HOW CAN THEY GET AWAY WITH THIS?

Some Basic Information

For

Long Term Disability Clients

The following is a short article intended for new clients with long term disability insurance claims subject to that federal law called the Employee Retirement Income Security Act of 1974 or simply ERISA.

Introduction

Many folks are shell shocked by the denial of their disability benefits. They cannot understand how such a thing could happen. The following is intended to act as a reality check for the disbelieving and to tell the reader a little bit about how the dark side gets away with it. Read on, but do not become too discouraged. Our firm helps people with long term disability claims which are subject to ERISA, as well as those which are not.

Things Do Not Seem Right

You obtained disability insurance through your employment. It may have been touted as a fringe benefit of the job. Your employer may have paid all or a part of the premium. The insurance was described as long term disability insurance or long term income protection. Your Long Term Disability Insurance was supposed to kick in and start paying a monthly benefit after you have been disabled for six (6) months. The shiny brochures said it would provide you with monthly income when you were disabled. It would replace some of your lost income with regular monthly payments. You were told that that monthly income could continue until you reached age 65 or normal retirement age. It sounded great. It really wasn't expensive. At least the cost was low when compared to the cost of an individual policy of disability insurance purchased from an agent. Such a deal!

Now you are disabled. You haven't worked for many months. You are depressed because you are hurt and/or sick and can no longer work. You are financially distressed. The disability benefits promised in the shiny brochure are not coming in. They either stopped or never began.

You cannot figure out what the problem is. All of your doctors tell you that you are disabled from work. Their reports have been submitted to the insurance company. Your doctors have even done some tests which indicate that you are not faking or exaggerating. The insurance company (or other firm handling your claim) has not had you examined by a doctor. They have not seen you in person. You have been successful in obtaining Social Security Disability Benefits. Clearly you are disabled! Yet the insurance company persists is saying you are not disabled, that your doctors have not submitted sufficient evidence of "impairment". It all seems wrong, unfair, maddening, bazaar.

You think of those ads you saw on TV. You are seriously injured. Lawyers should be chomping at the bit to take your case. You make some calls. Once they find out your case concerns insurance subject to ERISA, no one is interested. What's wrong? How can this be? This is America. How can they get away with this?

THE ANSWER: ERISA IS DIFFERENT

The Manner In Which An Erisa Claim Is Processed Before Suit is Different. The Way the Claim is Processed By the Court After Suit is Different. The Way the Claim Determination By the Insurance Company is Viewed by the Court is Different. The Differences are Not Favorable To the Claimant.

An ERISA benefit claim is decided based on the contents of a so-called "administrative record". Usually there is no testimony. There is no right to a jury trial. The cases are normally heard in federal court after so called administrative appeals are exhausted. If it is an insured disability plan, usually the same insurance company which denied the claim decides the administrative appeal of the denial. Exhaustion of administrative remedies (taking at least one appeal) is mandatory. If you do not take an administrative appeal, you may lose your case because of that fact alone. On the other hand, a poorly documented appeal usually means your case will be lost on judicial review. When and if you file suit, the case is determined based on the "administrative record". And the usual standard of review, that is the way the court views the determination made by the insurance company, is "arbitrary and capricious", not simply whether the insurance company was wrong in its determination.

Understanding what this means in practice requires an initial understanding of how an ERISA LTD claim proceeds through the legal system. The beginning is administrative process.

The "Administrative" Process in an ERISA Long Term Disability Case

At first your case is before the insurance company. During that time it is handled "administratively". Your case, and the beginning of the administrative record, begins with the completion by you of an application for benefits. The insurance company receives your application for benefits. It evaluates it and investigates your claim. It communicates with your employer and your doctor. The insurance carrier obtains some of your employment and medical records, may conduct surveillance, may have a physician review the file, and ultimately makes a decision as to whether to pay monthly benefits. They are usually deciding whether you are disabled within the meaning of the definition of disability contained within the insurance policy. If they deny benefits the insurance company is supposed to send you a letter telling you why they denied the claim and advising you of your right to "appeal" that denial. Usually you have 180 days from the date you receive the letter denying your claim to appeal.

A proper appeal usually is more than a simple "you're wrong, I am disabled" letter. A proper and potentially effective appeal should seek to convince the insurance company that they over looked something, that you are in fact disabled as that term is defined under the policy. Things that carriers frequently overlook include such items as medical records from one or more of your doctors, the duties of your occupation itself, the results of medical or other testing, the documented side-effects of medications you are taking, and other things too numerous to recount. Additionally there are sound arguments which need to be made as part of your

appeal in order to convince the insurance company to do the right thing and to pay benefits.

If your administrative appeal with the Insurance Company is denied, you are supposed to receive a letter advising you of their decision on your appeal of that denial. Among other things they are supposed to tell you why they upheld the denial of benefits and of your right to file suit under ERISA § 502 if you disagree with the insurance company's determination of your claim. At that point, the Administrative Record, the record of all the documents submitted to or considered by the insurance company with regard your claim, is usually considered closed. It is as if your case had been tried before a court and you lost. You now are free to pursue judicial review of the determination of the insurance company. In other words, you can file suit.

After Filing Suit - Judicial Review of Your Case

Judicial review of the decision denying benefits comes in federal court. If you file suit in state court, which is permitted on a benefits claim, the defendants will remove the case to federal court based on the fact that you are suing under a federal law. The defense reason for the removal to federal court is simple. It is to the insurance company's advantage. Federal courts tend to be more conservative. They tend to be more technical in the way they deal with cases than state courts. Federal judges are appointed for life. They never have to stand election. Hence

they are free to interpret the law in ways which some might see as unfair or unduly harsh and technical.

The federal judge usually will only consider documents which were submitted and given to the insurance company *before* they denied benefits on administrative appeal. Most benefit claims are limited to the "Administrative Record", the things and documents that the insurance company considered or had a chance to consider in determining the claim and the appeal from the denial of the claim. In other words, if a doctor's report was not submitted to the insurance company as part of the administrative appeal, the judge will usually not consider it.

In reviewing the denial decision by the insurance company, the court usually applies a standard of review (a way of looking at the record) called "arbitrary and capricious". The question to be decided by the judge is not just was the decision wrong, but whether it was so unsupported by evidence that no reasonable person could reach that decision. In essence, the judge must find the determination to be "unreasonable" from a legal standpoint. The judge may even think the decision to deny benefits was wrong. But that is not enough. It must be unreasonable in order for the claimant to obtain relief. For example, if the insurance company can frame the issue on the claim as a dispute between experts, (your doctor says you are disabled and their doc says you are not), overturning the decision to deny benefits can be very difficult.

The court is supposed to factor in the affect of the inherent conflict of interest of the insurance company. There clearly is a conflict of interest. The insurance

company is deciding whether to pay out its own money on the claim. And we know that insurance companies do not make money by paying claims.

Experienced Erisa counsel can often bring out evidence of how the conflict of interest may have affected the decision of the insurance company. There are arguments to be made that the conflict tainted the decision to such an extent that it was "arbitrary and capricious". There also are technical arguments that the usual "arbitrary and capricious" standard does not apply because of technical defects in the plan documents.

But even with experienced ERISA counsel, successful pursuit of a disability claim subject to ERISA is a complex and difficult task. However, proceeding without the representation of an experienced ERISA attorney is even more difficult, frustrating, and downright dangerous from the legal perspective. To do so is to proceed as a blind man attempting to walk through a minefield. Disaster lurks with every step.

Conclusion

ERISA benefit claims are different. They are handled in ways that are very different from most insurance claims. Many of the differences are counter-intuitive; they are contrary to one's normal expectations about how things are supposed to work. ERISA benefit cases are often difficult to win. But with proper representation undertaken early in the process, the chances for favorable results increase significantly.

Disclaimer: Obviously, the foregoing document is intended only to provide general information. ERISA is complex and there are many exceptions and qualifications applicable to the general statements made in this document. It is not to be relied upon in the place and stead of professional advice on your particular matter.

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