefits [such that] it is clear that seeking further administrative review would be futile").

For Third Circuit law discussing the exhaustion requirement see:

D'Amaco v. CBS Corp., 297 F.3d 287 (3d Cir. 2002) (distinguishing between exhaustion requirements for claims to recover benefits under a plan (where exhaustion is required) versus a claim for recovery under other statutory sections of ERISA.

Zipf v. American Telegraph. & Telephone Co., 799 F.2d 889 (3d Cir. 1986) (employee is not required first to exhaust her benefit plan's internal procedures before bringing her claim under Section 510 that her employer fired her to prevent her from obtaining disability benefits).

Harrow v. Prudential Ins. Co., 279 F.3d 244 (3d Cir. 2002) (granting summary judgment for the employer, finding that the employee had failed to exhaust his administrative remedies under the plan and failed to make the requisite showing of futility).

"Except in limited circumstances . . . a federal court will not entertain an ERISA claim unless the plaintiff has exhausted the remedies available under the plan." Weldon v. Kraft, Inc., 896 F.2d 793, 800 (3d Cir. 1990) (citing Wolf, 728 F.2d at 185); Zipf v. Am. Tel. & Tel. Co., 799 F.2d 889, 892 (3d Cir. 1986); see also Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980) ("Sound policy requires the application of the exhaustion doctrine in suits under [ERISA]."). Courts require exhaustion of administrative remedies "to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a non-adversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned." Amato, 618 F.2d at 567. Moreover, trustees of an ERISA plan "are granted broad fiduciary rights and responsibilities under ERISA . . . and implementation of the exhaustion requirement will enhance their ability to expertly and efficiently manage their funds by preventing premature judicial intervention in their decision-making processes." *Id.*; see also Zipf, 799 F.2d at 892 ("When a plan participant claims that he or she has unjustly been denied benefits, it is appropriate to require participants first to address their complaints to the fiduciaries to whom Congress, in Section 503, assigned the primary responsibility for evaluating claims for benefits.").

Harrow at 253.

## V. PROCEDURAL ISSUES IN ERISA LITIGATION

### A. Original Jurisdiction is in the Federal Courts

Under ERISA § 502 (e)(1), federal courts have exclusive jurisdiction over all actions brought under Title I of ERISA by the Secretary of Labor, a plan participant, beneficiary or fiduciary, except for claims for the recovery of benefits or to enforce rights under the plan, which jurisdiction is shared concurrently with state and federal courts.

If an action is brought in state court on a claim for a recovery of benefits, claims based on other provisions of ERISA cannot be joined since ERISA provides for original jurisdiction on all claims except those based on ERISA § 502 (a)(1)(b). Shiffler v. Equitable Life Assurance, 609 F. Supp. 832 (E.D. Pa. 1985).

### B. Venue

Venue for suits brought in district courts lies 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. Section 502 (e)(2). Actions against the Secretary of Labor may be brought in the

district where the plan has its principal office or in the District of Columbia. Section 502 (k).

### C. Removal from State Court

Removal from state to federal court is provided for in 28 U.S.C. § 1441, which states:

(a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending. For purposes of removal under this chapter, the citizenship of defendants sued under fictitious names shall be disregarded.

(b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

Generally, a claim may only be removed when the federal question appears on the face of a well-pleaded complaint. Where, as in ERISA, Congress has so preempted the field in this area of law that any claim brought is necessarily federal in character then removal is proper. Aetna Health Inc. v. Davila, 542 U.S. 200 (2004); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987) (common law causes of action filed in state court that are pre-empted by ERISA and come within the scope of § 502(a)(1)(B) are removable to federal court under 28 U. S. C. § 1441(b)).

### D. Time for Removal.

The defendant may remove the action under 28 U.S.C. § 1446 (b), within thirty (30) days of after receipt by the defendant, through service or otherwise of the copy of the complaint or service of the summons, whatever period is shorter. Once the defendant files the Notice of Removal, he must give written notice to all adverse parties and file a copy of the notice with the clerk of the State court from which the matter is being removed, which shall effect the removal. 28 U.S.C. § 1446 (d).

### E. Statute of Limitations

The statute of limitations under ERISA is dependent upon the nature of the claims being pursued. ERISA provides for a variety of claims including claims for denial of benefits, failure to make contributions to a plan, breach of fiduciary duty under the plan, discrimination in the administration or denial of benefits, and interference with protected rights under a plan, among other causes of action.

### 1. Breach of Fiduciary Duty

ERISA sets forth a specific statute of limitations for breach of fiduciary duty claims under 28 U.S.C. § 1113:

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.

### 2. Suit for Denial of Benefits

With respect to claims for recovery of benefits under § 1132, ERISA is salient to the statute of limitation. Courts must look to the most analogous state law to “borrow” a statute of limitations. Federal courts will generally apply the law of their forum state. In the Third Circuit, the courts have applied the statute of limitations for contract actions as the most analogous to ERISA claims for benefits. Minnis v. Baldwin Bros. Inc., 150 Fed. Appx. 118, 2005 U.S. App. LEXIS 17655 (3d Cir. April 14, 2005); Syed v. Hercules Inc., 214 F.3d 155, 159 (3d Cir. 2000); see also Henglein v. Colt Indus., 260 F.3d 201, 208 (3d Cir. 2001) (noting that ERISA does not contain its own statute of limitations and, therefore, courts should look to the most analogous state provisions). In Pennsylvania, the statute of limitations for contract actions is four years. See 42 Pa. C.S.A. § 5525(8).

### 3. Accrual of the Cause of Action

The determination of when a cause of action accrues under ERISA is a question of federal law. The time for accrual varies with the nature of the claim being brought under the statute. Claims for recovery of benefits under Section 502(a)(1)(b) are generally found to accrue at the time when the plaintiff learns that he will not be receiving benefits, for example when the plaintiff receives notice of the denial of his claim.

Even when a state statute of limitation applies, the time at which a federal cause of action accrues is a matter of federal law. Connors v. Hallmark & Son Coal Co., 290 U.S. App. D.C. 170, 935 F.2d 336 (D.C. Cir. 1991); Keystone Ins. Co. v. Houghton, 863 F.2d 1125, 1127 (3d Cir. 1988)(RICO action) (*overruled sub nom. on other grounds*

Klehr v. O.A. Smith Corp., 521 U.S. 179 (1997)). The general rule of accrual of a federal claim is when a plaintiff becomes aware or reasonably should become aware of the facts underlying the claim. Connors v. Hallmark, *supra* (noting that at least eight federal courts of appeals have so held) (citations omitted); Connors v. Beth Energy Mines, Inc., 920 F.2d 205, 212 (3d Cir. 1990) (in an action by the trustees to collect delinquent contributions to a plan, applying the general rule that plaintiff's cause of action accrued when plaintiff knew or should have known).

#### F. Jury Trial

As a general concept there is no right to a jury trial for claims involving a denial of benefits under ERISA § 502(a)(1)(b), which cause of action is equitable in nature. Pane v. RCA Corp., 868 F.2d 631 (3d Cir. 1989).

#### G. Judicial Review

Despite the policy of protecting the rights of plan participants, judicial review of ERISA claims have devolved into an administrative review process of a plan decision maker, giving all due deference to the plan. The administrative law paradigm has all by swallowed the courts willingness to review these cases under "normal" standards of review. During the administrative review process itself, plan administrators have multiple opportunities to prop up otherwise defective records and to delay the payment of benefits to qualifying participants, with out recourse to the participant.

The two salient questions posed in the review of the denial of benefits claims (disability and otherwise) are 1) what standard of review will be applied, and 2) what evidence will be admitted before the Court.

#### H. Standard of review

##### 1. Arbitrary and capricious standard

Questions of the appropriate standard of review of ERISA claims could comprise a treatise unto itself. The Supreme Court in Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 109 S. Ct. 948 (1989) let the whole camel into the tent. In an apparent attempt to apply the principles of trust law, the Court held that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a 'de novo' standard *unless* the benefit plan gives to the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. After Firestone, the rush was on to amend ERISA plans to specifically reserve to the plan administrator the "sole discretion" to "interpret the terms of the plan" and to decide claims for benefits under the plan. Most, if not all plans written or amended since Firestone have added the "sole discretion" language that has resulted in an "arbitrary and capricious" standard of judicial review.

## 2. Expansion of the plan administrator's authority

The Court in Black and Decker Disability Plan v. Nord, 538 U.S. 822, 123 S. Ct. 165 (2003), relying on Firestone, further expanded the discretionary power of the plan administrator with respect to the denial of disability benefits under an ERISA plan. In rejecting the “treating physician’s rule,” which gave due deference to the weight of a treating physician’s opinion as applied to Social Security claims, the Court found that

Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician. But, we hold, courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.

Id. at 834.

## 3. Sliding scale where a conflict of interest arises

The Third Circuit has permitted a sliding scale approach with “intermediate scrutiny” or a heightened review, whenever it appears that there may be a conflict of interest on the part of the plan. Pinto v. Reliance Standard Life Insurance Co., 214 F.3d 377 (3d Cir. 2000) (an insurer who both funded and administered an ERISA plan had a conflict of interest that “warranted a heightened form of the arbitrary and capricious standard of review”); Smathers v. Multi-Tool, Inc., 298 F.3d 191, 198 (3d Cir. 2002) (heightened arbitrary and capricious standard should apply where the employer would sustain direct financial harm if the claim was paid); Kosiba v. Merck & Company, 384 F.3d 58 (3d Cir. 2004) (heightened standard of review may be warranted if there is a “demonstrated procedural irregularity, bias or unfairness in the review of the claimant's application for benefits.”)

In Kosiba, the Court found that the documented evidence including reports from the physicians, the medical file and the SSA disability determination demonstrated that the employee had total disability. The employer intervened in the appeal by seeking an independent medical examination, even though its insurance administrator had not. The Court concluded that the procedural irregularity of the employer’s intervention warranted more stringent scrutiny than the deferential arbitrary and capricious standard of review. Id. at 68.

### I. Evidentiary Matters

#### 1. Consideration of evidence not before the administrator

The general rule is that when the deferential or “arbitrary and capricious” standard of review is applied, that evidence beyond what was considered in the administrative record should not be considered by the reviewing court.

Under the arbitrary and capricious standard of review, the "whole" record consists of that evidence that was before the administrator when he made the decision being reviewed. Mitchell v. Eastman Kodak, 113 F.3d 433 (3d Cir 1997); See Luby v. Teamsters Health, Welfare and Pension Trust Funds, 944 F.2d 1176 (3d Cir. 1991); Woolsey v. Marion Laboratories, Inc., 934 F.2d 1452, 1460 (10th Cir. 1991).

Under a de novo standard of review, the court in its discretion may allow the plaintiff to introduce evidence not before the plan administrator where the record is insufficiently developed in order for the court to make its review. See Luby at 1185. Also, the court in its discretion may allow evidence outside the administrative record in a number of exceptional circumstances, *i.e.*, if it is necessary to determine whether a conflict of interest exists. Quesinberry v. Life Insurance Co., 987 F.2d 1017 (4<sup>th</sup> Cir 1993).

## VI. IS THAT ALL THERE IS?

### A. Damages

At the end of the day, what is the plaintiff able to recover in a successful claim for the denial of ERISA benefits? Under 29 U.S.C. § 1132 (a)(1)(b), a plaintiff can recover benefits due to him under the terms of his plan, or to clarify his rights to future benefits under the terms of his plan.

Yes, you heard it. After wading through the swamp of administrative review and appeal, and passing the "arbitrary and capricious" standard, there is nothing for the successful plaintiff to recover other than those benefits that he otherwise would have been entitled to under the terms of the plan. There are no provisions for "extra-contractual" damages, for compensatory or punitive damages, or for any other monies other than pre-judgment interest. State law bad-faith claims that would allow for contractual damages are pre-empted by ERISA's broad reach.

### B. Attorney's Fees

Under ERISA, the court in its discretion may allow a reasonable attorney's fee and costs of the action to either party. The Court of Appeals for the Third Circuit has used the following five-factor test for determining, whether an award of fees to a prevailing party is warranted under § 1132 (g):

- (1) the offending parties' culpability or bad faith;
- (2) the ability of the offending parties to satisfy an award of attorneys' fees;
- (3) the deterrent effect of an award of attorneys' fees against the offending parties;
- (4) the benefit conferred on members of the pension plan as a whole; and
- (5) the relative merits of the parties' positions.

See Ursic v. Bethlehem Mines, 719 F.2d 670, 673 (3d Cir. 1983). The court has instructed that "there is no presumption that a successful plaintiff in an ERISA suit

should receive an award in the absence of exceptional circumstances." McPherson v. Employees' Pension Plan of Am. Re-Insurance Co., Inc., 33 F.3d 253, 254 (3d Cir. 1994) (citing Ellison v. Shenango. Inc. Pension Rd., 956 F.2d 1268, 1273 (3d Cir. 1992)). Furthermore, according to the court of appeals, district courts must articulate their analyses and conclusions as to each of the live factors. See Anthuis v. Colt Indus. Operating Corp., 971 F.2d 999, 1012 (3d Cir. 1992).

## VI. CONCLUSION

There are those of you as plaintiff's lawyers who may find yourselves asking, then why do we march into this battle, given that the army on the other side is much better outfitted and armed? For this, I will give you a multiple choice answer, and you may chose both. Check box number one to follow in the words of Alfred Lord Tennyson, The Charge of Light Brigade, "Their's not to reason why, their's but to do and die." Check box number two if hope springs eternal that Congress will right the wrongs of the statute as written and interpreted. As of this writing, there is pending in the House of Representatives bill HR 3789 sponsored by Representative Robert E Andrews,

"to amend title I of the Employee Retirement Income Security Act of 1974 to provide, in the case of an employee welfare benefit plan providing benefits in the event of disability, an exemption from preemption under such title for State tort actions to recover damages arising from the failure of the plan to timely provide such benefits."

Boldly they rode and well, Into the jaws of Death, Into the mouth of Hell. <sup>2</sup>

Every long journey begins with a small step.

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<sup>2</sup> Tennyson, Alfred Lord, The Charge of the Light Brigade