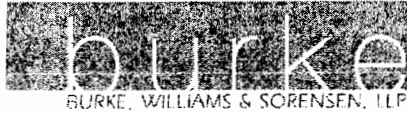




Disability Litigation Update

A Survivor's
Guide
for 2008

For Copies of Material Covered
EASTERN CLAIMS GROUP, INC.



DISABILITY LITIGATION UPDATE:
A SURVIVOR'S GUIDE FOR 2008
EASTERN CLAIMS CONFERENCE

February 25, 2008

Paper by

Melissa M. Cowan is a partner with Burke, Williams & Sorensen LLP in its Los Angeles office. Her diverse practice encompasses complex commercial litigation on behalf of life, health and disability insurers, as well as defense of agents/brokers and religious organizations. Her areas of expertise include ERISA, bad faith, and fraud. She has successfully represented clients in federal and state courts at both the trial and appellate levels, including obtaining a jury award of punitive damages against a fraudulent insured. Ms. Cowan received her J.D. degree from University of California, Los Angeles, in 1994, and graduated *summa cum laude* with a B.S. in finance from California State University, Long Beach, in 1991.

Keiko J. Kojima is a graduate of Brown University (*magna cum laude*) and UCLA School of Law. She is an associate at Burke, Williams & Sorensen, LLP in Los Angeles. Her practice focuses on the representation of insurers, third party administrators and employers in ERISA litigation, and the representation of insurers in life, health and disability litigation.

Jeff Cedrone is the head of the Litigation and Employment group in the Sun Life Financial law department in Wellesley Hills, Massachusetts. His responsibilities include managing lawsuits nationwide involving group life, disability, and medical stop loss insurance, individual life insurance and annuities. He provides risk assessment and counseling to Sun Life Financial's business units on a wide array of issues, including proper claim procedures, product development, and recommended business practices. Prior to Sun Life, Mr. Cedrone worked in private practice in Boston.



TABLE OF CONTENTS

	Page
I. Contract Interpretation	1
A. Objective vs. Subjective Evidence of Disability: Where Do You Draw the Line?.....	1
B. Occupation vs. Job: What Should You Consider?.....	3
II. Claims Handling.....	5
A. Medical Reviews.....	5
1. Cases Upholding the Use of Medical Reviews.....	5
2. Cases Criticizing the Use of Medical Reviews.....	7
B. Risk of Relapse	8
C. Offsets	10
D. Proof of Loss.....	10
E. Surveillance.....	11
F. Physical Disability vs. Mental Disability: One or Both?	12
III. Litigation	13
A. New Causes of Action.....	13
1. ERISA: The RICO Challenge.....	13
2. Individual Disability Cases: No Immunity From Extortion Claims	13
B. Standard of Review Issues for ERISA Cases	14
1. Attacks on the Discretionary Clause in ERISA Cases.....	14
2. De Novo Review Cases: Evidence Outside the Administrative Record	16

3.	Post- <i>Abatie</i> Abuse of Discretion Cases	18
4.	Procedural Irregularities under the DOL Regulations	19
	(a) Disclosure of “Relevant” Documents	19
	(b) Notice of Adverse Benefit Determination	21
	(c) Timing of Decisions.....	22
	(d) Procedures on Appeal	25
5.	What upcoming ERISA issues will be decided by the U.S. Supreme Court next?.....	25
C.	Discovery: What Should You Expect?	26
	1. ERISA	26
	2. Individual Disability Cases	30
D.	Statute of Limitations.....	33
E.	Attacks on the Attorney-Client Privilege.....	33
	1. ERISA – The Fiduciary Exception	33
	2. Individual Disability Cases	35
F.	Analysis of Bad Faith Allegations in Individual Disability Cases	35
	1. What Constitutes Bad Faith	35
	2. What Is Not Bad Faith	37



DISABILITY LITIGATION UPDATE: A SURVIVOR'S GUIDE FOR 2008

EASTERN CLAIMS CONFERENCE

February 25, 2008

I. Contract Interpretation

A. Objective vs. Subjective Evidence of Disability: Where Do You Draw the Line?

Whether a claimant can support a disability claim based on objective or subjective evidence is often the topic of debate, especially with self-reported claims of fibromyalgia, pain syndromes, and depression on the rise. Claimants typically argue that subjective evidence is sufficient to justify their claims, regardless of whether objective evidence of disability exists, if their doctors certify their disabilities. However, insurers and plan administrators contend that a diagnosis cannot equate with disability, such that objective evidence is necessary to corroborate the claimants' inability to work. Courts have split on this issue, although several decisions helpful to the insurance industry have come out in the past year.

- ***Denmark v. Liberty Life Assur. Co. of Boston*, 481 F.3d 16 (1st Cir. 2007):** The court drew the distinction between requiring objective evidence of a diagnosis, which is impermissible for a condition such as fibromyalgia that does not lend itself to objective verification, and requiring objective evidence that the plaintiff is unable to work, which is allowed. The plaintiff failed to provide evidence sufficiently relating her restrictions either to the specific physical requirements of her job or to her overall stamina. This lack of objective evidence, in conjunction with the three medical reviews and the surveillance evidence, provided substantial evidence to support the insurer's decision to deny the plaintiff's claim for LTD benefits.

- ***Corry v. Liberty Life Assur. Co. of Boston*, 499 F.3d 389 (5th Cir. 2007):** The court upheld the denial of the plaintiff's long-term disability claim based on fibromyalgia. The plaintiff maintained that the plan administrator discounted and ignored her subjective claims of pain and disability. The court disagreed and found the insurer had considered those complaints. The opinions of three consulting physicians constituted substantial evidence in support of the administrator's determination that the plaintiff did not have a disability that precluded full-time sedentary work.

- ***Meyers v. Hartford Life and Acc. Ins. Co.*, 489 F.3d 348 (8th Cir. 2007):** The court held that the insurer did not abuse its discretion in determining that the plaintiff, who allegedly suffered from chronic back pain, was not totally disabled from

her sedentary job. While there was “a good deal of evidence that she has or has had a number of painful conditions, including low back pain, myalgia, and arthralgia,” there was no evidence that the medicine that she took was not effective in relieving the pain. Further, the plaintiff had complained about pain for quite some time before she quit her job, and she nevertheless had been able to work.

- ***Oliver v. Coca Cola Co.*, 497 F.3d 1181 (11th Cir. 2007):** The court held that the Plan’s denial of long-term disability benefits, based solely on the alleged lack of “objective” evidence to corroborate employee’s subjective complaints of pain, was arbitrary and capricious. The court reasoned that medical evidence, especially as it relates to pain, can be inherently “subjective” in that it cannot be quantifiably measured. Here, the Plan did not require objective evidence as a prerequisite to coverage, did not perform an independent medical examination, did not identify any evidence that conflicted with the plaintiff’s diagnosis of fibromyalgia and chronic pain syndrome, and mischaracterized the evidence the plaintiff submitted. In essence, the Plan denied the claim not on the basis of conflicting, reliable evidence, but rather, it ignored relevant medical evidence in order to arrive at the conclusion it desired.

- ***Muzyka v. Unum Life Ins. Co. of America*, 195 Fed.Appx. 904 (11th Cir. 2006) (unpublished):** The plaintiff claimed that she was disabled from performing “any gainful occupation” due to fibromyalgia, chronic fatigue syndrome, and depression. The insurer admitted liability under the any occupation period by paying approximately nine months of benefits under a reservation of rights. The Eleventh Circuit affirmed the district court’s grant of summary judgment in the insurer’s favor, finding that the record supported the insurer’s determination that the plaintiff was capable of performing light to sedentary work. The plaintiff’s diagnosis was not supported by the record, she was not under the regular care of a doctor as required by the Plan, and the questionnaires by her doctor contained only self-reported symptoms and limitations which were not supported or corroborated by other evidence in the record. The court rejected the plaintiff’s argument that the insurer’s payment of nine months of benefits was an admission of liability.

- ***Johnson v. Metropolitan. Life Ins. Co.*, 437 F.3d 809 (8th Cir. 2006):** The plaintiff claimed to be disabled from rheumatoid arthritis and fibromyalgia. The insurer terminated her claim due to the absence of objective evidence of a physical functional capacity impairment. The denial letter stated that her self-reported, subjective complaints, without supporting objective medical findings of documented functional impairment, are insufficient to provide proof of disability. The plaintiff argued that requiring objective medical evidence of her disability constituted a procedural irregularity and/or was an abuse of discretion. The Eighth Circuit acknowledged that trigger-point findings consistent with fibromyalgia could constitute objective evidence of the disease. However, in the plaintiff’s case, all of the objective medical evidence, including the

tender points test, indicated that she did not suffer from rheumatoid arthritis or fibromyalgia to the point of disability. Moreover, even one of her treating physicians suspected that she was exaggerating her symptoms. The court held that the employee's benefit claims were properly denied.

- ***Pralutsky v. Metropolitan Life Ins. Co.*, 435 F.3d 833 (8th Cir. 2006):** The Eighth Circuit found that the district court erred in granting a plan participant summary judgment as the administrator's reliance on the absence of objective evidence for its denial of long-term disability benefits did not justify abandoning the deference normally accorded an ERISA plan administrator's decision. Under the normal standard, the administrator's decision was reasonable. "It is not unreasonable for a plan administrator to deny benefits based upon a lack of objective evidence." *Id.* at 839 (quoting *McGee v. Reliance Std. Life Ins. Co.*, 360 F.3d 921, 924-25 (8th Cir. 2004).

B. Occupation vs. Job: What Should You Consider?

Plan administrators and insurers frequently assess claimants' occupations by using the Dictionary of Occupational Titles ("DOT") from the Department of Labor, often labeling claimants' positions in a general fashion as requiring "sedentary," "medium" or "heavy" work. Plaintiffs argue that this approach does not account for the actual job duties that must be analyzed within "own occupation" or "regular occupation" policies.

- ***Loban v. Prudential Ins. Co. of Am.*, 2008 U.S. App. LEXIS 137 (9th Cir. 2008) (unpublished):** The district court concluded that travel was not a material and substantial duty of the plaintiff's regular occupation as a Regional Director for Market Deployment and therefore determined that he was not disabled within the occupational disability provision of the plan. The *de novo* standard of review applied. The plaintiff disputed the district court's seemingly discretionary finding that it was reasonable for the insurer to find that travel was not a material and substantial duty of his regular occupation. The Ninth Circuit agreed with the plaintiff and held that the district court failed to consider a letter from the plaintiff's direct supervisor explaining that as part of his job, he was expected to travel "anywhere, anytime, and at any cost to secure business." The court held that this evidence should have been considered. The case was remanded to the district court to determine whether the plaintiff was disabled, and if necessary, to supplement the record with additional evidence on the travel issue. There was no discussion in the Ninth Circuit's opinion of whether the policy included national economy language.

- ***Bishop v. Long Term Disability Income Plan of SAP Am.*, 232 Fed. Appx. 792 (10th Cir. 2007) (unpublished):** The plaintiff's employer accommodated his health condition so that he did not have to travel in his occupation. When the employer went through a reorganization, plaintiff's position was eliminated. He submitted a disability claim. In denying the plaintiff's long-term disability benefits, the insurer

considered the plaintiff's occupation as a technology consultant as it was normally performed in the general labor market in the national economy, not his ability to perform his job duties per se, although the policy did not contain national economy language. The insurer concluded that because the plaintiff could perform light duty work and because the DOT defined technology consulting as sedentary work, the employee was able to perform the essential duties of his regular occupation. The court held that based on this policy language, the relevant standard was whether the employee was capable of performing his own job with his employer at the time he was terminated. The court found that the insurer's failure to address whether traveling was an essential duty of the employee's job at the time of his termination rendered the decision arbitrary and capricious. Although the insurer argued the employer's accommodation rendered travel a nonessential duty of the job, the court's review did not compel a finding that the accommodation was permanent and did not reveal why the accommodation ended.

- ***Pylant v. Hartford Life and Acc. Ins. Co.*, 497 F.3d 536 (5th Cir. 2007):** The plaintiff argued that the insurer incorrectly defined the Plan term "your occupation" by reference to the DOT, rather than according to the duties she actually performed as a technical writer. The court held that the insurer did not abuse its discretion by relying on the DOT. Reliance on the DOT to determine the plaintiff's job duties was appropriate "because 'insurers issuing disability policies cannot be expected to anticipate every assignment an employer might place upon an employee outside the usual requirements of his or her occupation.'" *Id.* at 540 (citing *Richards v. Hartford Life & Accident Ins. Co.*, 356 F. Supp. 2d 1278 (S.D. Fla. 2004)), *aff'd*, 153 Fed. Appx. 694 (11th Cir. 2005). There was no discussion in the opinion of whether the policy included national economy language. *See further discussion of this case under the "Surveillance" section.*

- ***Whitmore v. Standard Ins. Co.*, 2007 U.S. Dist. LEXIS 93267 (E.D.Mo. 2007):** The claimant argued that the insurer improperly defined her occupation as a legal secretary according to the DOT instead of considering the job requirements of her actual position. The court stated that the issue had not been raised before the Eighth Circuit. It agreed with the Sixth Circuit that using the DOT to determine the definition of an employee's "own occupation" was reasonable. *See Osborne v. Hartford Life and Accident Ins. Co.*, 465 F.3d 296, 299 (6th Cir. 2006). Because the insurer had discretion to interpret the policy, the court held that the insurer did not improperly utilize the DOT in determining whether the claimant was disabled from her own occupation. There was no discussion in the opinion of whether the policy included national economy language.

- ***Frei v. Hartford Life Ins. Co.*, 2006 U.S. Dist. LEXIS 12846 (N.D. Cal. 2006):** The plaintiff argued that the insurer erred in denying benefits based on the plaintiff's ability to work in a sedentary position in general, rather than her ability to work in her own specific position as a sales assistant. The policy provided that "own occupation" means "your occupation as it is recognized in the general workplace" and

does not mean “the specific job you are performing for a specific employer or at a specific location.” Based on a medical review, the insurer concluded that the plaintiff no longer satisfied the policy definition of disability because none of her restrictions or limitations would prevent her from performing the essential duties of her sedentary occupation as a sales assistant. The court held that the insurer abused its discretion by determining that only disability from any sedentary position would trigger coverage under the policy. In essence, the defendant erroneously applied a virtual “any occupation” standard to its “own occupation” policy. The court relied on the reasoning stated in *Kinstler v. First Reliance Std. Life Ins. Co.*, 1997 U.S. Dist. LEXIS 10284, * 7-8 (S.D.N.Y. 1997), which held that the term “regular occupation” should be construed to mean “a position of the same general character as the insured’s previous job, requiring similar skills and training, and involving comparable duties,” and that the application of the DOT was improper because utilizing the general definition ignored the skills and training and comparable duties required by the plaintiff’s specific job.

- ***McCready v. Standard Ins. Co.*, 417 F.Supp.2d 684 (D. Md. 2006)**: In this ERISA case, the court held that where the policy defined “own occupation” as “not limited to your job with your Employer,” the insurer was to evaluate the plaintiff’s position as a legal secretary against professions of the same general character as the plaintiff’s position with her former employer. The analysis of occupation was not limited to the plaintiff’s specific job with her employer.

II. Claims Handling

A. Medical Reviews

Insurers and ERISA fiduciaries routinely rely on the opinions and findings of medical reviewers in evaluating disability claims. Claimants and their attorneys argue that these reviews are biased in favor of insurers. The courts have both upheld and criticized claims decisions based on the existence of in-house and peer medical reviews. The thoroughness of the review appears to be a key factor in courts’ assessments.

1. Cases Upholding the Use of Medical Reviews

- ***Wilson v. 21st Century Ins. Co.*, 42 Cal.4th 713 (Cal. 2007)**: The California Supreme Court acknowledged that a medical review, without an independent medical examination, “might reveal an indisputably reasonable basis to deny the claim without further investigation.” *Id.* at 723. The Court declined to pronounce as a general rule that the lack of an independent medical examination alone constitutes bad faith. An insurer’s good or bad faith should be evaluated in light of the totality of the circumstances surrounding its actions.

- ***Rutledge v. Liberty Life Assur. Co. of Boston*, 481 F.3d 655 (8th Cir. 2007)**: The court held that it was not required to accept the assessment of plaintiff's treating physician over that of (1) the plaintiff's other treating physicians who concluded that he was able to work with minimal restrictions, and (2) the opinions of the insurer's medical reviewers, who concluded that the participant was able to perform sedentary work with few restrictions. Further, the insurer was not required to have an independent medical examination performed to support its claims decision. "An ERISA plan administrator need not order an independent medical examination when the insured's evidence supporting a disability claim is facially insufficient." *Id.* at 661.

- ***McKeldin v. Reliance Std. Life Ins. Co.*, 2006 U.S. Dist. LEXIS 16423 (D. Md. 2006) *aff'd*, 2007 U.S. App. LEXIS 24289 (4th Cir. 2007)**: The plaintiff, arguing for a *de novo* standard of review, criticized the insurer's partiality due to its reliance on an in-house medical review. The court observed that the insurer's decision to deny the claim for disability benefits, not the physician's review, was the issue at stake. The court found that the insurer had multiple, credible sources other than the physician's review from which to evaluate the claim, so the concerns about the physician's potential bias were irrelevant. After applying the a discretionary standard of review, the court found the insurer appropriately satisfied its obligations under the plan and ERISA when it determined that the claimant was not entitled to disability benefits.

- ***Davis v. Unum Life Ins. Co. of Am.*, 444 F.3d 569 (7th Cir. 2006)**: The plaintiff claimed to be disabled due to severe depression, memory loss, joint pain, and a stroke. The insurer paid benefits for the plaintiff's psychiatric disability until he reached the plan's 24-month mental health limitation. The claim was then denied as to the plaintiff's physical complaints, partly on the basis of three in-house medical reviews. The Seventh Circuit held that the insurer did not abuse its discretion in relying on the medical reviews. Whether a doctor is in-house or not is an irrelevant distinction. The insurer should not be penalized and is entitled to rely on its record reviews instead of conducting an independent medical examination since "doctors are fully able to evaluate medical information, balance the objective data against the subjective opinions of the treating physicians, and render an expert opinion without direct consultation." *Id.* at 577. The Court further upheld the brevity of the medical reviewers' reports, reasoning that "there is nothing in ERISA or our precedent requiring doctors to write like lawyers or plan administrators." *Id.* at 578.

- ***Parkman v. Prudential Ins. Co. of Am.*, 439 F.3d 767 (8th Cir. 2006)**: The Eighth Circuit held that the plan administrator did not abuse its discretion in denying the plaintiff's claim where it relied on an in-house physician review. The Court noted that the physician issued a 10-page summary of the participant's medical history and observed that her treating physicians disagreed regarding the extent of disability. The Court found that the insurer's physician carefully reviewed the medical records and various tests

administered to gauge the participant's condition. Consequently, the district court's conclusion that the administrator properly denied benefits was affirmed.

- ***Maynard v. CNA Group Life Assur. Co.*, 2006 U.S. Dist. LEXIS 1043 (D. Ariz. 2006)**: In concluding that the insurer did not abuse its discretion in denying the plaintiff's claim for disability benefits, the court rejected the plaintiff's arguments that the reviewing physician (1) never examined plaintiff; (2) never contacted plaintiff's treating and consulting healthcare providers to discuss her "complex and debilitating illnesses"; and (3) never requested that plaintiff submit to an IME; as well as that (4) there was no peer review conducted on any of the submitted medical documentation and reports.

2. Cases Criticizing the Use of Medical Reviews

- ***Cooper v. Life Ins. Co. of North America*, 486 F.3d 157 (6th Cir. 2007)**: The court held that the insurer's reliance on the reports of the physician reviewers to uphold its denial of the plaintiff's claim was irrational, and thus its claims decision was arbitrary and capricious. The doctors failed to consider all of the medical evidence in the claim file, disregarded the insurer's instructions to speak to the claimant's treating physicians, and offered conclusory and unsupported statements that the documentation of the claimant's functional capacity was insufficient to support a finding of disability.

- ***Evans v. UnumProvident Corp.*, 434 F.3d 866 (6th Cir. 2006)**: The Sixth Circuit confirmed that the insurer abused its discretion in terminating the insured's disability benefits by failing to provide a reasoned explanation, based on the record and the express disability policy language, for terminating the insured's benefits. The court found that the insurer's decision to rely solely on file reviews by its in-house physicians was questionable in light of the critical credibility determinations made in those file reviews, the factual inaccuracies contained therein regarding the insured's treatment history, and the fact that the file reviews categorically dismissed the reliable opinion of the insured's treating physician that the stress factor militated against the insured's resumption of her administrative position.

- ***Work v. Hartford Life & Accident Ins. Co.*, 2007 U.S. App. LEXIS 21023 (3rd Cir. 2007)** (unpublished): The court held that the insurer's denial of long-term disability benefits was arbitrary and capricious due to its reliance on a paper medical review, which it found to be deficient. The reviewer's conclusion that the plaintiff could resume her position full-time appeared to rest entirely on the treating physician's report that she could use her hands and feet; handle, finger, and feel things; and occasionally lift weights under ten pounds, stoop, kneel, crouch, crawl, and reach above the shoulder and at waist level. However, in a 2002 letter to the insurer, the treating physician recommended that the plaintiff remain out of work. In his conversation with the medical reviewer, he told her, "it is possible that [Work] *might* be able to perform some part-time position at a sedentary level," but cautioned that "she would certainly need frequent

position changes, [and] the ability to sit and stand when needed." The treating physician also noted that during the plaintiff's visits to his office, she was "clearly uncomfortable" in either a sitting or standing position. In short, the treating physician never suggested that she could return to work on a full-time basis.

- ***Rabuck v. Hartford Life & Accident Ins. Co.*, 2007 U.S. Dist. LEXIS 80246 (W.D. Mich. 2007)**: The court took issue with the paper medical reviews used to support the insurer's termination of long-term disability benefits. The court held that where the conclusions from a file review include critical credibility determinations regarding a claimant's medical history and symptomatology, reliance on such a review may be inadequate. Whether a doctor has physically examined the claimant is one factor that the court may consider in determining whether a plan administrator acted arbitrarily and capriciously in giving greater weight to the opinion of its consulting physician. For example, the reviewer's emphasis on plaintiff's "ability" to play golf and fish as an indicator of plaintiff's "excellent" functional capacity was largely conjecture, and had the overwhelming appearance of improper "cherry-picking" the medical record, rather than a principled assessment of the plaintiff's daily activities.

B. Risk of Relapse

- ***Stanford v. Continental Cas. Co.*, 455 F.Supp.2d 438 (E.D.N.C. 2006)**: The plaintiff, a nurse anesthetist, developed an addiction to Fentanyl, a drug used as an anesthetic. He completed an inpatient drug treatment program, had a relapse, and entered another inpatient treatment program. The insurer approved his initial application for long-term disability benefits. The plaintiff did not relapse again, but entered a third inpatient treatment program, and was released by that facility to work if his access to narcotics was restricted. His treating physician stated that he suffered drowsiness as a result of his medications for depression and addiction and that he could not be around narcotics. Subsequently, the insurer terminated the long-term disability benefits. The court held that under the modified standard of review, the insurer did not abuse its discretion in determining that plaintiff had failed to produce adequate evidence of a continuous inability to perform the material and substantial duties of his own occupation. The plaintiff's potential for relapse of his addiction to Fentanyl did not render him disabled under terms of the plan. "[T]he medical evidence showed only that plaintiff presented a potential risk of relapse, and furthermore that the terms of the policy do not cover such a potential risk." *Id.* at 444.

- ***Abdel-Malek v. Life Ins. Co. of N. Am.*, 359 F.Supp.2d 912 (C.D. Cal. 2005)**: The plaintiff, a doctor for Southern California Permanente, underwent successful heart bypass surgery and was permitted to return to work part-time at 80% of his workload. Partial disability benefits were initially paid, then later denied on the grounds the plaintiff was capable of full-time work. Plaintiff's treating physician advised that

full-time work would put plaintiff at risk for a future heart attack. Plaintiff sued for ERISA benefits. The case was settled for a payment of a portion of past benefits, and the insurer's agreement to conduct medical and vocational assessments to evaluate future benefits. The vocational assessment concluded that plaintiff's position generated a stress level of 8 on a scale of 1 to 10. A cardiologist then examined plaintiff to determine whether he could work greater or equal to 80% of his job. He opined that there was no medical reason for plaintiff to reduce his work by 20%. However, he also determined that plaintiff was at risk for a future cardiac event because of his perceived work stress, which could be associated with coronary artery disease; thus, he either needed to change his employment relationship or to obtain further stress reduction therapy. The court ultimately concluded that requiring the insured to be "capable" of working full-time as a physician included a requirement that the work not put him at substantial risk to his health. The Court cited the Third Circuit's rule in *Lasser v. Reliance Standard Life Insurance Co.*, 344 F.3d 381 (3d Cir. 2003) that a plaintiff's decision to work at all, in the face of an increased health risk, does not defeat a finding of disability. The court reasoned that plaintiff's choice to expose himself to this risk did not undo his disability. The court concluded the insurer was required to pay benefits for the 20% of the time the plaintiff did not work.

• ***Napoli v. First Unum Life Ins. Co.*, 2005 U.S. Dist LEXIS 7310 (S.D.N.Y. 2005):** The plaintiff, a bond trader who was insured under a regular occupation policy governed by ERISA, had suffered a heart attack at work and had emergency bypass surgery. Plaintiff's physician submitted an affidavit which stated that the extreme stress of his occupation could progress his coronary artery disease and exacerbate his heart condition, leading to a heart attack. The insurer's cardiologist noted that Plaintiff performed well on his stress test and that the risk of an acute cardiac event due to stress was so small that it was not quantifiable. Benefits were denied. At trial, the court applied the following test to assess plaintiff's risk of disability: "Is it likely that the person would have returned to work, even if he did not have disability insurance or other substantial assets?" *Id.* at *21. The court reasoned that this rule of thumb "reflects the fact that in our society, a party is not considered disabled from performing his job whenever there is 'even the slightest risk that the stress of his work might cause another heart attack.'" *Id.* After expanding the record to hear testimony by the two medical experts, the court held that the plaintiff, who had successfully recovered from surgery, had the physical capacity to perform his occupation and the risk of another coronary incident occasioned by job stress if he had returned to work was insignificant. The court found a reasonably prudent person would not be deterred from returning to work by the same risks involved.

C. Offsets

• ***Blankenship v. Liberty Life Assur. Co. of Boston*, 486 F.3d 620 (9th Cir. 2007)**: The Ninth Circuit held that the plaintiff's retirement funds that were directly rolled over into his individual retirement account (IRA) were not "received" within the meaning of policy provision calling for the offset of "received" retirement funds. Employing the doctrine of *contra proferentem*, the court held that the "definition of receipt is one that requires possession. . . ." *Id.* at 626. Thus, the plaintiff's disability benefits were not subject to reduction based on the distribution of his retirement benefits.

• ***Carstens v. U.S. Shoe Corporation's Long-Term Benefits Disability Plan*, 2007 WL 3236353 (N.D. Cal. 2007)**: The long-term disability plan provided that the Plan may offset payments for any "Periodic benefits, for *loss of time* on account of the Employee's disability, under or by reason of-- . . . the United States Social Security Act." *Id.* at *1 (emphasis added). The court held that the Social Security dependent benefits received on behalf of the plaintiff's son did not constitute replacement benefits for the plaintiff's "loss of time," but were payments to children "for the purpose of their support and maintenance." Therefore, the dependent benefits could not be offset under the Plan.

• ***Elgin v. Aetna Life Ins. Co.*, 2007 WL 1034988 (D. S.C. 2007)**: The insurer paid disability benefits based on the plaintiff's torn rotator cuff. In doing so, an offset was taken for the plaintiff's workers' compensation benefits, which were being paid because of a carpal tunnel syndrome diagnosis. The plaintiff then settled his worker's compensation claim for a lump sum payment. The plaintiff maintained that the insurer could not offset his worker's compensation benefits because the physical causes of the two benefits were different. The court ruled that the insurer was entitled to offset all of the worker's compensation benefits, based on the clear and unambiguous language of the plan, which allowed the long-term disability benefits to be offset by "[t]emporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss or bodily function or capacity." The court further held that the lump sum nature of the worker's compensation benefits did not preclude the offset.

D. Proof of Loss

• ***Sousa v. Unum Life Ins. Co. of America*, 2007 WL 4578299 (C.D. Cal. 2007)**: The insurer requested that the claimant provide continuing "proof of loss" of his disability from "any occupation" when the "own occupation" disability period expired. Although the claim was based on an orthopedic disability, the insured provided

psychiatric records as part of his “proof” of disability, which suggested he was exploring job alternatives, possibly purchasing a new business, and leading a more active lifestyle than he had previously conveyed to the insurer. The insurer interviewed the claimant, who denied working and claimed he mainly stayed at home. The insurer nonetheless requested that the claimant submit additional documentation to support his disability claim, including updated psychiatric and financial records. When the plaintiff failed to produce the requested documents, the insurer terminated his “any occupation” benefits. After the plaintiff sued, the parties conducted discovery and stipulated that ERISA applied. The insurer also obtained information to confirm that the claimant had purchased a business and had been working. At trial, the court upheld the termination of the claim, finding that the plaintiff failed to comply with the proof of loss requirements and failed to disclose his true work activities. The court also found that the insured had failed to exhaust his administrative remedies, thereby barring his claim for further benefits.

E. Surveillance

- ***Pylant v. Hartford Life and Acc. Ins. Co.*, 497 F.3d 536 (5th Cir. 2007):** The insurer’s special investigations unit (“SIU”) conducted video surveillance of the plaintiff’s daily activities for two days. During that time, the SIU observed and recorded the plaintiff engaging in various activities that contradicted her claimed limitations, including driving her children to school, removing a child weighing over twenty pounds from the rear of her car, carrying that child with both hands into her home, and holding an infant for eighteen minutes while standing. The court upheld the insurer’s denial of her claim, noting that the insurer based its decision on various sources, including the surveillance videotape, which “showed a mobile person capable of performing a sedentary occupation.” *Id.* at 540.

- ***Mote v. Aetna Life Ins. Co.*, 502 F.3d 601 (7th Cir. 2007):** The surveillance videotape showed the plaintiff performing activities which she claimed to be unable to accomplish, such as operating a motor vehicle, kneeling, moving repeatedly, and stooping. The reviewing physician changed his opinion after viewing the videotape footage. The court held that the use of surveillance videotape of a participant’s activities, and its reliance on the reviewing physician, did not render denial of long-term disability benefits arbitrary and capricious. The doctor was justified in altering his opinion regarding the plaintiff’s ability to work after viewing the videotapes because her “activities on the videotapes were exactly the type of additional, contrary evidence upon which he conditioned his original opinion. . .” *Id.* at 609. In addition, the record reflected that the plan relied upon the videotapes “merely as one piece of the puzzle in its deliberative process and, while they may have altered the outcome, they were not the sole basis for the Plan’s denial of Mote’s claim.” *Id.*

- ***Opeta v. Northwest Airlines Pension Plan for Contract Employees*, 484 F.3d 1211 (9th Cir. 2007):** The plaintiff was captured on videotape performing light yard work. However, the surveillance evidence was not provided to the independent medical reviewer and not part of the administrative record. The court held that this evidence was not relevant to the district court's review because the administrator's evaluation of the physician's assessment was not based on the surveillance.

- ***Tsoulas v. Liberty Life Assur. Co. of Boston*, 454 F.3d 69 (1st Cir. 2006):** The plaintiff, who claimed to be disabled from multiple sclerosis, was videotaped performing numerous activities that were inconsistent with her claimed limitations. The surveillance video depicted her standing, walking, and driving without assistance, shopping for groceries, and lifting groceries into her car. She was also seen on a multi-day trip during which she went to restaurants, nightclubs, and a mall. The plaintiff maintained that the surveillance did not positively support a conclusion that she was capable of performing all of the responsibilities of her job on a full-time basis. The court acknowledged that while the plaintiff's job duties differed from the activities portrayed in the surveillance videos, the insurer's inference – that the conflict between her self-reported limitations and her actual activities suggested an ability to perform her occupational responsibilities – was not arbitrary and capricious. It found no error in the district court's determination that the insurer could have rationally concluded that the plaintiff's physical abilities largely comported with the DOT's description of the physical requirements of her occupation.

F. Physical Disability vs. Mental Disability: One or Both?

- ***McKoy v. International Paper Co.*, 488 F.3d 221 (4th Cir. 2007):** The plaintiff submitted a disability claim based on a shoulder injury and substantial cognitive deficits. The insurer failed to evaluate his mental condition, only concluding that the plaintiff was not disabled from a physical standpoint. The Fourth Circuit held that it was an abuse of discretion for the insurer to only evaluate his physical condition and never squarely addressing his borderline retarded mental condition. Despite the fact that the file was reopened solely to permit the plaintiff to present evidence of his mental disability, the insurer only had the file reviewed by an orthopedist. This constituted an abuse of discretion. Summary judgment in favor of the plaintiff was correctly granted.

III. Litigation

A. New Causes of Action

1. ERISA: The RICO Challenge

• ***Weiss v. First Unum Life Ins. Co.*, 482 F.3d 254 (3rd Cir. 2007)**: The Third Circuit held that a private right of civil action under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C.S. §§ 1961-1968, is available to an insured whose ERISA disability benefits are terminated. The plaintiff brought suit under the RICO statute against his insurer, claiming that the insurer discontinued payment of his disability benefits as part of its racketeering scheme involving an intentional and illegal policy of rejecting expensive payouts to disabled insureds. The district court dismissed his claim, believing that the allowance of such a RICO claim would interfere with New Jersey's Insurance Trade Practices Act ("ITPA") and thus ran afoul of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. The Third Circuit reversed. Analyzing the RICO claim under the factors identified in *Humana Inc. v. Forsyth*, 525 U.S. 299 (1999), the Third Circuit found that: (1) the ITPA did not provide a private right of action; (2) the insured had a common law right of action for recoupment of benefits; (3) it was possible that damages would be available for the insured's claim under the Consumer Fraud Act, N.J. Stat. Ann. § 56:8-2, and that an insurer's racketeering scheme would constitute a distinct and egregious tort under New Jersey law such that punitive damages would be available; (4) there was no "declared state policy" mandating the exclusivity of the ITPA as a remedy for insurance fraud; and (5) deeming federal civil RICO suits to be unavailable would deprive insurers of an important weapon of self-defense. Thus, the court held that New Jersey's scheme did not intend to be exclusive and that RICO did not disturb or interfere with New Jersey's state insurance regime but, rather, it supplemented the statutory and common law claims for relief.

2. Individual Disability Cases: No Immunity From Extortion Claims

Plaintiffs are constantly seeking new ways to allege that insurers have acted in bad faith or are liable for other tort claims related to claim denials. The following high-profile case upheld an extortion claim against an attorney in purported settlement negotiations, when such civil claims had previously not been allowed. A clever plaintiff's attorney may argue that an extortion cause of action can stand against an insurer, whether or not tied to bad faith allegations, due to questionable tactics in settlement talks, investigation and fraud reporting activities.

• ***Flatley v. Mauro*, 39 Cal.4th 299 (Cal. 2006)**: A woman accused Michael Flatley, of "Lord of the Dance" fame, of sexual assault, alleging that he had raped her in a Las Vegas hotel. Through her attorney, she threatened to sue unless he agreed to pay a

“seven figure” settlement; likewise, if Flatley did not pay, the attorney claimed he would expose Flatley to unfavorable publicity. Flatley countered with a lawsuit against the woman and her attorney, claiming extortion, intentional infliction of emotional distress and defamation. The court held that the lawyer’s conduct constituted extortion as a matter of law. Under the California Penal Code, extortion is the threat to accuse the victim of a crime or “expose, or impute to him . . . any deformity, disgrace or crime” accompanied by a demand for payment to prevent the accusation, exposure, or imputation from being made. Calif. Pen. Code, § 519. His communications threatened to “accuse” Flatley of, or “impute to him,” “crime[s]” and “disgrace” unless Flatley paid a minimum of \$1 million of which the attorney was to receive 40 percent. “That the threats were half-couched in legalese did not disguise their essential character as extortion.” The attorney’s letter accused Flatley of rape and also imputed to him other, unspecified violations of various criminal offenses involving immigration and tax law as well as violations of the Social Security Act. With respect to these latter threats, the letter went on to threaten that “[w]e are positive the media worldwide will enjoy what they find.” However, whether Flatley in fact committed any violations of these various laws was irrelevant. The threat to disclose criminal activity entirely unrelated to any alleged injury suffered by the attorney’s client “exceeded the limits of respondent’s representation of his client” and was itself evidence of extortion. The court emphasized that its discussion of what constituted extortion as a matter of law was limited to the specific and extreme circumstances of this case. The “opinion should not be read to imply that rude, aggressive, or even belligerent prelitigation negotiations, whether verbal or written, that may include threats to file a lawsuit, report criminal behavior to authorities or publicize allegations of wrongdoing, necessarily constitute extortion.” *Id.* at 332.

B. Standard of Review Issues for ERISA Cases

1. Attacks on the Discretionary Clause in ERISA Cases

Discretionary clauses affect the standard of review a court applies when reviewing an insurer’s claim determination. If the disability policy contains a discretionary clause, the court will apply a deferential “abuse of discretion” standard of review to the insurer’s claim determination and seek to determine whether the insurer had a rational basis for its claim determination. If the policy does not contain a discretionary clause, the court will apply a “de novo” standard of review, which grants no deference to the insurer’s claim determination, and seek to determine whether the determination was correct.

In 2002, the National Association of Insurance Commissioners (“NAIC”) adopted a Model Act that prohibited the use of discretionary clauses in health insurance policies. In 2004, the NAIC extended the prohibition to group disability insurance policies. Since 2002, six states, California, Illinois, Michigan, New Jersey, New York and Utah, have banned, or sought to ban, the use of discretionary clauses in group disability insurance policies.



Since the NAIC's promulgation of the Model Act, the states listed above have opined that discretionary clauses are inequitable, misleading, unfair, and deceptive, and have taken the following actions to ban them from group disability insurance policies:

California: In October 2005, the California Department of Insurance ("CDOI") issued a letter to insurers indicating it would ban discretionary clauses from insurance policies. The insurance industry sued the CDOI to prevent it from doing so. In July 2007, following the settlement of the litigation and the settlement of a related case brought by The Hartford against the CDOI, group disability insurance policies may no longer contain discretionary clauses. However, as discussed below, the Ninth Circuit has recently held that the CDOI's position cannot affect existing policies.

Illinois: As of July 1, 2005, Ill. Adm. Code Title 50, section 2001.3 prohibits group disability insurance policies from containing a provision that purports to "reserve discretion to the health carrier to interpret the terms of the contract . . ."

Michigan: As of March 1, 2007, Administrative Rules 500.2201 and 500.2202 prohibit any provision in an insurance policy which "purports . . . to grant deference in subsequent proceedings to the insurer's decision, denial, or interpretation on terms, coverage or eligibility for benefits." In August, 2007, the insurance industry filed a lawsuit against the Office of Financial and Insurance Services seeking a declaration that the Rules are preempted by ERISA and cannot be enforced. The lawsuit is pending.

New Jersey: As of January 1, 2008, N.J.A.C. 11:4-58 prohibits group disability policies from containing discretionary clauses that "reserve sole discretion to the carrier to interpret the terms of the policy or contract . . ." A carrier "may include a provision stating that the carrier has the discretion to make an initial interpretation as to the terms of the policy or contract, but that such interpretation can be reversed by . . . a court of law."

New York: On June 29, 2006, the New York State Insurance Department ("NYSID") issued Circular Letter No. 14, which stated that the NYSID would draft a regulation that "prohibits the use of discretionary clauses in all new and existing accident and health policies [and] life insurance policies . . . upon renewal, modification, alteration or amendment on or after the effective date of the regulation." The NYSID has since drafted Regulation 184, but it has not been implemented.

Utah: As of March 21, 2003, Utah Admin. Code R590-281-1 et seq., prohibits the use of discretionary clauses in group disability insurance policies that are issued to benefit plans that are not subject to ERISA.

Two Ninth Circuit decisions have recently neutralized the attacks on the discretionary clause by the CDOI:

- ***Saffon v. Wells Fargo & Co. Long Term Disability Plan*, __ F.3d __, 2008 WL 80704 (9th Cir. 2008)**: The Ninth Circuit ruled that California law does not authorize the Commissioner of the CDOI to nullify an ERISA plan’s grant of discretionary authority retroactively. “Assuming that the Commissioner may prohibit insurance companies from using this discretionary clause in future insurance contracts, he cannot rewrite existing contracts so as to change the rights and duties thereunder.” *Id.* at *2. *Cf. Peterson v. Am. Life & Health Ins. Co.*, 48 F.3d 404, 410 (9th Cir.1995) (“[A]n otherwise valid [insurance] policy is a binding contract and governs the obligations of the parties until the Commissioner revokes his approval”).

- ***Baida v. First Unum Life Ins. Co.*, 2007 WL 4467637 (9th Cir. 2007) (unpublished)**: The Ninth Circuit rejected the plaintiff’s reliance on the CDI’s attack on discretionary clauses and expressly upheld the discretionary clause in the insurer’s policy. The Court ruled that the CDI’s “Letter opinion per CIC § 12921.9: Discretionary Clauses” and “Notice to Withdraw Approval and Order for Information” do not render the discretionary clause in the plan unenforceable. An opinion letter “merely states the opinion of the insurance commissioner, and does not have the force of law.” *Id.* at *1. In addition, California Insurance Code Section 10291.5(b) does not grant beneficiaries the right to “reform the nature of his policy and obtain benefits for which he never bargained by engaging courts to second-guess the Commissioner’s approval of the policy.” *Id.* at *2. Moreover, the Ninth Court held that the CDI’s withdrawal of its approval of the insurer’s policy does not apply retroactively. The Ninth Circuit ultimately concluded that the district court correctly reviewed the insurer’s decision to deny the plaintiff’s claim for an abuse of discretion.

2. De Novo Review Cases: Evidence Outside the Administrative Record

- ***Jewell v. Life Ins. Co. of North America*, 508 F.3d 1303, 2007 WL 4218919 (10th Cir. 2007)**: The court held that post-litigation letters written by the plaintiff’s doctors and an affidavit by the plaintiff himself were inadmissible. Under the factors announced in *Hall v. Unum Life Ins. Co. of America*, 300 F.3d 1197, 1203 (10th Cir. 2002), a party seeking to introduce evidence from outside the administrative record in a *de novo* case has the burden to establish that proffered evidence: (1) is necessary to conduct adequate *de novo* review; (2) could not have been submitted to the plan administrator at time challenged decision was made; (3) is not cumulative or repetitive; and (4) is not simply better evidence than claimant mustered for claim review. The plaintiff did not establish that the extra-record evidence was necessary for the court’s review and was not different in kind than what was in the administrative record. “The record already contained Dr. Peters’ contemporaneous views, and extra-record evidence cannot be used to edit or redo the record.” *Id.* at 1316. Likewise, there was nothing in

the plaintiff's affidavit that "could not have been submitted to the plan administrator at the time the challenged decision was made." *Id.* At 1317(citing *Hall*, 300 F.3d at 1203).

- ***Opeta v. Northwest Airlines Pension Plan for Contract Employees*, 484 F.3d 1211 (9th Cir. 2007):** The Ninth Circuit held that the district court abused its discretion in this *de novo* review case in admitting a videotape of the plaintiff performing light yard work and admitting the testimony of the videographer, the plaintiff and his doctor. The court emphasized that "a district court should exercise its discretion to consider evidence outside of the administrative record 'only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision.'" *Id.* at 1216 (emphasis in original) (quoting *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, (9th Cir.1995)). Because the videotape was not presented to the independent medical examiner, it was not relevant to the district court's review of the Plan's interpretation of the physician's assessment. Likewise, the additional testimony was irrelevant to determining whether the Plan correctly or incorrectly denied benefits based on the doctor's evaluation, which was the only question properly before the district court.

- ***Sloan v. Hartford Life and Acc. Ins. Co.*, 475 F.3d 999 (8th Cir. 2007):** The Eight Circuit held that the district court did not abuse its discretion in a *de novo* review case by considering a Social Security decision favorable to the insured, which was issued more than two years after the insurer's final administrative decision. The court approved of the district court's four reasons for admitting the additional evidence: (1) the insurer stipulated to the dismissal of the first federal court action for the specific purpose of allowing the plaintiff to pursue his social security claim; (2) the social security definition of disability was very similar to the definition of disability in the plan; (3) the district court considered the administrative law judge's credibility determinations regarding the plaintiff's subjective complaints of pain to be highly probative of the ultimate question of disability; and (4) equity weighed in the plaintiff's favor because he had received disability benefits for nearly thirteen years before the insurer's termination.

- ***Patton v. MFS/Sun Life Financial Distributors, Inc.*, 480 F.3d 478 (7th Cir. 2007):** The court held that the district court erred in denying the plaintiff's motion to re-open discovery for the purpose of deposing his treating physician so he could explain his contradictory statements relied on by the insurer. The doctor initially opined that the plaintiff would be permanently restricted and be able to perform only light duty work. Later, he stated that the plaintiff had been released without any restrictions, yet he submitted another statement supporting the plaintiff's disability from his occupation. The court acknowledged that in the Seventh Circuit, a district court in *de novo* cases has discretion to "limit the evidence to the record before the plan administrator, or . . . [to] permit the introduction of additional evidence necessary to enable it to make an informed and independent judgment." *Id.* at 484 (citing *Casey v. Uddeholm Corp.*, 32 F.3d 1094,

1099 (7th Cir.1994)). The court reasoned that the relatively slight cost in depositing the physician would result in an unusually high payoff in increased accuracy, because the case hinged in part on factual determinations, which, given the contradictory evidence in the record, were “little better than guesses.” *Id.* at 493.

3. Post-*Abatie* Abuse of Discretion Cases

- ***Post v. Hartford Ins. Co.*, 501 F.3d 154 (3rd Cir. 2007)**: The Third Circuit found that a heightened standard of review was warranted due to the cumulative procedural irregularities committed by the insurer. In particular, the insurer attempted to use the claimant’s Social Security benefits to offset her disability benefits despite the plan not allowing such an offset; it terminated her benefits in part because she allegedly refused to undergo a functional capacity examination when the record reflects that she did not refuse the exam; it relied heavily on a medical records review; it continued to investigate her claim after surveillance showed that she did not leave her home; it pursued her tax returns in the face of ambiguous plan language; and it ignored the Social Security finding of disability despite its relevance. Because the district court only used a slightly heightened review, as opposed to a highly searching standard, the case was remanded to the district court for a determination under the correct standard.

- ***Baida v. First Unum Life Ins. Co.*, 2007 WL 4467637 (9th Cir. 2007) (unpublished)**: The Ninth Circuit ruled that the insurer did not abuse its discretion when it denied the plaintiff’s claim for disability benefits. Although the district court’s opinion was rendered before *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir.2006), the court held that the district court’s decision would have been sufficient under the more heightened, skeptical abuse of discretion review required by *Abatie*. The record showed that the district court allowed the plaintiff and her counsel multiple opportunities to submit additional evidence, the insurer thoroughly reviewed and considered all new evidence, and conducted independent medical reviews of the plaintiff’s condition. The insurer therefore engaged in an “ongoing, good faith exchange of information” with the plaintiff.

- ***Frost v. Metropolitan Life Ins. Co.*, 470 F.Supp.2d 1101 (C.D.Cal. 2007)**: The plaintiff, an operations manager/vault cashier at a bank, claimed that she was disabled due to problems with cognition, ambulation, and the use of her upper extremities. Her neurologist could not provide a diagnosis but opined that she was disabled. The insurer terminated the claim after obtaining multiple medical reviews which found that while there was some degree of impairment, the plaintiff was not fully disabled. In one of the first decisions to analyze a disability claim under the standards set forth in the Ninth Circuit decision, *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (2006) , the court concluded that the insurer’s decision was entitled to deference and that the structural conflict of interest should not be weighed heavily in deciding whether the insurer abused its discretion. The plaintiff failed to establish that the insurer did not

adequately investigate or credit the evidence. The court held that the insurer did not abuse its discretion in terminating long-term disability benefits. Neither the insurer nor its physician consultants were required to disregard the opinions of the plaintiff's other doctors which were less than favorable to her, nor were they required to ignore the medical tests and evidence which contradicted the plaintiff's subjective complaints of pain and lack of cognitive ability.

4. Procedural Irregularities under the DOL Regulations

In 2000, the Department of Labor ("DOL") revised the regulations which govern health and disability claim procedures subject to ERISA. *See* 29 C.F.R. §2560.503-1. The revised regulations, which apply to claims submitted on or after January 1, 2002, imposed increased requirements on claims administrators during both the initial claims process and for the mandatory review on appeal, as well as various consequences for administrators that failed to abide by the new requirements. These regulations go hand-in-hand with the ERISA-mandated claim procedures outlined in 29 U.S.C. Section 1133, which require plan administrators to give "adequate notice" to claimants regarding the basis for a claim denial and afford a reasonable opportunity for claimants to obtain a "full and fair review" of the claim denial.

Although the revised DOL regulations have been in force for over five years, many questions still exist as to their interpretation and application. Claimants' attorneys frequently argue that violation of the regulations affects the standard of review applicable to benefits decisions and the make-up of the administrative record subject to review by the court. Case law in past years has revealed courts' differing views on administrators' violations of failure to the disclosure, notice, timing, and appeals requirements of the regulations.

(a) Disclosure of "Relevant" Documents

Under the revised regulations, administrators are required to produce, upon request and free of charge, "all documents, records and other information relevant to the claimant's claim for benefits." 29 C.F.R. 2560.503-1(h)(2)(iii). "Relevant" documents are those which (a) were relied on in making a benefit determination; (b) were submitted, considered or generated during the course of making the benefit determination, regardless of whether relied upon; (c) demonstrate compliance with the administrative processes and safeguards designed to verify that the claim determinations are made in accordance with governing plan documents; and (d) constitute a statement of policy or guidance for the plan regarding the denied benefit for the claimant's diagnosis, regardless of whether such advice or statement was relied on in making the benefit determination. 29 C.F.R. 2560.503-1(m)(8)(i)-(iv).

The recent trend among claimants and their attorneys is to ask for documents generated during the appeal process, such as independent medical examination reports, functional capacity evaluations, and vocational assessments, to be produced before the final benefit decision is made. They primarily rely on *Abram v. Cargill, Inc. and Associated Companies Long Term Disability Plan*, 395 F.3d 882 (8th Cir. 2005), where the court concluded that such information is necessary to engage in a “meaningful dialogue” in order afford a “full and fair review” of the claim decision on appeal. 29 U.S.C. §1133.

- ***Metzger v. UNUM Life Insurance Co. of America*, 476 F.3d 1161 (10th Cir. 2007):** The plaintiff argued that the insurer failed to provide her with a “full and fair” administrative review by denying her the opportunity to respond to the opinions of its medical reviewers during the course of her administrative appeal. The court held that a plan administrator is not obligated to provide a claimant with access to the reports of appeal-level reviewers prior to a final decision on appeal. As long as the appeal-level reviews “analyze evidence already known to the claimant and contain no new factual information or novel diagnoses,” this was consistent with “full and fair review.” Otherwise, “[p]ermitting a claimant to receive and rebut medical opinion reports generated in the course of an administrative appeal – even when those reports contain no new factual information and deny benefits on the same basis as the initial decision – would set up an unnecessary cycle of submission, review, re-submission, and re-review.” *Id.* at 1167.

- ***Peterson v. Fed. Express Corp. Long Term Disability Plan*, 2007 U.S. Dist. LEXIS 41590 (D. Ariz. 2007):** The court rejected the plaintiff’s contention that a higher standard of review was warranted because the plan failed to disclose the reports from its medical reviewers prior to issuing the final benefits determination. The court held that the purpose of ERISA’s requirement of full and fair review was satisfied because, even without disclosure of the reports, the plaintiff had enough information to adequately prepare for her lawsuit.

- ***Niles v. American Airlines, Inc.*, 2007 U.S. Dist. LEXIS 708 (D. Kan. 2007):** The court rejected plaintiff’s argument that she was not given a full and fair review because she had no opportunity to respond to the independent physician’s report. The court held that a rebuttal or last look by the claimant is not among the requirements for a full and fair review. The court reasoned that if the drafters of the regulations had intended that a claimant be provided an opportunity to review and rebut the independent medical evaluation, they would have expressly stated so in the full and fair procedures requirements. The plaintiff’s proffered procedure would “pose the specter of endless review, undermining the finality and certainty of the time periods established in the regulation. If a claimant were to review the independent health care professional’s findings, then submit rebuttal containing medical information, this would be followed by

another required administrator's evaluation by an independent health professional." *Id.* at *38.

(b) Notice of Adverse Benefit Determination

The ERISA regulations mandate a baseline procedural protection that the claimant be given sufficient notice of why the claim was denied so that he or she can submit a meaningful appeal. Denial letters must give (1) the specific reason(s) for the claim determination, (2) the specific plan provisions on which the denial is based, (3) 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, (4) an outline of the steps required if the claimant wishes to request an appeal, and (5) citation to an "internal rule, guideline, protocol, or other similar criterion" relied on in making the adverse determination. 29 C.F.R. §2560.503-1(g)(i)-(v)(A). These rules apply to both initial claims determination letters, as well as determinations on appeal.

• ***Saffon v. Wells Fargo & Co. Long Term Disability Plan*, __ F.3d __, 2008 WL 80704 (9th Cir. 2008)**: The court held that the insurer failed to provide a "full and fair review" of the participant's claim because it tacked on a new reason for denying benefits in its final decision. Specifically, the insurer noted for the first time on appeal that the lack of functional capacity evaluation prevented its ability to objectively measure and document the plaintiff's current level of functioning. "Insofar as MetLife believed that a functional capacity evaluation, or some other means of objectively testing Saffon's ability to perform her job, was necessary for it to evaluate Saffon's claim, it was required to say so at a time when Saffon had a fair chance to present evidence on this point." *Id.* at *7. The Ninth Circuit remanded the claim to the district court to allow the plaintiff an opportunity to present evidence of a functional capacity evaluation or other objective evidence. The court provided guidance that the plaintiff need not present the results of such an evaluation, but may instead, offer evidence that such evidence is not available or not particularly useful in diagnosing her ability to return to her job. The court found that as a practical matter, it may be unnecessary for the district court to determine the degree of deference to give the insurer's decision, as the admission of significant new evidence will require a *de novo* reconsideration of the decision. (This decision seems contrary to *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 966-67 (9th Cir. 2006), which instructs that *de novo* review applies only if the administrator's procedural violations are flagrant and caused undue prejudice.)

• ***Wenner v. Sun Life Assur. Co. of Canada*, 482 F.3d 878 (6th Cir. 2007)**: The insurer initially approved disability benefits for the claimant, who had suffered a heart attack, and periodically requested updated medical information. The insurer terminated the claim because it did not receive the updated medical information. The plaintiff later contended that the insurer's letters were sent to the wrong address, although he somehow received the termination letter, appealed and submitted medical information.

After reviewing the supplemental materials submitted, the insurer determined that the plaintiff was not disabled. The insurer's letter on appeal did not provide a means for a second appeal. The Sixth Circuit held that the insurer failed to comply with the notice requirements because the rationale on appeal (finding of no disability) was different than the original basis for the termination (failure to provide medical information). Instead of remanding the claim, the Sixth Circuit held that the appropriate remedy for this procedural violation was the reinstatement of benefits – a remedy. The dissent noted that providing a substantive remedy would unduly increase the stakes because plaintiffs with non-meritorious claims will have an incentive to raise procedural challenges in the hopes of obtaining the reinstatement of benefits.

- ***Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621 (7th Cir. 2005)**: The Court determined that the plan's denial letter did not substantially comply with DOL regulations. Specifically, the letter did not set forth the specific reasons for the denial of benefits as it failed to incorporate the expert's report, did not refer to the plan provision on which the denial was based, did not identify any information that would have allowed the claimant to perfect her claim for appeal, and did not describe the plan's review procedures and time limits. Because the letter did not provide the opportunity for a full and fair review, the Court retroactively reinstated disability benefits.

- ***King v. Hartford Life & Acc. Ins. Co.*, 414 F.3d 994 (8th Cir. 2005)**: In an accidental death case, the Court rejected the administrator's "post hoc rationalization" offered during litigation to justify the claim decision that was reached on different grounds during the administrative process. The Court concluded that the new basis for denial was an unreasonable interpretation of the plan and was inconsistent with the reasons offered in the initial denial.

(c) Timing of Decisions

The revised DOL regulations significantly shortened the deadlines for administrators to render initial claim determinations and decisions on appeal. The former regulations required claim decisions to be made within 180 days from the filing of the claim, otherwise the claim was "deemed denied" and the claimant permitted to proceed to the appeal stage. 29 C.F.R. §§2560.503-1(e)(1), (e)(2), (e)(3) (2000). The former regulations also required a decision on appeal to be made within 60 days, or if "special circumstances" exist, not later than 120 days after receipt of the request for review. 29 C.F.R. §2560.503-1(h)(1)(i) (2000). Otherwise, failure to comply meant the claim was "deemed denied on review" and the claimant was permitted to proceed to litigation. 29 C.F.R. §2560.503-1(h)(4) (2000).

Under the revised regulations, an administrator must give notice of an initial adverse claim decision "within a reasonable period of time, but not later than 45 days

after receipt of the claim by the plan.” 29 C.F.R. §2560.503-1(f)(3). Two extensions of up to 30 days each may be requested if the administrator notifies the claimant before the expiration of the current deadline, if such an extension is necessary due to matters beyond the control of the plan. *Id.* However, the extension request must (a) “specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues,” and (b) give the claimant at least 45 days within which to provide the specified information. *Id.*

Likewise, the revised regulations require an administrator to issue a decision on appeal not later than 45 days after receipt of the claimant’s request for review. 29 C.F.R. §§2560.503-1(i)(1) and (i)(3). An administrator may only obtain one extension of time, not to exceed 45 days from the end of the initial 45-day period, if special circumstances warrant an extension. *Id.* Again, the notice for the extension must delineate the specific reasons requiring the extension and the date the plan expects to render a decision. *Id.*

Despite the shortened time limitations imposed by the revised regulations, the DOL added tolling provisions for initial claims and claims on appeal if the administrator is waiting on information from the claimant. 29 C.F.R. §2560.503-1(f)(4), (i)(4). Still, if the administrator fails to comply with these requirements, a claimant shall be “deemed to have exhausted the administrative remedies available under the plan” and entitled to pursue litigation. 29 C.F.R. 2560.503-1(l).

Many courts have yet to address the impact of these new timing requirements and the difference between the shift from “deemed denied” to “deemed exhausted.” Those courts which have considered these changes frequently seek guidance from cases interpreting the former regulations. We should see more litigation on these issues in the coming year.

- ***Tsagari v. Pitney Bowes, Inc. Long-Term Disability Plan*, 473 F.Supp.2d 334 (D. Conn. 2007):** The plan failed to notify the plaintiff of its intent to seek an extension of the 45-day period to make a determination on her appeal until two weeks after the deadline. The plan argued that it substantially complied with the timing requirements. The court agreed, holding that while the plan’s “timing was not perfect, [it] substantially complied with the applicable deadlines.” Thus, the plan’s claims decision was to be considered under the arbitrary and capricious standard of review.

- ***Towner v. CIGNA Life Ins. Co.*, 419 F.Supp.2d 172 (D. Conn. 2006):** Under the current DOL regulations, the administrator’s decision on appeal was 31 days late. During the appeal, the company had written to the claimant acknowledging the appeal, offered to consider additional information, advised the claim was being evaluated by a medical professional, and notified the claimant of the need of an extension of time provided by the regulations. After the regulatory deadline, an in-house doctor reviewed

the claim, resulting in a denial of the appeal. The district court held that the new regulations do not impact the *Nichols* rule that late appeals decisions do not normally receive arbitrary and capricious review. The court determined the administrator had not “substantially complied” with the regulations because there was no good faith exchange of information or ongoing productive evidence-gathering process during the delay. The court applied a *de novo* review, ultimately finding in the plaintiff’s favor.

- ***Gatti v. Reliance Std. Life Ins. Co.*, 415 F.3d 978 (9th Cir. 2005):** The administrator upheld a claim denial on appeal 177 days after receiving the claimant’s request for administrative review and invited the claimant to provide any additional evidence to support her claim. Another review was requested, but the administrator waited 279 days to conclude that the information submitted was insufficient to reverse its denial. Analyzing the prior DOL regulations, the Ninth Circuit found that the district court had erred in applying a *de novo* review based on the administrator’s missed deadlines. The Court held that it would be inconsistent with *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984) to change the standard of review based on technical violations of ERISA’s requirements unless those violations are so flagrant as to alter the relationship between the employer and employee, thereby causing the beneficiary substantive harm. *Gatti* therefore limited *Jebian* to cases where the administrator failed to comply with plan terms as opposed to the federal regulations.

- ***Nichols v. Prudential Ins. Co. of America*, 406 F.3d 98 (2nd Cir. 2005):** The administrator failed to render a formal decision on an appeal after 197 days, and the claimant filed suit. The district court applied the former DOL regulations and remanded the case to the administrator for further assessment. The Second Circuit disagreed. It reasoned that even if the plan documents gave discretionary authority, which it did not find, the claim was “deemed denied” because the administrator had not made a valid exercise of discretion or even rendered a decision within the regulatory time frame. Therefore, the district court must apply a *de novo* standard of review in evaluating the claim decision. The Court refused to apply a “substantial compliance” approach to the regulations.

- ***Jebian v. Hewlett-Packard Co. Employee Benefit Plan*, 349 F.3d 1098 (9th Cir. 2003), cert. denied, 2005 U.S. App. LEXIS 5037 (U.S. 2005):** The plan failed to respond to an administrative appeal within the 60-day deadline imposed by the former DOL regulations and did not request information from the claimant until the 119th day, one day short of the 120-day requirement for final determination. The plan contained a “deemed denied” provision for decisions not timely made. The district court concluded the claim was “deemed denied” based on the plan terms and the DOL regulations, but nonetheless applied an abuse of discretion standard of review and granted summary judgment to the plan. The Ninth Circuit reversed and held that an administrator’s failure to render a decision within the time allotted by the plan changed the standard of review

from abuse of discretion to *de novo*, if it was more than a minor procedural violation. The court allowed an exception to *de novo* review where the administrator could demonstrate “substantial compliance” with the deadlines by having maintained an “ongoing, meaningful dialogue.” *Id.* at 1107.

(d) Procedures on Appeal

The DOL regulations require every employee benefit plan to establish and maintain a procedure by which a claimant can appeal an adverse benefit determination, and also require that the administrator comply with certain guidelines which will afford a full and fair review of that determination. 29 C.F.R. §§2560.503-1(h)(1), (2). In addition to these general rules, the revised regulations impose detailed procedures governing an ERISA administrator’s review of an initial adverse claim determination. Specifically, (1) the plan may not afford deference to the initial adverse benefit determination; (2) the review must be conducted by an appropriate fiduciary who is neither the person who made the initial determination or his/her subordinate; (3) in a case requiring medical judgment, the review must include consultation with a health care professional with appropriate training and experience in the medical field involved in the medical judgment; and (4) the records must identify the medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, whether or not the advice was relied on. 29 C.F.R. 2560.504-1(h)(3), (h)(4).

• ***Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389 (5th Cir. 2006):** The Fifth Circuit determined that Aetna failed to comply with ERISA procedures due to procedural irregularities. Not only did Aetna fail to identify the vocational expert consulted, but it shifted its justification for upholding the claim denial on appeal. As such, the claimant was unable to challenge Aetna’s information or obtain meaningful review of the reason his benefits were terminated. The court reviewed Aetna’s claim decision under a modified abuse of discretion standard and concluded it had abused its discretion as the record reflected no vocational analysis which would support its decision. The court refused to consider DOT information offered by Aetna during litigation because it fell outside the administrative record.

5. What upcoming ERISA issues will be decided by the U.S. Supreme Court next?

In the year 2008, we can look forward to seeing whether the United States Supreme Court and the circuits will reassess their treatment of structural conflicts of interests. As the Supreme Court held nearly 20 years ago, if a plan grants the insurer the right to determine eligibility for benefits or to construe the terms of the plan, it has discretionary authority. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Under a discretionary standard, if the administrator is operating under a conflict of interest, the arbitrary and capricious standard is still applicable, but the conflict must

be weighed as a “facto[r] in determining whether there is an abuse of discretion.” *Firestone*, 489 U.S. at 115. One type of conflict is the structural conflict of interest that courts have found to exist where the insurer is both the claim decision maker and payor of benefits. The circuits have adopted different approaches to factor structural conflicts into the review of ERISA benefits decisions. The majority of the circuits (Third, Fourth, Fifth, Ninth, and Tenth) have found that a plan administrator that also pays plan benefits is operating under a conflict of interest that must be taken into account in judicial review of the benefit decision. The First and Seventh Circuits have found that the mere fact that a plan administrator also pays benefits is not a conflict that courts necessarily have to take into consideration, while the Second and Eighth Circuits have required that some evidence be presented that an administrator was influenced by the conflict before a more stringent review would be triggered. In the Eleventh Circuit, once the structural conflict of interest is established, the burden shifts to the administrator to prove that its decision was not influenced by a conflict.

The circuit courts and even the U.S. Supreme Court have been urged to help resolve the split among the circuits. A petition for certiorari was filed in *MetLife v. Glenn*, 461 F.3d 660 (6th Cir. 2006), in which the Supreme Court invited the Solicitor General to file a brief on behalf of the United States. In its brief, the Solicitor General advised that the Supreme Court should resolve the circuit split, taking the position that a structural conflict is a factor that must be taken into account by the reviewing court. It advocated that the Supreme Court adopt a version of the “sliding scale” test, whereby the amount of deference applied by the Court is determined by the extent of the conflict. This case is being closely followed.

It appears that the First and Eleventh Circuits are also prepared to reconsider their position on structural conflicts of interest. In *Denmark v. Liberty Life Assurance Co.*, 481 F.3d 16, 19 (1st Cir. 2007), two of the three panel judges endorsed reexamining the proper standard of review in an *en banc* hearing. The petition for rehearing *en banc* is presently pending before the First Circuit, which is apparently awaiting resolution of *MetLife v. Glenn*. Likewise, early this year, the panel in *Doyle v. Liberty Life Assur. Co.*, 2008 U.S. App. LEXIS 176 (11th Cir. 2008), found that the heightened arbitrary and capricious standard was troublesome, and urged an *en banc* review to consider adopting a “workable” standard.

C. Discovery: What Should You Expect?

1. ERISA

Discovery is becoming increasingly more common in ERISA cases. Plaintiffs typically assert the need for discovery to determine whether there was a conflict of interest, which could impact the standard of review. To that end, plaintiffs have issued written discovery and sought depositions of claims consultants, medical reviewers,

examiners, and others, to critique the claim and assert that these individuals' findings were tainted by bias, for instance, based on the compensation they received from the administrator. In recent years, the courts have become more willing to grant such discovery. However, the courts have cautioned that discovery in ERISA cases should be limited, and not a mere rehashing of the claim. In a sensible approach, some courts, including the First and Seventh Circuit, have insisted that the plaintiff make a threshold showing of an actual conflict on the face of the administrative record before discovery may be had.

- ***Asuncion v. Metropolitan Life Ins. Co.*, 493 F.Supp.2d 716 (S.D.N.Y. 2007)**: After reviewing the insurer's contracts with two independent medical personnel *in camera*, the court held that one of the contracts did not have to be produced because nothing suggested that the doctor served in anything other than an independent capacity. However, the court ordered the contract with the other doctor to be produced because there was a suggestion in the contract that the doctor may have been hired to serve as a consultant in the first instance as the result of her espousal of a particular point of view as to whether it was generally in a claimant's best interest to work, rather than to receive disability benefits.

- ***McInerney v. Liberty Life Assur. Co.*, 2007 U.S. Dist. LEXIS 40962 (W.D. Tenn. 2007)**: The court denied discovery purportedly relevant to bias, conflict of interest, and the manner in which the decision to terminate benefits was reached. The discovery requests sought the identity of the individuals who participated in the decision to terminate the disability benefits, the title and compensation of such persons, whether the employer of the doctors who reviewed the file was owned by or affiliated with the insurer, the number of claims each physician reviewed for the insurer in the years 2005 and 2006, the amount paid by the insurer to each physician in 2005 and 2006, the number of chronic regional pain syndrome patients each physician had treated over the past ten years, and the number of disability claims involving chronic regional pain syndrome each physician had consulted on during the past ten years. In the Sixth Circuit, there is no automatic right to limited discovery as to procedural irregularities, and some initial showing of procedural irregularity must be presented before discovery will be allowed in ERISA cases. The court held that the plaintiff did not meet this standard.

- ***Security Mut. Life Ins. Co. of New York v. Joseph*, 2007 WL 1944345 (E.D.Pa. 2007)**: The court held that "in order to receive discovery beyond the claims administrator's determination, a claimant alleging a conflict of interest must demonstrate that the plan administrator had an inherent structural conflict of interest, point out specific indicia tending to indicate the existence of a conflict of interest in the non-inherent conflict context or demonstrate a procedural irregularity, bias or unfairness in the claims review process on the face of the administrative record." The mere allegation that a plan administrator had a conflict of interest was alone insufficient to warrant discovery. The

court held that because the ERISA plan was funded and administered by an allegedly inherently conflicted administrator, the insurer should be submitted to limited discovery on the issue of the conflict of interest.

- ***Doe v. Hartford Life and Acc. Ins. Co.*, 2007 WL 1963019 (D.N.J. 2007):** The court upheld the magistrate judge’s decision to grant the insurer’s motion to compel the depositions of the plaintiff’s treating physicians in order to clarify the medical terminology in the case. The treating physicians, who opined that the plaintiff’s bipolar disorder was biological in nature, supported the plaintiff’s claim that his condition was not subject to the “mental illness” limitation in the long-term disability policy. The plaintiff argued that the depositions should be disallowed because the case was subject to the arbitrary and capricious standard of review. The court disagreed, holding that the depositions fell within the Third Circuit’s “medical issues” exception to the general rule. “[T]he District Court may take further evidence to aid in its understanding of the medical issues involved.” *Id.* at *2 (citing *Kosiba v. Merck & Co.*, 384 F.3d 58, 67 n. 5 (3d Cir. 2004)).
- ***Groom v. Standard Ins. Co.*, 492 F.Supp.2d 1202 (C.D.Cal. 2007):** The court held that an ERISA plaintiff is entitled to limited discovery concerning the question of a conflict of interest subsequent to the Ninth Circuit’s decision in *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006). “However, such discovery must be narrowly tailored and cannot be a fishing expedition.” *Id.* at 1205. (The specific discovery requests were not identified in the opinion.)
- ***Baldoni v. UNUMProvident*, 2007 U.S. Dist. LEXIS 14127 (D. Or. 2007):** The court denied the plaintiff’s requests for discovery seeking broad, generalized information regarding the insurer’s handling of other claims and disputes, as well as its general financial performance over an extended period of time. The court held that the rationale for constraining discovery in ERISA cases remains equally in force after *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (2006). Discovery should only be allowed when narrowly tailored to significantly illuminate the conflict’s effect on the specific benefit decision under review. Here, the discovery sought was not tailored to show the effect of the structural conflict of interest on the specific decision at issue with any more precision than the information already in plaintiff’s possession or in the public realm.
- ***Broeski v. Provident Life and Acc. Ins. Co.*, 2007 WL 1704012 (N.D. Ill. 2007):** The court denied the plaintiff’s requested discovery on conflict of interest issues (actual requests unspecified) based on the standards presented in *Semien v. Life Insurance Company of North America*, 436 F.3d 805 (7th Cir. 2006). In *Semien*, the Court held that “[a] claimant must demonstrate two factors before limited discovery becomes appropriate. First, a claimant must identify a specific conflict of interest or instance of misconduct. Second, a claimant must make a prima facie showing that there is a good cause to believe limited discovery will reveal a procedural defect in the Plan

administrator's determination." The court held that the plaintiff's allegations of bias by the independent medical examiner were insufficient to trigger discovery. "The fact that a doctor is regularly consulted by an insurance company (or defense interests more generally) does not, *ipso facto*, render the doctor biased. Were that the case, any time an insurer used in-house doctors in deciding eligibility for benefits, a plaintiff challenging a denial of benefits could claim bias and open the door to discovery. Such a result would make discovery in those cases the rule and not the exception, which plainly is not the law." *Broeski*, at *1. Moreover, the plaintiff's reliance on the regulatory settlement agreement entered into by the insurer, which contained no findings or admissions of misconduct, did not entitle her to discovery.

- ***Arnold ex rel. Hill v. Hartford Life Ins. Co.*, 2007 WL 1389606 (W.D.Va. 2007)**: The court granted the plaintiff relief from the scheduling order to seek discovery. In this *de novo* accidental death insurance case, the decedent was killed in a motorcycle accident. His blood alcohol level was .18%. Based on this result, the insurer denied the claim on the basis that it was reasonably foreseeable that death or serious injury could occur. The plaintiff requested a deviation from the scheduling order to conduct discovery regarding the accuracy of the blood test taken by the medical examiner. Her request was granted.

- ***Termini v. Life Ins. Co. of North America*, 2007 WL 1556850 (E.D.Va. 2007)**: The court permitted discovery regarding an accidental death insurance claim subject to *de novo* review. The decedent sustained injuries as a result of a fall while jogging. Because of the fall, the decedent suffered a basilar skull fracture and subarachnoid hemorrhage. The insurer denied the claim, contending that it was not proven that the decedent's death resulted solely from an accident, and not by sickness, disease, or bodily infirmity. The court permitted discovery, finding that resolution of the dispute in litigation required an understanding of complex medical terminology and causation. Under these exceptional circumstances, along with plaintiff's allegation that the insurer did not evaluate all of the evidence available to it in administering plaintiff's claim, the court found that the admission of additional evidence was warranted.

- ***Doe v. MAMSI Life and Health Ins. Co.*, 448 F.Supp.2d 179 (D.D.C. 2006)**: A plaintiff whose ERISA health care benefits were denied sought discovery regarding the total number of benefits claims for treatment of bulimia nervosa and number of claims denied. The court denied the requests as seeking information far beyond the administrative record and the scope of permissible discovery in a case subject to deferential review.

- ***Pylant v. Hartford Life & Acc. Ins. Co.*, 2006 U.S. Dist. LEXIS 2106 (N.D. Tex. 2006)**: The court granted the plaintiff's motion to compel answers to interrogatories and document requests with respect to the plan administrator's compensation of its employees involved in the disability claim. The court denied

discovery as to the number of record reviews done by the consultants that examined the insured.

- ***Samedy v. First Unum Life Ins. Co. of Am.*, 2006 U.S. Dist. LEXIS 13375 (E.D.N.Y. 2006)**: The court permitted the deposition of the insurer's claims handler to allow the plaintiff to determine whether insurer's decision to deny benefits was influenced by a conflict of interest.

2. Individual Disability Cases

Traditionally, in discovery and at trial, insurers have tried to limit discovery in bad faith claims by arguing that the analysis of whether bad faith conduct exists should be restricted to whether the specific claim at issue was reasonably handled on its merits. That fight, however, has proven more difficult at the discovery stage of litigation since *State Farm Mutual Automobile Insurance Co. v. Campbell*, 538 U.S. 408 (2003). In *Campbell*, the Supreme Court held that a punitive damages award of \$145 million, where full compensatory damages were \$1 million, was excessive and violated the Due Process Clause of the Fourteenth Amendment. As part of its decision, the Supreme Court held that evidence of State Farm's dissimilar out-of-state conduct in its purported nation-wide scheme to meet corporate fiscal goals was inadmissible and should not have been relied on by the lower courts.

Similarly, in *Philip Morris USA v. Williams*, 127 U.S. 157, 127 S.Ct. 1057, 1063, (2007), the Supreme Court recently held that the Due Process Clause "forbids a State to use a punitive damages award to punish a defendant for injury that it inflicts upon nonparties." *Williams* clarified that a plaintiff may offer evidence of "harm to other victims" to show the reprehensibility of a defendant's conduct in a particular case. 1257 S.Ct. at 1063-64. "Evidence of actual harm to nonparties can help to show that the conduct that harmed the plaintiff also posed a substantial risk of harm to the general public, and so was particularly reprehensible." *Williams*, 127 S. Ct. at 1064. However, "a jury may not go further than this and use a punitive damages verdict to punish a defendant directly on account of harms it is alleged to have visited on nonparties." *Id.* Where the possibility of harm to defendants exists, a court "must provide some form of protection" to assure that juries are considering the proper question.

Courts are still trying to clarify the extent and nature of the nexus of the similarity of improper conduct that plaintiff insureds must demonstrate at trial. Because insureds must garner evidence of a nexus of similar harm to present as evidence of a bad faith pattern and practice, their discovery will likely become more far-reaching into areas of (1) the insurer's past similar conduct; (2) acts or harm to others in the same state; and (3) potential harm to others from the same or similar acts.

Several courts have recently addressed the scope of discovery in cases with bad faith allegations. For the most part, such courts are bypassing the limitations imposed by *Campbell* and opening the door to vast discovery so long as insureds alleged that insurers have a company-wide practice of misconduct that affects all states. The acknowledgement in *Williams* that evidence of actual harm to nonparties may be used to show a risk of harm to the general public furthers the prospect that broader discovery will be allowed. The courts rationalize such discovery on the grounds that relevancy is more loosely construed in pre-trial discovery than at trial.

- ***Etten v. U.S. Food Serv., Inc.*, 2006 U.S. Dist. LEXIS 10687 (N.D. Iowa 2006)**: The court allowed the plaintiff to obtain information regarding other bad faith lawsuits as relevant to a pattern of claims handling practices. However, the court rejected the plaintiff's request for reserve information and for the entire claim manual, when relevant portions had already been produced.

- ***Sherrill v. Progressive Northwestern Ins. Co.*, 2005 ML 475, 2005 Mont. Dist. LEXIS 1055 (D. Mont. 2005)**: The plaintiff sought discovery concerning denials of uninsured motorist claims made by other customers. The court found that *Campbell* did not apply to preclude such discovery because evidence of the insurer's prior bad acts could be admissible and relevant to assess the insurer's actions in other cases. The court allowed discovery of the names and address of other insureds who had been denied benefits, along with the basis for the denial of benefits, but denied discovery of other insureds' claims files and coverage opinions by counsel.

- ***Smith v. Budget Rent A Car of Bozeman*, 2005 ML 2037, 2005 Mont. Dist. LEXIS 1182 (D. Mont. 2005)**: The court accepted plaintiff's argument that *Campbell* did not bar discovery of insurer's out-of-state conduct to support a punitive damages claim. The court allowed discovery regarding all relevant claims manuals and lawsuits and denials from Montana and other states.

- ***Saldi v. Paul Revere Life Ins. Co.*, 224 F.R.D. 169, 2004 U.S. Dist. LEXIS 16318 (E.D. Pa. 2004)**: After paying insured's total disability claim for 17 months, the insurer denied the claim on the grounds that the insured's doctor said he could perform his occupation. The insured sued for breach of contract, as well as violations of Pennsylvania's unfair practices and bad faith statutes. The court allowed the insured's numerous, broad discovery requests based on the allegation that the insurer created a budget for claim payments and that termination ratios were used to make certain that claims stayed within that budget. Citing company-wide practices that had been used as evidence in other lawsuits against the same insurer, the district court allowed a wide spectrum of discovery, including production of internal corporate documents, personnel files, information regarding mergers with other companies, and affidavits/depositions given by employees who handled the insured's claim. The court also ordered depositions

of corporate designees on claims-handling policies and an in-house attorney who was consulted about the case in anticipation of litigation. The court only barred discovery that was “unrelated” to the allegation of bad faith practices, such as the insurers’ alleged practice of hiring IMEs when no IME had been performed on the claim, and documents regarding high legal exposure states if Pennsylvania was not one of them.

A few courts have limited over-reaching discovery:

- ***State ex rel. Erie Ins. Prop. & Cas. Co. v. Mazzone*, 648 S.E.2d 31 (W.Va. 2007)**: Claimant/respondent alleged bad faith against the insurer of a driver in an underlying negligence claim which settled. The trial court ordered production of the insurance company’s raw data indicating reserve amounts and the dates the reserves amounts were placed on the claim. The insurer petitioned for a writ of prohibition on the grounds that the materials were opinion work product and therefore privileged. The court found that the materials were prepared in the ordinary course of business and were neither prepared by an attorney nor prepared in anticipation of litigation, and therefore did not qualify as either fact or opinion work product.

- ***Cent. Ga. Anesthesia Servs., P.C., v. Equitable Life Assur. Soc’y of the United States*, 2007 U.S. Dist. LEXIS 53791 (M.D. Ga. 2007)**: Defendant denied benefits under a policy issued to plaintiff for the purchase of a disabled doctor’s interest. In the resulting breach of contract and bad faith action, the court held that information that could shed light on the reasonable and probable cause for the insurer’s refusal to pay the claim was discoverable, including reserves, employee compensation, and communications and financial statements regarding losses on business protection policies. However, information on why the insurer stopped selling and/or issuing disability income business protection policies was not discoverable.

- ***Hage v. UnumProvident Corp.*, 2006 U.S. Dist. LEXIS 518 (D. N.J. 2006)**: The court rejected the plaintiff’s efforts to obtain discovery related to his RICO claim, namely subpoenas relating to a report issued by the Georgia Department of Insurance, third parties, litigants and witnesses from other litigation involving the same defendant, and information regarding cases involving whistleblowers or punitive damages. The court denied plaintiff’s requests as unduly burdensome and unlikely to lead to the discovery of admissible evidence. The court affirmed the magistrate judge’s order to stay discovery on the RICO claim unless plaintiff was granted summary judgment on his bad faith claim.

- ***Bondex Int’l, v. Hartford Acc. & Indem. Co.*, 2006 U.S. Dist. LEXIS 6044 (N.D. Ohio 2006)**: The court required the production of reinsurance agreements for the plaintiffs’ policies, but rejected the request for reinsurers’ reserve settings. The court concluded that the amount of reserves reflected a business decision that was irrelevant to

the case issues. Moreover, the decision constituted the work product of legal counsel or the risk management department and was therefore protected work product.

- ***Nicholas v. Bituminous Cas. Corp.*, 2006 U.S. Dist. LEXIS 13271 (N.D. W.Va. 2006)**: The court denied plaintiffs' attempt to obtain reserve information to demonstrate bad faith claims handling. The court held that the reserve documents contained only the mental impressions, conclusions and opinions reached by line claims handlers in setting loss reserves for plaintiffs' claims and were protected work product. The reserve documents did not contain opinions from legal counsel concerning the investigation and defense of the insureds' interests in the underlying tort claim, which could potentially be discoverable with the assertion of the insurers' "advice of counsel" defense.

D. Statute of Limitations

- ***White v. Sun Life Assur. Co.*, 488 F.3d 240 (4th Cir. 2007)**: The insurer contended that the suit was time-barred by a plan provision because the statute of limitations began to run at an earlier date than federal law ordinarily provided. The district court held that ERISA's remedies framework did not permit a plan to start the clock on a beneficiary's cause of action before the beneficiary could file suit and that the denial of benefits constituted an abuse of discretion. On appeal, the court affirmed. The court held that the accrual provisions in the plan were contrary to the remedies framework established by ERISA, which required exhaustion of administrative remedies such that a cause of action did not accrue until a benefits claim was formally denied. The plan's provision acted as an incentive to delay resolution of a beneficiary's claims and generated uncertainty as to a beneficiary's rights.

E. Attacks on the Attorney-Client Privilege

1. ERISA – The Fiduciary Exception

Insurers typically assert that communications with in-house or outside counsel during the course of a claim are protected by the attorney-client privilege. However, an exception known as the "fiduciary exception" applies to void the privilege in ERISA cases. The fiduciary exception generally provides that "an employer acting in the capacity of ERISA fiduciary is disabled from asserting the attorney-client privilege against plan beneficiaries on matters of plan administration." *Becher v. Long Is. Lighting Co. (In re Long Is. Lighting Co.)*, 129 F.3d 268, 272 (2d Cir. 1997). The exception as applied in ERISA cases is rooted in two rationales. Some courts have held that the exception derives from an ERISA trustee's duty to disclose to plan beneficiaries all information regarding plan administration. See e.g., *Becher*, 129 F.3d at 271-272. Other courts have instead focused on the role of the trustee and have endorsed the notion that "as a representative for the beneficiaries of the trust which he is administering, the trustee

is not the real client in the sense that he is personally being served.” *United States v. Evans*, 796 F.2d 264, 266 (9th Cir. 1986).

- ***Wachtel v. Health Net, Inc.*, 482 F.3d 225 (3rd Cir. 2007)**: The Third Circuit held that the fiduciary exception to the attorney-client discovery privilege does not apply to an insurer and its corporate parents because “the plaintiff-beneficiaries are not the ‘real’ clients obtaining legal representation.” *Id.* at 234. In arriving at this conclusion, the court analyzed four factors to determine the identity of the client: (1) the unity of ownership and management; (2) conflicting interests regarding profits; (3) conflicting fiduciary obligations; and (4) payment of counsel with the fiduciary’s own funds. In addition, the court held that a fiduciary’s duty to disclose did not provide a rationale for applying the fiduciary exception. It reasoned that Congress specifically provided that the assets of an insurance company need not be held in trust. 29 U.S.C. § 1103(b)(1)-(2). Thus, it believed that Congress did not intend to impose upon insurance companies doing business with ERISA-regulated plans the same disclosure obligations that have been imposed upon trustees at common law.

- ***Asuncion v. Metropolitan Life Ins. Co.*, 493 F.Supp.2d 716 (S.D.N.Y. 2007)**: The court ordered the production of written communications concerning denial letters between the insurer’s case manager who handled the plaintiff’s claim for benefits and the insurer’s in-house attorney on several grounds. First, with regard to the attorney’s e-mail attaching a revised version of the case manager’s June 2005 denial letter to the plaintiff, the court held that the insurer made no showing that either the e-mail or its attachment met the criteria for a privileged communication. There was nothing in the documents that showed the court whether any legal advice was requested or provided. Second, communications regarding an April 2006 draft denial letter were subject to production due to the fiduciary exception. The insurer contended that the fiduciary exception did not apply because the communications were made after the challenged benefits determination took place. The court disagreed, holding that the draft letter did not represent a final decision regarding the plaintiff’s entitlement to benefits. The court held that even though the plaintiff had previously sued for benefits, suggesting an increased likelihood that she would sue again if her benefits were not restored, the mere fact that “an adversarial relationship existed as a general matter” as the result of the prior suit did not mean that the insurer was no longer required to act as a fiduciary with respect to any subsequently-presented claim. “The ‘mere prospect of litigation’ is not enough to ‘render communications between fiduciaries and counsel privileged, because the prospect of litigation is always present in decisions about whether to grant or deny benefits.’” *Id.* at 722 (citing *Black v. Bowes*, 2006 WL 3771097 (S.D.N.Y. 2006)).

- ***Smith v. Jefferson Pilot Financial Ins. Co.*, 245 F.R.D. 45 (D.Mass. 2007)**: The court held that the fiduciary exception defeated the insurer’s claim of privilege for communications between the claims personnel and in-house attorney during

a claim. With one exception, the documents at issue were generated in connection with the insurer's processing of the plaintiff's claim for benefits and before a final benefits determination was made. "Although they demonstrate that claims personnel were seeking advice for the purpose of responding to inquiries and assertions from Smith's attorney, the documents concern issues of plan administration and are entirely unrelated to the defense of a pending legal action or other non-fiduciary matter." *Id.* at *48. The court allowed the insurer to redact one document which contained internal settlement considerations.

- ***Shields v. Unum Provident Corp.*, 2007 WL 764298 (S.D. Ohio 2007):** In an action brought under both ERISA and RICO, the court held that the insurer waived attorney-client privilege because the withheld documents had been "exposed to all claims administrators as documentation of the claim handling process and were Bates numbered and included in the claim files," and that claims administrators employed by the insurer were "third parties" for purposes of the privilege analysis. The court further held that the documents fell squarely under the fiduciary exception to the attorney-client privilege because they "appear to be directed only at plan administration, rendering advice (if any) on the claims before the final denial of the claims," and because no legal advice was given for the personal protection of the administrators.

2. Individual Disability Cases

- ***Merrick v. Paul Revere Life Ins. Co.*, 500 F.3d 1007 (9th Cir. 2007):** The Ninth Circuit upheld the district court's order suppressing certain evidence placed in the claim file after litigation commenced. The district court found that the insurers withheld evidence that they were ordered to produce regarding their post-litigation treatment of the plaintiff's claim. The insurers had contended that they did not withhold any privileged documents. However, they invoked the attorney-client privilege in response to a specific document production request, and continued to do so even after the magistrate judge instructed them not to invoke the privilege unless the privilege was actually shielding documents. The Ninth Circuit found that the defendants' pre-trial conduct and the dearth of documents actually produced supported an inference that the defendants withheld documents in violation of the magistrate's order. The district court's order granting plaintiff's *motion in limine* as a discovery sanction was affirmed.

F. Analysis of Bad Faith Allegations in Individual Disability Cases

1. What Constitutes Bad Faith

- ***Wilson v. 21st Century Ins. Co.*, 42 Cal.4th 713 (Cal. 2007):** The insurer initially denied underinsured motorist (UIM) coverage to the plaintiff, a 21-year-old woman, contending that it was "unlikely" that cervical disc bulges were caused by a

high-speed car accident, but instead were related to pre-existing scoliosis and degenerative disc disease. The claims examiner did not obtain a medical review before rendering his opinion. The insured initiated arbitration. After retaining independent physicians to examine Wilson and review her medical records, 21st Century paid the remainder of her UIM policy limit. Wilson sued, alleging that 21st Century's initial denial of benefits and the subsequent two-year delay in payment breached the covenant of good faith and fair dealing. 21st Century moved for summary judgment/adjudication of the bad faith cause of action on the grounds that its decision to deny the claim was reasonable as a matter of law. The superior court granted the motion, but the Court of Appeal reversed. The reversal was upheld by the Supreme Court, which analyzed the bad faith claim under the "genuine dispute" doctrine, noting that the rule only exists where the insurer's position is maintained in good faith and on reasonable grounds. *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.*, 90 Cal.App.4th 335, 347 (2001). The Court held that the claims examiner's decision lacked thorough investigation and a fair evaluation. It rejected the insurer's arguments that grounds existed for a genuine dispute: that the first x-ray was normal, that the plaintiff incurred relatively low medical expenses; and that she traveled extensively post-accident. The court pointed out that the insurer did not deny the existence of disc changes but alleged the damage was pre-existing; that the claim had not been denied on the grounds of modest medical bills and that the plaintiff's claim included future medical damages; and that travel to Europe and Australia did not contradict her claim of continuing neck pain. The dissenting opinion held that 21st Century's actions were reasonable, given that the plaintiff's own experts could not agree on the extent of her injuries.

- *Merrick v. Paul Revere Life Ins. Co.*, 500 F.3d 1007 (9th Cir. 2007): The Ninth Circuit upheld a jury verdict finding bad faith on the part of insurers who denied a long-term disability claim under an "own occupation" policy. The plaintiff was a partner at a venture capital firm who claimed to be disabled from chronic fatigue syndrome. The plaintiff's bad faith expert testified that the insurers engaged in a number of bad faith practices, including: training its claims representatives in "objectification" and "round tabling" claims; attempting to settle for a fraction of the total amount (and threatening to sue for reimbursement if the plaintiff refused to settle); insisting upon "objective medical evidence"; and seeking to get the claim off the books before the end of the fiscal year. The Ninth Circuit ruled that under Nevada law, the evidence was more than sufficient to support the jury's bad faith verdict. Viewing the evidence in the plaintiff's favor, the jury could have found that the insurers conducted a biased investigation of his claim as part of an improper company-wide initiative to target and terminate expensive "own occupation" policies. The jury also could have found that the insurers misrepresented the terms of the policy by requiring the plaintiff to present "objective medical evidence" of his disability. The court concluded there was substantial evidence before the jury that the insurers should be liable for punitive damages.

- ***Lumbermens Mut. Cas. Co. v. Combs*, 873 N.E.2d 692 (Ind. 2007)**: The insured, a radiology technologist, claimed to be disabled due to myelodysplastic syndrome, anemia, fibromyalgia, chronic fatigue, and other conditions. The insurer terminated the insured's disability payments after concluding that she had responded well to treatment and was able to work. The jury found in favor of plaintiff on the contract claim in the amount of \$22,583.75 and on the bad faith claim in the amount of \$1,500,000. The court upheld the bad faith verdict, holding that a reasonable juror could have found that the insurer's claims practices, as implemented in the insured's case, were geared toward terminating her claim and generating profits regardless of her health status. Evidence supporting the verdict included: the reviewing physicians were not permitted to contact the claimant's treating physicians, all of whom considered her to be disabled; the reviewing doctor never conducted a follow-up review of her updated medical records; the insurer ignored the reviewing rheumatologist's request for an independent medical examination and additional diagnostic tests; and the insurer ignored the claimant's Social Security disability determination, but then terminated her claim on the same day that it recouped over \$23,000 in Social Security disability income back benefits. Upon terminating the claim, the insurer realized a profit of over \$356,000. In light of this evidence and other additional facts, the court concluded that the trial court did not err in denying the insurer's judgment on the evidence on the plaintiff's bad faith claim.

2. What Is Not Bad Faith

- ***Zembko v. Northwestern Mut. Life Ins. Co.*, 2007 WL 948323 (D.Conn. 2007)**: The claimant, an attorney, claimed to be disabled from her occupation due to depression and anxiety a month after her license to practice law was suspended. She sued the insurer for breach of contract, bad faith, and negligent infliction of mental and emotional distress. The court granted summary judgment in favor of the insurer on all three causes of action. It found no causal connection between the plaintiff's inability to practice law and her depression and anxiety. The plaintiff was no longer able to perform her regular occupation as an attorney because her license to practice law was revoked, not as a result of her illness. Accordingly, the insurer did not breach its implied duty of good faith and fair dealing. There was no evidence of a sinister or dishonest purpose when the insurer denied her claim for disability benefits. Under the terms of the policies, as well as public policy considerations, the insurer had no contractual obligation to honor the plaintiff's claim for disability benefits, and its denial of her claim was reasonable as a matter of law.

- ***Phelps v. Unum Provident Corp.*, 2007 U.S. App. LEXIS 19111 (6th Cir. 2007) (unpublished)**: The court held that the insurer was entitled to summary judgment on a bad faith claim because it was not unreasonable for the insurer to believe that the plaintiff, a dentist, no longer met the definition of total disability when he returned to work part-time.

- ***Starr-Gordon v. Mass. Mut. Life Ins. Co.*, 2006 U.S. Dist. LEXIS 83110 (E.D. Cal. 2006):** Plaintiff, a dental hygienist who worked part-time in her husband's dental office, submitted a claim for disability based upon shoulder and low back pain. The court held that there was no bad faith related to either the benefit termination or the investigation process of the her claim. The decision to terminate benefits was reasonable under the circumstances: the plaintiff had waited for over a year to make her claim; the evidence ultimately produced to document plaintiff's claim was equivocal and suggested that plaintiff's symptoms might improve; and video surveillance, and the reports of medical consultants reviewing that footage, revealed that the plaintiff's claims of injury were false or exaggerated. The court held that, viewed collectively, the evidence established sufficient justification for the insurer's termination of benefits such that it could not be held liable for bad faith. The court rejected the plaintiff's argument that the genuine dispute doctrine is only limited to situations where there are serious evidentiary disputes, as when parties offer the conflicting reports of doctors. Moreover, the court held that the insurer did not fail to investigate in a thorough and non-biased manner.

- ***Cranmore v. UNUM Provident Corp.*, 430 F. Supp. 2d 1143 (D. Nev. 2006):** The court held that the plaintiff failed to raise a genuine issue of material fact that the defendants had no reasonable basis for disputing coverage and that the defendants knew or recklessly disregarded the fact that there was no reasonable basis for disputing the claim. The plaintiff did not raise the possibility that she was disabled upon leaving her job as a security officer until her deposition. The defendants thus had a reasonable basis to deny coverage from January 2000 to April 2001. Further, after April 2001, the plaintiff's recurrent disability was more than six months after the accident. The denial of benefits for that period was not unreasonable because the policy's plain terms did not cover recurrent disability over six months from the original accident. Plaintiff could only show coverage through the application of the process of nature rule. Because Nevada has not adopted the rule expressly, the defendants' denial of coverage even when notified about the rule's potential application was not unreasonable. Finally, the court held that the plaintiff had not raised a genuine issue of material fact that the defendants acted with oppression, fraud, or malice to support a punitive damage award.

- ***Saldi v. Paul Revere Life*, 2006 U.S. Dist. LEXIS 1315 (E.D. Pa. 2006):** The court held that the defendants' payment of the disability claim under a reservation of rights did not constitute bad faith: "Preliminarily, we note that the basic purpose of a reservation of rights suggests that it is not, in itself, grounds for a bad faith claim. A reservation of rights allows an insurer to make payments to an insured while maintaining the right to seek reimbursement if it later becomes clear that the insured was not entitled to the payments. *Mass. Cas. Ins. Co. v. Rossen*, 953 F. Supp. 311, 315 (C.D. Cal. 1996)." *Saldi*, at *6.