What Do You Mean I'm Not Disabled? Handling Short and Long-Term Disability Claims

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What Do You Mean I'm Not Disabled! The Long and Short of Handling Short and Long Term Disability Claims

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1. **Introduction**:

   a. Many employment practitioners may be overlooking valuable short and long term disability claims with the individuals they represent. Often, employees have short or long term disability (referred to as STD or LTD) plans as employment benefits. Some forget about the benefits, some think it is futile to apply for them. However, it is an area that employees and their attorneys should look for and consider when evaluating employment related claims, options and avenues for action.

   b. The following materials address the basics of short and long term disability claims. The bulk of the information relates to long term disability claims governed by ERISA but much of the information applies equally to STD claims. These materials will provide insights into the administrative process of obtaining benefits, appealing benefit denials and litigating ERISA related benefits claims.

   c. These materials are more basic in nature and do not address all of the nuances of this area of practice for the more experienced STD/LTD practitioner. For instance, the materials do not address breaches of fiduciary duty or equitable relief. Nor do they address claims under health care insurance plans, pension plans, or technical plan violations regarding plan documents and the like. The cited cases and their outcomes are very fact specific, like many employment claims. But, this overview should provide the interested practitioner a good sense of what to look for concerning short or long term benefits claims in order to help their client navigate this challenging, and often overlooked, area.

2. **Key terms and definitions :**

   a. Generally, any employer provided STD/LTD plans will be considered an "employee welfare benefit plan" covered by ERISA, assuming the employer is covered by ERISA and meets the requisite definitions.

      i. Employee Welfare Benefit Plan definition:

         1. The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was …established or

maintained by an employer …for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, …benefits in the event of sickness, accident, disability, death or unemployment…

a. 29 USC §1002(1).

2. However, an Employer's plan for salary continuation to employees in the event of their disability may not be a covered welfare plan and/or subject to ERISA.

a. 29 CFR §2510.3-1(b)(3).

i. Coverage:

a. ERISA will cover any employee benefit plan maintained or established by an employer engaged in commerce or is any industry or activity affecting commerce.

i. 29 USC §1003 (a) (1).

b. ERISA will not cover:

i. Governmental plans-

1. 29 USC §1003 (1)

2. Defined as any plan established or maintained for employee of the US government, State government or political subdivision or agency or instrumentality of the above.

a. 29 USC §1003 (32).

ii. Church plans

1. 29 USC §1003 (2)

2. Defined as a plan established and maintained for benefit of employees of a church or convention or association of churches which are tax exempt.

a. 29 USC §1003 (33)(A).

iii. A plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws.

1. 29 USC § 1003(3)

ii. Employer Definition:

1. 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.

a. 29 USC §1002(5)

3. **Who Can Take Action**:

a. A civil action may be brought—

i. by a participant or beneficiary to recover benefits due under the terms of their plan, to enforce their rights under the terms of the plan, or to clarify their rights to future benefits under the terms of the plan;…

ii. by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

1. 29 USC §1132(a)1(A)-(B) and (a)3.

b. These materials will not address equitable relief.

4. What Action Should Be Taken First

a. Filing the Claim per Plan requirements.

i. File or commence filing claims pursuant to the STD/LTD policy and/or the summary plan description (SPD).

1. ***Practice Pointers***:

    a. It may be obvious, but make sure that any claim is filed while the employee is employed with the employer providing the benefit.

    b. Typically, the terms of the policy require that the person be an employee and/or be employed for a certain period of time to be eligible for coverage.

    c. Every plan differs slightly. Be sure to review the plan terms for eligibility.

    d. Provide all relevant information which shows the claimant/employee is disabled within the meaning of the policy language.

    e. Try to provide doctor's reports or forms which analyze the claimant's condition in light of the policy language regarding disability.

        i. Such an opportunity typically arises after initial claim submissions.

5. What To Expect After Filing

Once filed, the claim enters a process (which can seem very long and drawn out from a claimant's perspective) of record gathering, possible independent medical evaluations, functional capacity evaluations, record reviews, requests for extension and other time consuming processes. Eventually, a determination is made, which may or may not need to be appealed, and which will, of course, result in further record gathering, reviews and other delays.

a. Claims Procedure

    i. The claim process is subject to reasonable procedures.

        1. 28 CFR §2560.503-1 (b)

    ii. The process must not inhibit claim filing.

        1. For example, fees cannot be charged to file a claim.

            a. 28 CFR §2560.503-1 (b)(3)

iii. For plans providing disability benefits, the plan must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

    1. 29 CFR § 2560.503-1

iv. Notification of adverse benefit determination should occur within 45 days. A plan administrator may request an additional 60 days (in 30 day increments) if needed due to circumstances outside the plan's control. The participant must be informed about the standards on which entitlement to the benefit is based (which plan provisions), any unresolved issues and any additional information need to resolve such issues. The employee/participant should be given at least 45 days to provide the specified information.

    1. 28 CFR § 2560.503-1 (f)(3)

v. An adverse determination (benefit denial and/or benefit termination) must reference the reasons for the determination, the specific plan provisions relied upon, describe any additional information needed to perfect the claim, why such information is needed, and describe review procedures and time limits with a description of ERISA rights.

    1. 28 CFR §2560.503-1 (g)(i)-(iv).

vi. An adverse benefit determination concerning disability benefits must provide a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    1. The views of the claimant's treating health care professionals and vocational professionals who evaluated the claimant;

    2. The views of medical or vocational experts whose advice was obtained by the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

3. A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

4. Either the specific internal rules, guidelines, protocols, standards or other similar criteria the plan relied upon in making the adverse determination or a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

    a. 29 C.F.R. § 2560.503-1(g).

vii. Appealing an Adverse Determination:

1. Every appeal is subject to a full and fair review.

    a. 28 CFR §2560.503-1 (h)(1).

2. To be full and fair the procedure must provide:

    a. At least 60 days from receipt of determination to appeal.

    b. Provide opportunity for written comments, submission of other documents, records, etc.

    c. Provide claimant free access to documents, records and other information relevant to the claim.

    d. Provide review of all new information, even if not part of the initial determination.

        i. 28 CFR §2650.503-1 (h)(2)(i)-(iv).

    e. Provide that before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination in connection

with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

f. Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond prior to that date

    i. 29 C.F.R. § 2560.503-1

g. In addition to specific reasons for the decision, the plan provisions relied upon, a statement that the claimant is entitled to the claim file, and any voluntary appeal procedures available, a plan determination after appeal/review must also include:

    i. an explanation of the basis for disagreeing with or not following the views presented by claimant's treating health care professionals treating the claimant and claimant's evaluating vocational professionals;

    ii. the views of medical or vocational experts whose advice was obtained by the plan concerning the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

    iii. a disability Social Security Administration determination provide by the claimant.

    iv. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

1. 29 C.F.R. § 2560.503-1

viii. Per ERISA cases, you must exhaust administrative procedures before commencing legal action or relief will be barred.

1. *Yaek v. Life Ins. Co. of North America,* 2012 WL 359913 *1 (D.Minn. 2012); *Midgett v. Washington Group Intern. Long Term Disability Plan*, 561 F.3d 887, 898 (8th Cir. 2009)(citations omitted).

2. However, a claimant may be excused from exhausting administrative remedies if further procedures would be futile. Further procedures will be deemed futile if there is doubt about whether the agency could grant effective relief.

    a. *Midgett,* 561 F.3d at 898. (citations omitted)

3. Unsupported and speculative claims of futility do not excuse a claimant's failure to exhaust administrative remedies. A claimant must show it is certain the claim will be denied on appeal, not merely that there is doubt that an appeal will result in a different decision.

    a. *Id.* (citations omitted); *Chorosevic v, MetLife Choices,* 600 f.3d 934, 945 (8th Cir. 2010)(citations omitted).

    b. Courts have waived the exhaustion requirement where plan administrators have failed to perform a necessary duty like providing an explanation of the claim appeal procedure.

        i. *Yaeck,* 2012 WL 359913 at *1 (citations omitted).

ix. ***Practice Pointers***:

1. Appealing an adverse determination is a critical area in the process!

2. This is an opportunity to request the claim file which is essential to appealing the determination and important for any future actions.

3. The claim file is the record upon which all future actions will be based, both administratively and in litigation.

4. This is the best opportunity for a claimant employee to provide all relevant information in order to appeal the administrative determination and/or to set the stage for future litigation.

    a. Relevant information may vary to include updated or new medical records, narrative reports, vocational evaluations (Functional Capacity Evaluations) Social Security determinations and the like.

5. Remember, depending upon various factors discussed *infra*, a court will not be conducting a *de novo* review of the case. The court will be forced to look at the claim file and administrative determination as the record and decision upon which it will base its future decision. Thus, the importance of the appeal and providing of all relevant information.

6. After Exhausting Administrative Steps -- Litigation

a. Who are the Defendants?[1]

i. Employer, Plan Administrator, or Both?

1. Usually, the plan administrator (likely, but not always, an insurance company) is the appropriate defendant.

    a. See, *Layes v. Mead*, 132 F.3d 1246, 1249 (8th Cir. 1998)(citations omitted)(sole administrator of LTD plan proper defendant, not employer); *Price v. Xerox Corp.,* 379 F.Supp.2d 1026, 1028 (D. Minn. 2005) (citations omitted) (benefit plan itself ordinarily the primary defendant in action to recover benefits).

    b. However, if an employer controls administration of a plan, they could be a proper defendant.

        i. *Layes*, 132 F.3d at 1249 (citing *Daniel v. Eaton Corp*., 839 F.2d 263, 266 (6th Cir. 1988)); *see also*, *Werb v. ReliaStar Life Ins. Co*., 847 F.Supp.2d 1140

[1] This can be a complicated and fact intensive analysis focusing on who controls administration of a plan, who is a plan vs. claim administrator and other questions. In light of the more general nature of these materials, the analysis will be more general.

(D.Minn. 2012)(citing *Slayhi v. High-Tech Inst., Inc*., 2007 WL 4284859 *10 (D. Minn. 2007)(proper defendant under §1132(a)(1)(B) is party with authority to pay benefit claims from plan assets.)).

2. Naming the employer as a defendant, in addition to an insurance company or others, is an option, under appropriate circumstances.

    i. *Werb*, 847 F.Supp.2d at 1150-51(citations omitted)(ERISA plans are not the only defendant and it could also be that"…[i]n order to obtain complete relief, a successful plaintiff may need to assert claims against both a plan and its sponsor and/or administrator under the plan.")

3. ***Practice Pointers****:*

    a. There may be situations where an employer pays a claim which is accepted or denied by a third party plan administrator.

    b. When in doubt about which entity controls plan administration, name the employer and the plan insurer until further determinations are made regarding which defendant actually controls administration of the plan.

b. Venue

    i. ERISA or ERISA based STD/LTD claims will normally wind up in Federal court.

        1. ERISA pre-empts state law claims which are based upon ERISA covered plans usually resulting in removal to Federal court if initially venued in State court.

            a. 29 USC §1144 (a).

        2. Other bases for removal to Federal Court:

            a. Federal Question Jurisdiction:

i. If an ERISA claim is clearly set out in a State court complaint, removal is available on federal question grounds.

b. Diversity:

i. Oftentimes, plan administrators are insurance companies headquartered in other states. Thus, diversity may be present, if the amount in controversy meets jurisdictional requirements. If so, removal is available.

ii. Privately Purchased STD/LTD Policies or STD/LTD plans through ERISA exempt entities may be asserted in state or federal court.

1. Such claims will be based upon breach of contract principles and state common laws or statutes will apply. However, diversity may still apply and could result in removal from state court.

c. Statute of Limitations:

i. Different time limits apply to ERISA claims versus typical breach of contract claims. Even non-ERISA breach of contract claims may be subject to different statutes of limitations, depending on the specific terms of a policy.

ii. ERISA claim for STD/LTD benefits

1. Two year statute of limitations in Minnesota.

a. Because ERISA has no specific statute of limitations, the most closely analogous state statute of limitations applies. In Minnesota, that is the two year time limit governing actions to recover lost wages or benefits.

i. Minn.Stat. §541.07 (5)(2000); *see Abdel v. U.S. Bancorp,* 457 F.3d 877, 880 (8th Cir.2006)(citing *Cavegn v. Twin City Pipe Trades Pension Plans*, 223 F.3d 827, 829-830 (8th Cir. 2000)).

iii. Non-ERISA Breach of contract claim for STD/LTD benefits

1. Two, three or six year statute of limitations may apply, depending on the facts of the case and on the policy language.

a. Two year limit may apply assuming the STD/LTD policy relates to wages.

    i. Minn. Stat. §541.07(5)

b. Three year limit may apply if the policy language follows Minn. Stat. §62A.04, subd. 2(11) which describes a three year limit on "Legal Actions" for accident and health insurance policies.

    i. Minn. Stat. §62A.04, subd. 2(11); *Matthew v. Unum Life Ins. Co. of Am.*, 639 F.3d 857, 866 (8th Cir. 2011)(*citing Ryan v. ITT Life Ins. Corp*., 450 N.W.2d 126, 128-129 (Minn. 1990)(citations omitted)).

    ii. Three year limit may override ERISA two year time limit as it has been found to be a reasonable limit in ERISA cases.
        1. *Czech v. UNUM Life Ins. Co. of America*, 2009 WL 5033961 * 4 (D. Minn. 2009)(parties to a contract are free to adopt contractual limitations period different from the relevant statute of limitations provided the period is reasonable)(citations omitted).

c. Six year limit may apply if the policy is considered non-wage related under Minn. Stat. §541.07(5) and does not contain language pursuant to Minn. Stat. §62A.04, subd. 2(11). The policy would then be a simple contract.

    i. Minn. Stat. §541.05, subd.1 (1) which provides that the six year period applies to a contract where no other limit is expressly prescribed.

iv. When does the cause of action accrue?

1. ERISA governed claims accrue according to the Federal common law "discovery rule" and time limits therefore begin to run "…after a claim for benefits has been made and has been formally denied." The claim accrues when there is repudiation by a fiduciary that is clear and made known to the beneficiary.

a. *Czech,* 2009 WL 5033961 *4-5(citations omitted)(finding Eighth Circuit seemed to favor applying accrual date most favorable to plaintiff and held that accrual did not start until conclusion of the claim appeal); *see Abdel,* 457 F.3d at 881 (viewing facts most favorable for plaintiff, ERISA claim accrued on the expiration of plaintiff's time to appeal the claim denial).

2. Accrual from the point of repudiation of benefits controls, despite contrary policy language regarding accrual.

a. *Id*.

v. ***Practice Pointers:***

1. If possible, bring legal action within two years, the shortest of the potential limitations which may apply.

2. Better safe than sorry.

d. The Court does **NOT** conduct a *de novo* review of ERISA based claims.

The standard of review in ERISA based claims for benefits is a high one and very deferential to the plan administrator's decision. Thus, such claims can be difficult to prevail on, even under solid factual scenarios. Because the Court does not conduct a *de novo* review of the case, one can appreciate the importance of taking full advantage of the claims procedure to insure all relevant information is in the claim file, which becomes the record on judicial review. The district court acts more like an appellate court when examining ERISA based claims.

i. Standards of review

1. Generally, abuse of discretion is the standard:

a. If the plan documents grant a plan administrator *discretion* to determine eligibility for benefits and interpret plan terms.

i. *Green v. Union Security Ins. Co.,* 646 F.3d 1042, 1050 (citing *Midgett,* 561 F.3d at 893; *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

b. **BUT**: effective January 1, 2016:

i. No policy, contract, certificate, or agreement offered or issued in Minnesota providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or provide a standard of review that is inconsistent with the laws of this state, or less favorable to the enrollee when a claim is denied than a preponderance of the evidence standard.

ii. Minn. Stat. Ann. § 60A.42 (2016)

iii. There are no cases construing this statutory term or its effects as of the date of these materials.

c. ***Practice Pointers****:*

i. Look for discretion granting language in the plan policy and/or summary plan description.

ii. If the grant of discretion is only in the SPD but not in the plan itself such language does not vest an administrator with discretion.

1. *Yaeck*, 2012 WL359913 at *2 (*citing Jobe v. Medical Life Ins. Co.*, 598 F.3d 478, 483-86 (8th Cir. 2010)(invalidating grant of discretionary authority where plan was silent on discretion and SPD language only enlarged administrator authority)).

iii. If the policy does not grant discretion, *de novo* review rather than abuse of discretion will apply.

1. The *de novo* review should be more along the lines of a breach of contract review focusing on the terms of the plan and whether the administrator's decision under such terms was a breach.

iv. Determine whether the plan was offered or issued in Minnesota or renewed after the January 1, 2016 effective date of the state ban on discretionary clauses.

d. Absent a policy subject to the discretionary ban, a court will only overturn a plan administrator's decision if it was arbitrary and capricious assuming it contained appropriate discretion granting language.

i. *Humphrey v. Prudential Ins. Co. of America,* 791 F.Supp.2d 655, 663-64 (D.Minn.2011)(citing *Jackson v. Prudential Ins. Co. of America,* 530 F.3d 696, 701 (8th Cir. 2008)).

e. As long as the plan administrator provides a reasonable explanation supported by substantial evidence the decision will be upheld.

i. *Id.* (citations omitted).

f. Substantial evidence means "more than a scintilla but less than a preponderance."

i. *Khoury v. Group Health Plan, Inc*., 615 F.3d 946, 952 (8th Cir. 2010)(citations omitted).

g. The court focuses on whether a reasonable person *could* have made the similar decision not that a reasonable person *would* have reached that decision.

i. *Id.* (citations omitted).

ii. ***Practice Pointers***:

1. Be sure when commencing suit that your evidence (the claim file) contains information that shows the administrator should not have made the adverse decision. The mere fact that another, equally reasonable decision, could result from the same file, does not equal abuse of discretion.

h. The *Finley* test of reasonableness:

    i. Was the plan administrator's interpretation of the plan:

        1. Consistent with the plan's goals;

        2. Did it render any of the plan language meaningless or internally inconsistent;

        3. Did it conflict with the substantive or procedural requirements of ERISA;

        4. Similarly followed in the past; and

        5. Was it contrary to the clear policy language.

            a. *Id*. (*citing Finley v.* Special *Agents Mutual Benefit Assoc., Inc*., 957 F.2d 617, 621 (8th Cir. 1992)).

i. The Court will review only the final claims decision and not the "initial, often succinct denial letters," in order to ensure the development of a complete record, *Id*. at 952 (citing *Wert v. Liberty Life Assur. Co. of Boston*, 447 F.3d 1060, 1066 (8th Cir.2006).

j. Conflicts of interest may be taken into account in determining abuse of discretion.

    i. A conflict exists when a plan administrator both evaluates claims for benefits and pays such claims.

        1. *Id*. (citing *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105, 112, 128 S.Ct. 2343, 2348-49 (2008)).

    ii. The higher the likelihood the conflict affected the decision, the more weight the court should place on it in deciding if it led to abuse of discretion.

        1. *Id.* (citations omitted).

iii. The conflicts of interest could act a tiebreaker when other factors are closely balanced.

1. *Glenn*, 554 U.S. at 117.

k. Ultimately, the factors "inform [a court's] analysis," " '[t]he dispositive principle remains ... that where plan fiduciaries have offered a "reasonable interpretation" of disputed provisions, courts may not replace [it] with an interpretation of their own—and therefore cannot disturb as an "abuse of discretion" the challenged benefits determination.' "

i. *Kutten v. Sun Life Assur. Co. of Canada*, 759 F.3d 942, 944 (8th Cir. 2014)(citations omitted).

2. Sliding Scale Standard of Review—Is it available?

a. An earlier pre-*Glenn* 8th Circuit case, *Woo v. Deluxe Corp*., 144 F.3d 1157 (8th Cir.1988) adopted a "sliding scale" approach to reviewing LTD ERISA claims. *Woo*, 144 F.3d at 1161-1162. This standard allowed for flexibility in applying the abuse of discretion standard in circumstances where conflicts of interest or procedural irregularities were present.

i. Procedural Irregularities

1. Procedural irregularities could include a failure to follow claims handling procedures, *Chronister v. UNUM Life Ins. Co of America,* 563 F.3d 773, 776 (8th Cir. 2009), a plan administrator's dishonest actions or improper motives, *Johnson v. Met. Life Ins. Co.,* 437 F.3d 809, 813 (8th Cir. 2006), or failure to conduct medical evaluations or appropriate medical inquiries*, Wakkinen v. UNUM life Ins. Co. of America*, 531 F.3d 575, 582-83 (8th Cir. 2008).

2. Post-*Glenn* there is a question about whether evidence of procedural

irregularities which cause a serious breach of a plan administrator's fiduciary duties, still trigger the *Woo* "sliding scale" less deferential standard of review.

a. *See, Wrenn v. Principal Life Ins. Co*., 636 F.3d 921, 927 (n.6)(8th Cir. 2011)(procedural irregularity component of *Woo* may still apply in 8th Circuit)(citing *Wakkinen, 5*31 F.3d at 582(continue to examine procedural irregularities under *Woo*); *but see Chronister*, 563 F.3d at 776 (procedural irregularity is one factor under *Glenn* abuse of discretion standard)); *Boyd v. ConAgra Foods, Inc.*, 879 F.3d 314, 320 (8th Cir. 2018)("Our circuit has not definitively resolved the impact of *Glenn* on the 'procedural irregularity component' " of *Woo*.)(citations omitted)).

b. *Glenn* also clarified that a sliding scale standard was not available merely based on a conflict of interest. *Id.,(* citing see also *Cooper v. Metro. Life Ins.*, 862 F.3d 654, 660 (8th Cir. 2017) ("[Eighth Circuit] precedent ... has consistently rejected the notion that the mere presence of a potential conflict of interest is sufficient to warrant a less deferential standard.")).

ii. ***Practice Pointers***:

1. Best practice would be to make both arguments that sliding scale should apply, but, if not, consider procedural irregularities as a factor showing abuse of discretion.

2. Additional arguments for de novo standard of review may also be made if the policy was offered, issued or renewed in Minnesota in 2016 or later and subject to the discretionary language ban.

    a. See section d.i 1b. *supra*.

e. Discovery or Supplementing the record is limited for ERISA based claims.

i. Additional evidence gathering is not part of the deferential review in ERISA STD/LTD claims and is even discouraged in *de novo* review of such claims.

1. *Humphrey v. Prudential Ins. Co. of America,* 791 F.Supp.2d 655, 665 (D. Minn.2011)(citing *Brown v. Seitz Foods Inc. Disability Benefit Plan,* 140 F.3d 1198, 1200 (8th Cir. 1998)(internal citations omitted))(further citations omitted).

ii. However, if good cause is shown, a Court may admit additional evidence.

1. *Brown*, 140 F.3d at 1200 (citations omitted).

2. Good cause usually focuses on whether a claimant had an opportunity to present such additional evidence during the administrative proceedings.

    a. *Humphrey*, 791 F.Supp.2d at 665.

3. ***Practice Pointers****:*

    a. Remember to take advantage of the claims procedure whenever possible and provide all relevant information.

    b. Get the claim file to make sure it contains all the information you would want a court to review because you will likely have no further opportunity to add to that record. Make sure a positive Social Security Administration decision is included, if available.

    c. Sometimes an ERISA based claim, with its tightly controlled discovery and administrative record can be a benefit—while both parties to the lawsuit will be stuck

with administrative record, it will save time and expense, bypassing costly medical depositions, out of state witnesses and lengthy discovery.

i. If the same case was not governed by ERISA, parties would surely be deposing treating doctors, reviewing doctors, claims specialists making decisions, appeals specialists, functional capacity evaluators, etc. You get the picture…EXPENSIVE and time intensive.

f. Disposition of ERISA based lawsuits.

i. Cases are oftentimes resolved at the Summary Judgment stage.

1. Both parties assert cross motions for summary judgment.

2. ERISA based cases are prime candidates for summary judgment given the standard of review and the fixed administrative record.

g. Remedies

i. For the most part, claimants will be seeking recovery of their benefits due.

1. A favorable decision will most likely result in a plan being ordered to pay a claimant their back benefits to date and to place that claimant "back on claim" subject to the terms and conditions of the plan.

2. ***Practice Pointers***:

a. Some individuals will not want to be put "back on claim" fearing future termination of benefits, triggering new appeals and/or litigation, not to mention the scrutiny of the LTD plan, which can include routine medical evaluations, request for records updates, and surreptitious surveillance to ensure the claimant is not acting inconsistently with their represented disability.

b. Thus, if there is a favorable outcome for the claimant, the topic of closing out a claim could be broached.

i. A plan is not compelled to close out a claim.

ii. In negotiating lump sum buyouts, plans may assume an SSDI offset, if SSDI is not currently being collected, but has been sought.

1. The argument is: If the plan is buying you out because you are disabled, then you should be receiving SSDI, too.

ii. Attorney's Fees

1. In any action to recover benefits, the Court has discretion to award reasonable attorney's fees and costs to either party.

a. 29 U.S.C. §1132(g)(1).

2. A fee claimant must show some degree of success on the merits.

a. *Hardt v. Reliance Standard Life Ins. Co.,* 130 S.Ct. 2149, 2158 (2010).

3. The fee claimant need not be the prevailing party to be eligible for an attorney's fees award.

a. *Hardt,* 130 S.Ct. at 2156.

4. The Courts should also bear in mind:

a. "ERISA is remedial legislation which should be liberally construed to effectuate Congressional intent to protect employee participants in employee benefit plans. A district court considering a motion for attorney's fees under ERISA should therefore apply its discretion consistent with the purposes of ERISA those purposes being to protect employee rights and to secure effective access to federal courts."

i. *Starr v. Metro Sys., Inc*., 461 F.3d 1036, 1040 (8th Cir.2006).

5. ***Practice Pointers***:

    a. While language to recover fees is favorable and one need not fully prevail on all issues to recover fees, the statute does provide that the court may award fees to EITHER party.

    b. Thus, a claimant should be advised of the possibility that fees could be awarded to the plan if the plan achieves some success on the merits.

7. **Special Issues to Consider in STD/LTD Claims**

A practitioner must be aware of the interplay between disability discrimination laws, social security disability income claims, and the long term disability claims. All three areas intersect and can result in unwanted consequences for the unwary.

a. The inherent tension between LTD disability vs. Social Security Disability vs. ADA/MHRA disability discrimination.

    i. Consider a claimant's potential claims when pursuing LTD claims.

        1. Be aware that when a claimant applies for LTD benefits they are necessarily representing that they cannot perform, at the least, their own occupation and maybe any occupation.

        2. Most LTD policies require that the claimant apply for Social Security Disability Income (SSDI) benefits because any SSDI benefit is an offset to an LTD benefit and thus lessens the LTD plan financial obligations.

            a. Generally, this application requires that the applicant represent they cannot perform ANY job.

        3. Thus, if a claimant receives a favorable determination regarding LTD and/or SSDI, the claimant is then considered by the LTD plan and/or the Social Security Administration as unable to perform their occupation and/or any occupation.

    ii. The Legal Rub :

        1. If the claimant wants to pursue a disability discrimination claim which can frequently be present in STD/LTD scenarios, they may

be estopped to do so because of the representation they made to claim LTD and/or SSDI benefits.

a. It is very difficult to claim that an employee/claimant is a qualified disabled person under the ADA or MHRA (which, of course means they can perform their job with or without reasonable accommodation) while at the same time claiming they cannot perform their own or any occupation for purposes of LTD/SSDI.

2. ***Practice Pointers***:

a. Consider whether you will be asserting disability discrimination claims because that may affect advice about pursuing an LTD claim.

b. Also consider obtaining written permission/acknowledgment that some claims may not be pursued because of the competing requirements needed for other related claims.

iii. The Financial Rub:

1. If a claimant receives LTD payments and is subsequently awarded SSDI status, they will usually receive an SSDI lump sum back benefit payment because the disability benefit start date is usually retroactive.

a. A nice thing, except that if that SSDI lump sum back payment covers the same time period in which a claimant was receiving full LTD benefits, the LTD plan will want to be paid back their claimed resulting overpayments.

2. Practice Pointers:

a. The moral of the story is: Advise the claimant to save the lump sum until the overpayment issue is resolved.

8. **Conclusion**:

a. Benefits claims under ERISA can raise a variety of issues. It is important to remember to utilize and exhaust the administrative process before litigation. It is also important to remember that pursuing ERISA based STD/LTD claims may have an impact (possibly adverse) on other planned litigation. A practitioner

needs to be aware of all avenues of relief, the processes to follow, the obstacles to recovery and the potential pitfalls which are ever present with these claims.

General STD/LTD Claim Process Checklist

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- Is the individual still employed by the company providing the benefit?
    - If not, claim may not be viable.
- If still employed, has a claim already been filed?
    - If not, get forms to file while still employed.
- Is the plan covered by ERISA?
- Has a determination been issued?
    - If yes, does it need to be appealed?
        - If yes, commence appeal process
            - Request claim file
            - Gather additional records to support appeal
            - Submit perfected appeal within allotted appeal time frame.
    - Has appeal determination been issued?
        - Did the determination adequately describe the basis for decision?

- Was result satisfactory?
    - If not, does the plan call for another voluntary or mandatory appeal?
    - If so, follow appeal process
        - Request any additional claim file information.
        - Provide supplemental records or other information as needed to perfect appeal.

- Has subsequent appeal determination been issued?
    - Was result satisfactory?
        - If not, evaluate options for lawsuit

- Lawsuit considerations
    - Have administrative procedures been exhausted?
    - Determine applicable statute of limitations for filing.
    - Who are the appropriate parties?
    - Venue
    - What standard of review might apply?
        - When was the policy issued, re-issued ?
        - Any procedural irregularities?

- What are damages?
    - Back benefits calculation
    - Any social security or other offsets?
- Are there other claims available, too?