Long-Term Disability Claims: A Primer for Social Security Attorneys

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How often, in the course of your Social Security practice, has a client approached you with a question regarding long-term disability (LTD) benefits? With 32.1 million Americans, or approximately 22 percent of the U.S. workforce, receiving employer-sponsored disability insurance, and many more purchasing individual disability policies, the subject is bound to come up.[1]

Unfortunately, for many attorneys, the mere mention of the Employee Retirement Income Security Act of 1974 is enough to make them wince with pain. ERISA, 29 U.S.C. §§ 1001 et seq., which governs nearly all employer-sponsored benefits, including disability benefits, is so famously complicated that one court has described it as "Everything Ridiculous Imagined Since Adam."[2]

This article seeks to dispel some of the misapprehensions about the ERISA statute. It will endeavor to show that, at least as far as disability benefits are concerned, there are more similarities between the Social Security Act and the ERISA statute than initially meet the eye—as well as some important differences. It is our hope that after reading this article, you will be able to answer questions about long-term disability benefits with aplomb.

ERISA: A Brief Overview

ERISA was originally enacted in 1974 to protect pension plan participants and beneficiaries following the catastrophic collapse of the Studebaker pension plan in 1963.[3] The statute requires employers to hold pension benefits in trust and imposes upon them fiduciary duties to invest prudently and to administer plans solely in the interest of plan participants and beneficiaries.

During the drafting process, Congress expanded ERISA to apply not only to pension benefits but also to welfare benefits, even though the latter need not be held in trust and are exempt from the statute's vesting provisions.

ERISA applies to all employer-sponsored benefit plans except government and church plans, although church plans can opt into ERISA's protections. Many short-term disability plans, also known as "salary continuation programs" or "payroll practices," also fall outside ERISA's purview.

ERISA preempts all state laws that "relate to any employee benefit plan," except for criminal laws and laws that regulate insurance, banking, and securities. 29 U.S.C. § 1144. Employers can avoid being subject to state insurance law by "self-funding" their plans through a trust or through their general assets.

ERISA's Requirement of a "Full and Fair Review"

The ERISA statute provides, at 29 U.S.C. § 1133, that claimants are entitled to written notice that a claim for benefits has been denied and an opportunity for a "full and fair review" by the fiduciary denying the claim. Courts have interpreted that provision to give rise to a "duty to exhaust administrative remedies" prior to filing suit, even though nowhere in the text of the ERISA statute does it say appeals are mandatory.[4]

The U.S. Department of Labor has promulgated regulations interpreting what constitutes a "full and fair review."[5] Among other things, claimants have the right to request, free of charge, reasonable access to copies of all documents, records, and other information "relevant" to their claim for benefits. The ERISA statute also requires plan administrators to comply with a request for plan documents within 30 days or face a statutory penalty of up to $110 per day for noncompliance.[6]

Plan administrators must provide claimants with "at least" 180 days to submit an appeal.[7] Claimants who submit a late appeal run the risk of having their appeal denied and having their lawsuit dismissed for failure to exhaust, although plan administrators may, in their discretion, accept a late appeal if the claimant provides an explanation.[8] Upon receipt of an appeal, the plan administrator must issue a decision within 45 days, but it can request a one-time exten-

sion of up to 45 days, for a total of 90 days. A plan administrator's failure to comply with these timelines generally enables a claimant to proceed directly to court.

ERISA and the Social Security Act

The relationship between benefit eligibility under an ERISA LTD disability insurance plan and disability under the Social Security Act has charted a wavering course through the courts. Although the standards of disability are often virtually identical, for many years the deference owed to an award of SSDI or SSI varied from circuit to circuit.[9] Then, in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003), the U.S. Supreme Court brought a halt to a growing trend in long-term disability cases for granting automatic deference to the opinion of the treating doctor so long as her opinion is supported by and not inconsistent with the other evidence. Due to *Nord*, because an insurer is not required to give deference to the opinion of a treating physician over its own file-review opinion, a finding of disability by the Social Security Administration (SSA) may not be given great weight by the court if the insurer produces a well-documented and reasoned file-review opinion.

However, upon a review of the relationship between SSA benefits and LTD eligibility by the Supreme Court five years later in *Metropolitan Life Insurance Co. v. Glenn*, 554 U.S. 105, 115 (2008), it became clear that disability determinations made by the SSA are relevant to disability determinations made under ERISA plans and that a claim administrator's failure to substantively consider the determination in making its own benefit decisions "suggests arbitrary decision-making."[10] The Court went even further to state that it is "procedurally unreasonable" to ignore an SSA finding without adequate reasons when the insurer (as it often does) provides SSA representation and reaps the financial reward of the benefit award.

Following *Glenn*, nearly all of the circuit courts have incorporated and expanded upon this requirement. The court in *Raybourne v. CIGNA*, 700 F.3d 1076 (7th Cir. 2012), echoed the *Glenn* finding and made it clear that insurers need to directly address the Social Security determination and have the burden of explaining why it reached a different decision. *Melech v. Life Ins. Co. of N. Am.*, 739 F.3d 663 (11th Cir. 2014) recently held that a disability insurer must obtain and consider Social Security evidence even if the claimant did not provide it.

Failing to adequately consider an award of Social Security disability benefits under the *Glenn* model has specifically landed two insurers in trouble. Following investigations by state insurance commissioners, both Unum and CIGNA have entered into regulatory settlement agreements, binding themselves to more robust consideration of the findings of the Social Security Administration.[11] The SSA concessions were reached after the state insurance commissioners determined that the insurers routinely ignored favorable rulings under the SSA guidelines, even after providing representation to apply for benefits.

Nonetheless, there are three main differences between making disability determinations under the SSA guidelines and ERISA plan guidelines that have permitted insurers to deny or terminate benefits in the face of an SSA award. The first difference still remains from the *Nord* decision discussed above—because there is no treating-physician rule, a disability insurer can often successfully refute an SSA finding by supplying a sufficiently supported file-review opinion. The second difference involves determinations made within the medical-vocational (grid) framework—a concept that generally does not exist in LTD benefit plans. The third difference regards an LTD policy's limitations on the length of payable benefits for certain specific illnesses.

Once a claimant reaches age 50, the SSA will routinely use the grid guidelines to find that individual disabled, even if it is clear that the individual would be disabled without the aid of the framework. Although many LTD benefit plans have income thresholds within their "any occupation" standard of disability, the plans do not utilize a rigid grid-type system related to the age and experience of a participant. Thus, (with some notable exceptions) courts have given insurers much more leeway in disregarding an SSA award when that award utilized the grid framework, because the determination was made under a "different standard."[12]

Lastly, many LTD plans specifically limit the length that benefits are payable for certain defined illnesses. Mental illness limitations, typically to 24 months of benefits, are the most common; however, some plans also have limitations for other "subjective symptom" illnesses such as chronic fatigue syndrome, fibromyalgia, and sick building syndrome. Although the insurer bears the burden of proving the applicability of any benefit limitations, once that limitation is established, an award of SSA disability benefits based primarily upon a limited condition would obviously not carry much weight if the individual seeks to establish ongoing LTD eligibility due to a co-morbid physical condition.

Coordination With Other Benefits

After a claimant establishes eligibility for LTD insurance benefits, the benefit amount is usually calculated as a percentage of previously earned income, payable monthly, as defined by the policy's terms. But most disability insurance benefit plans are written to coordinate with the insured's other sources of income, allowing the benefit plan to reduce its monthly obligation (up to a defined minimum benefit) by subtracting the benefit amounts received from other sources. That process is commonly referred to as offset and may involve a number of income sources.

The most common LTD policy offset is for Social Security benefits. That offset would include not only the insured's own primary benefit, but any dependent benefit she also may become entitled to. If the policy were to extend benefit payments beyond the insured's normal retirement age, retirement benefits (including any early retirement benefits) would also become an offset. The significant financial benefit of an award of SSA benefits clearly explains why, as touched on above, an insurer will almost always pay for and require the insured to apply for SSDI benefits once LTD benefits become payable.

Along the same lines, distributions under a defined benefit or defined contribution plan may also be considered offsetting income under an LTD policy. Payments for 401Ks are especially vulnerable here—although a distribution at retirement would not be offset, an individual may unwittingly offset his monthly LTD payment by taking an early 401K distribution. Early or accelerated payments under a defined benefit pension plan may also offset the monthly LTD benefit amount and are often explicitly defined as an offset for plans issued to employers that maintain a pension scheme.

Finally, any other payments related to an injury that caused disability may likely be defined as an offset under the LTD policy. Both worker's compensation benefits and third-party tort recoveries for

lost wages are generally included as offsetting income, whether the award is disbursed monthly or in a lump sum. However, when a tort recovery extinguishes the worker's compensation claim, at least one court has held that the offset would still stand even if the tort award is used to pay back the workers' compensation carrier— a practice the SSA explicitly rejected in POMS § DI 52001.090.13

ERISA Litigation

The ERISA statute affords very limited remedies. Participants and beneficiaries may bring suit to recover benefits due under the plan, for a declaratory judgment or an injunction, for plan-wide relief, and for "other appropriate equitable relief."[14] In addition, successful claimants may recover attorney's fees, prejudgment interest, and costs.[15]

Importantly, ERISA does not provide for compensatory or punitive damages. However, courts will fashion an equitable remedy where the plan does not otherwise provide relief.[16] State courts enjoy concurrent jurisdiction over suits for benefits; all other suits must be brought in federal court.

The ERISA statute is silent as to what standard of review applies to benefit claims; however, in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), the Supreme Court ruled that a denial of benefits is reviewed under the de novo standard "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case the denial of benefits is reviewed only for abuse of discretion. Immediately following *Firestone*, nearly every plan administrator amended its plan to include language conferring discretion upon plan administrators to interpret the terms of the plan and to make benefit determinations. Plaintiff's attorneys have challenged the validity of these "discretionary clauses" with varying success. Additionally, under the leadership of the National Association of Insurance Commissioners, at least 20 states have adopted some form of ban on discretionary language in disability insurance policies, although those laws are ineffective against self-funded plans.

A consequence of deferential review is that discovery in ERISA benefit denial cases tends to be extremely limited. Generally speaking, ERISA litigation conducted under the abuse of discretion standard of review is conducted based on the "administrative record" developed prior to litigation, much like in Social Security proceedings.[17] That has changed somewhat since *Metro. Life Ins. Co. v. Glenn*, *supra*, in which the Supreme Court arguably opened the door to discovery pertaining to the plan administrator's conflict of interest as both the evaluator and payor of claims, although this remains a hotly debated subject within the courts.[18]

Frequently Asked Questions

My client stopped working five years ago. Can he still apply for disability benefits?

Yes. Most disability plans have a "proof of loss" provision that requires written proof of claim to be submitted within 30 to 90 days but no later than one year. However, in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), the Supreme Court ruled that the notice-prejudice rule, which requires insurers to demonstrate they have been unfairly prejudiced by late notice of claim, is saved from ERISA preemption. Thus, participants in insured plans who reside in states that have adopted the notice-prejudice rule may prevail in a claim for long-term disability benefits, notwithstanding late notice of claim. Even claimants who don't satisfy the foregoing criteria should still submit a claim, because a plan administrator may always entertain late claims in its discretion, particularly if the claimant provides a good reason for the delay.

If an individual misses the 180-day appeal deadline, should she still appeal?

Yes. A plan administrator may, in its discretion, entertain a late appeal, particularly if the claimant provides a good reason for the delay. *See Edwards v. Briggs & Stratton Ret. Plan*, 639 F.3d 355, 363 (7th Cir. 2011) (dismissing suit where claimant submitted appeal 11 days late and failed to provide an explanation). A better strategy, however, if the claimant knows his or her appeal will be late, is to write to the plan administrator before the 180 days expires to request an extension.

If my client is terminated by her employer, will that affect her disability benefits?

Generally, no. So long as the claimant is "actively employed" on the date the disability arises, the claimant is covered under the disability plan, regardless if his or her employment is subsequently terminated. However, some plans exclude coverage for employees that are terminated "for cause," so claimants should always consult the plan documents.

My client's short-term disability benefits were denied. Can he still apply for long-term disability benefits?

Generally, yes. Unless the disability plan specifically states that receipt of short-term disability benefits is a prerequisite to applying for long-term disability benefits (most do not), the plan administrator should conduct an independent examination as to whether the claimant qualifies for long-term disability benefits. Although it may seem counterintuitive, claimants should apply for long-term disability benefits even if their short-term disability claim has been denied, because failure to do so could dramatically reduce the amount of benefits recovered in subsequent litigation.

My client's claim was denied based on a pre-existing condition, even though she worked for her former employer for many years. How can that be?

When an employer switches long-term disability carriers, or when one company is acquired by another company, participants and beneficiaries in the new plan may find that their claims are subject to a pre-existing condition limitation, unless the new plan is carefully drafted. Employees in these circumstances should demand written assurance from their employer of their grandfathered status in advance of any changes to their policy.

Fortunately, in *Hardt v. Reliance Std. Life Ins. Co.*, 560 U.S. 242, 245 (2010), the Supreme Court clarified that a court may, "in its discretion," award fees and costs "to either party" as long as the fee claimant has achieved "some degree of success on the merits," which in *Hardt* included a remand to the plan administrator for further consideration of the plaintiff's entitlement to benefits.

Finally, the ERISA statute does not set forth a statute of limitations for benefit claims brought under 29 U.S.C. § 1132(a)(1)(B). Instead, courts imply the statute of limitations from the most analogous state statute (usually breach of contract), unless the plan contains a contractual limitations period. But in the recently decided *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013), the Supreme Court resolved a circuit split regarding whether the statute of limitations for benefit claims is tolled during the appeals process, ruling that an ERISA plan's contractual limitations period can be enforced, so long as the claimant has a "reasonable" time after exhausting his or her administrative remedies to file suit. This decision has generated a great deal of uncertainty as to how to calculate the statute of limitations, particularly in cases where benefits are terminated after being paid for a number of years.

Conclusion

Appeals and litigation under the ERISA statute bear many similarities to Social Security practice, although the administrative law paradigm has questionable applicability to ERISA proceedings. Nevertheless, many of the concepts discussed in this article should already be familiar to Social Security practitioners. We hope this article will prove useful to you in your Social Security practice, and maybe even inspire you to handle an ERISA case yourself. ⊙

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Endnotes

[1]www.pressherald.com/2014/07/17/employers-dropping-long-term-disability-coverage/.

[2]*Florence Nightingale Nursing Service Inc. v. Blue Cross and Blue Shield*, 832 F. Supp. 1456, 1457 (N.D. Al. 1993), *aff'd*, 41 F.3d 1476 (11th Cir. 1995).

[3]In an attempt to compete for talent with the Big Three automakers in the midst of its financial collapse, Studebaker repeatedly promised increased future pension benefits to its employees without any hope of ever funding the future obligations. Upon its closure in December 1963, the company terminated the pension plan, costing its employees approximately $15 million dollars in promised benefits. The Studebaker failure moved Congress to enact the Employee Retirement Income Security Act in 1974. *See* James A. Wooten, *"The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA,* 49 Buff. L. Rev. 683 (2001).

[4]*E.g., Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 650 (7th Cir. 1996) (affirming that the district court, in its discretion, may require exhaustion as a prerequisite to filing a federal lawsuit).

[5]29 C.F.R. § 2560.503-1.

[6]29 U.S.C. §§ 1024(b), 1132(c).

[7]29 C.F.R. § 2560.503-1(h)(3).

[8]*E.g., Edwards v. Briggs & Stratton Ret. Plan*, 639 F.3d 355, 363 (7th Cir. 2011) (dismissing suit where claimant submitted appeal 11 days late and failed to provide an explanation).

[9]*Compare Madden v. ITT Long Term Disability Plan for Salaried Employees,* 914 F.2d 1279, 1286 (9th Cir.1990), *cert. denied,* 498 U.S. 1087, 111 S.Ct. 964, 112 L.Ed.2d 1051 (1991); *Coker v. Metropolitan Life Ins. Co.,* 281 F.3d 793 (8th Cir.2002) with *Ladd v. ITT Corp.,* 148 F.3d 753 (7th Cir. 1998); *Calvert v. Firstar Finance Inc.*, 409 F.3d 286 (6th Cir. 2005).

[10]*Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.3d 758, 776-777 (7th Cir. 2010).

[11]www1.maine.gov/pfr/insurance/Admin_Enforcement_Actions/RSA_2013/CIGNA_RSA.pdf; www.maine.gov/pfr/insurance/unum/unum_exam_settlement.htm.

[12]When courts have utilized the grid findings as evidence of disability under an LTD plan, they typically do so under a more traditional transferrable skills analysis—the insured was not highly educated and had no transferrable skills, and thus the grid was used to illustrate the futility of finding alternative suitable employment. *See Demirovic v. Building Service 32B-J Pension Fund,* 467 F.3d 208, 216 (2d Cir. 2006) (holding that the medical-vocational rules form an instructive framework for analyzing disability claims); *Poulos v. Motorola Long Term Disability Plan,* 93 F. Supp. 2d 926, 932 (N.D. Ill. 2000) (same).

[13]*Connecticut General Life Insur. Co.,* 272 F.3d 127 (2d Cir. 2001). Although the SSA also has an offset for workers' compensation benefits, POMS § DI 52001.090 requires that no offset be taken when the tort award pays back the workers' compensation carrier, because it is as if the workers' compensation payments had never been made.

[14]29 U.S.C. § 1132. However, an award of benefits is not assumed. In yet another similarity between ERISA and Social Security litigation, federal courts often remand the decision back to the plan administrator for further evaluation even though ERISA, unlike the Social Security Act, does not expressly authorize remands. *See generally Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 978 (7th Cir. 1999).

[15]29 U.S.C. § 1132(g).

[16]*Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (awarding equitable relief pursuant to 29 U.S.C. § 1132(a)(3) where the ERISA statute would otherwise provide no relief).

[17]*See, e.g., Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981-982 (7th Cir. 1999) ("Deferential review of an administrative decision [*982] means review on the administrative record.").

[18]*See, e.g., Dennison v. MONY Life Ret. Income Sec. Plan for Emple.*, 710 F.3d 741 (7th Cir. 2013) (acknowledging a "softening" in the availability of conflict discovery following *Glenn*).