Annual Life, Health & Disability Law Report

Developments in Life, Health & Disability Case Law 2010

FOCUS: California

A summary prepared by Gordon & Rees LLP of the holdings, alphabetized by topic, of the cases published in 2010 applying California law, as well as select cases from other jurisdictions, which address the rights and duties of the insurance industry.

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DEVELOPMENTS IN CALIFORNIA & SELECT OTHER JURISDICTIONS CASE LAW 2010: LIFE, HEALTH & DISABILITY INSURANCE

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28 U.S.C. § 1920

Certain litigation costs not included under 28 U.S.C. § 1920 may be billed as attorneys' fees in ERISA cases if it is the prevailing practice in a given community for lawyers to bill those costs separately from their hourly rates. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (N.D. Cal. 2010).

Where costs associated with computer-based research were not included under 28 U.S.C. § 1920, but the prevailing party showed it was the practice for attorneys in a given community to bill clients separately for Westlaw charges, such costs were recoverable. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (N.D. Cal. 2010).

The District Court has the discretion to award reasonable attorneys' fee and costs to a prevailing party in an ERISA action under 29 USC § 1132(g)(1), but courts are limited to awarding only those types of costs allowed by 28 U.S.C. § 1920, governing taxation of costs. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (N.D. Cal. 2010).

29 U.S.C. § 1056(d)(3)(F)

29 U.S.C. § 1056(d)(3)(F) permits Qualified Domestic Relations Orders ("QDROs") to reassign surviving spouse benefits, under certain circumstances, if the QDRO expressly assigns surviving spouse rights to a former spouse. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

29 U.S.C. § 1132(g)(1)

The District Court has the discretion to award reasonable attorney's fee and costs to a prevailing party in an ERISA action under 29 USC § 1132(g)(1), but courts are limited to awarding only those types of costs allowed by 28 U.S.C. § 1920, governing taxation of costs. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (N.D. Cal. 2010).

Abuse of Discretion: Conflict of Interest

An inherent structural conflict of interest exists when the insurance company acts both funds the plan and acts as the claim administrator. *McIlhaney v. Anthem Life Ins.*, 2010 U.S. Dist. LEXIS 81552 (C.D. Cal. 2010).

On a case-by-case basis, the court weighs an administrator's conflict of interest as part of its abuse of discretion analysis to determine the level of skepticism, if any, to apply to the administrator's decision. *McIlhaney v. Anthem Life Ins.*, 2010 U.S. Dist. LEXIS 81552 (C.D. Cal. 2010).

The weight attributed to the conflict of interest includes consideration of (a) whether the administrator provided conflicting reasons for the denial, (b) whether the administrator failed to adequately investigate the claim, and (c) whether the administrator failed to credit plaintiff's (claimant's) reliable evidence. *McIlhaney v. Anthem Life Ins.*, 2010 U.S. Dist. LEXIS 81552 (C.D. Cal. 2010) citing *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 968-69 (9th Cir. 2006).

Denial of long term disability benefits despite medical provider's opinion that there was sufficient objective evidence that plaintiff (claimant) was psychiatrically disabled was an abuse of discretion. *McIlhaney v. Anthem Life Ins.*, 2010 U.S. Dist. LEXIS 81552 (C.D. Cal. 2010).

Administrator's failure to conduct further investigation as to when plaintiff (claimant) first started suffering from depression was abuse of discretion. *McIlhaney v. Anthem Life Ins.*, 2010 U.S. Dist. LEXIS 81552 (C.D. Cal. 2010).

The Social Security Administration awarding disability benefits to plaintiff (claimant) was a factor in the court's decision that plaintiff (claimant) was disabled, and it was an abuse of discretion to deny long term disability benefits. *McIlhaney v. Anthem Life Ins.*, 2010 U.S. Dist. LEXIS 81552 (C.D. Cal. 2010).

Abuse of Discretion: Weight Given to Quality and Quantity of Medical Evidence

Abuse of discretion can exist when proper weight is not given to the quality and quantity of the medical evidence. *Sterio v. HM Life*, 369 Fed. Appx. 801 (9th Cir. 2010).

To avoid the appearance of a conflict of interest that impacted the benefits decision, plan administrators should consider in-person medical evaluations of claimant. *Sterio v. HM Life*, 369 Fed. Appx. 801 (9th Cir. 2010).

Disregarding the determination of disability by the Social Security Administrator is a factor that can be considered in evaluating whether there was an abuse of discretion in the denial of benefits. *Sterio v. HM Life*, 369 Fed. Appx. 801 (9th Cir. 2010).

Not adequately investigating a claim and requesting the necessary medical documents is a factor the court can consider when deciding whether the plan administrator abused its discretion in denying benefits. *Sterio v. HM Life*, 369 Fed. Appx. 801 (9th Cir. 2010).

Plan administrator providing a new reason for the denial in its final decision prejudices the claimant by not allowing the claimant an opportunity to respond to the denial. *Sterio v. HM Life*, 369 Fed. Appx. 801 (9th Cir. 2010).

Accidental Death and Dismemberment Benefits

The term "accident" in an accidental death and dismemberment policy includes injuries sustained by an insured in an automobile accident where the insured is three times over the legal blood alcohol content limit unless specifically excluded in the policy language. *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010).

Arbitrary and Capricious Claim Handling

Where a claim administrator suggested the plaintiff obtain neurocognitive testing, and provided no specific guidance regarding the type of testing required or by whom it should be performed, the claim administrator could not reject the test results provided by the plaintiff on the grounds that they were performed by a clinical psychologist, instead of neuropsychologist. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Where a claim administrator made general requests for a functional capacity evaluation and cognitive testing and such test results were submitted by the plaintiff, the claim administrator could not deny the information by asserting new requirements that had not been previously revealed to the plaintiff. The court held the claim administrator moved the target and that this was indicative of arbitrary claims administration and a conflict of interest impacting the claim decision. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

When a claim administrator denies a claim based on a selective reading of evidence that is not reasonably consistent with the entire picture, such conduct can suggest arbitrary claim administration and that a conflict of interest impacted the claim decision. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Awarding Attorney's Fees Under ERISA

Before awarding attorney's fees under the ERISA fee statute, the court must first determine whether a litigant achieved some degree of success on the merits, and if so, the court then determines whether the factors enunciated in *Hummell v. Rykoff & Co.*, 634 F.2d 446 (9th Cir. 1980) weigh in favor of awarding fees, and only after both conditions are met may the court award attorney's fees. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

A litigant must achieve some success on the merits, before the court can consider applying the *Hummell* test, and this requirement is not satisfied by achieving a trivial success on the merits or purely procedural victory, but may be achieved if the court can fairly call the outcome of the litigation some success on the merits without conducting a lengthy inquiry into the question whether a particular party's success was substantial or occurred on a central issue. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

Where an insurer dismissed a counterclaim for overpaid benefits, the court of appeals assumed, without deciding, this qualified as some degree of success on the merits for the plaintiff, where the district court proceeded to apply the five factor *Hummell* test and denied the plaintiff's motion for attorney's fees. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

Where a disability insurer filed a counterclaim for overpaid attorney's fees and then subsequently dismissed it based upon new information that the plaintiff's Social Security Disability Income benefits had been retroactively adjusted, the court found the insurer acted in good faith and would not award the plaintiff attorney's fees despite finding the insurer could undoubtedly pay them, holding that no single *Hummell* factor is necessarily decisive. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

Court would not award a plaintiff ERISA plan participant attorney's fees where a disability insurer's counterclaim had merit at the time it was filed and the insurer subsequently dismissed its counterclaim upon finding that new information deprived its counterclaim of merit. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

Where an insurer acted in good faith both at the time it filed its counterclaim and when it subsequently dismissed it upon obtaining new information that deprived its counterclaim of merit, the court held the insurer acted in good faith and would not award the plaintiff ERISA plan participant attorney's fees. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

Breach of Fiduciary Duty Under ERISA

A claim for breach of fiduciary duty under ERISA Section 502(a)(3) was dismissed as improper, where relief was available based on plaintiff's claim for denial of benefits under ERISA Section 502(a)(1)(B). *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

Calculating ERISA Disability Earnings

Where an ambiguity existed in an ERISA disability plan regarding the inclusion of bonus amounts in calculating disability earnings, and by extension, partial disability benefits, the court held the ambiguity must be construed in favor of the employee and that bonuses must be excluded from calculating disability earnings. *Martorello v. Sun Life Assurance Co.*, 704 F.Supp.2d 918 (2010).

Where an ERISA plan's definition of "monthly earnings" expressly excludes bonuses, and the plan defines "disability earnings" as employment income an employee receives while partially disabled but is silent on whether bonuses are included as employment income, the court held an ambiguity existed that must be construed in favor of the employee so that bonuses are excluded from calculating disability earnings. *Martorello v. Sun Life Assurance Co.*, 704 F.Supp.2d 918 (2010).

Where an ambiguity existed in an ERISA disability plan regarding whether bonuses should be included when calculating a plaintiff's disability earnings, the court held the ambiguity must be construed in favor of the plaintiff so that bonuses are excluded from the calculation, and remanded the matter to the insurer to calculate the amount of benefits. *Martorello v. Sun Life Assurance Co.*, 704 F.Supp.2d 918 (2010).

Compulsory Cross-Claims

In an action for wrongful denial of disability benefits, a successor insurer or plan administrator who fails to assert, in the same action, its indemnity claim against the preceding insurer waives its indemnity claim under FRCP 13(a) if the claim arises out of the same transaction giving rise to the benefits dispute and does not require bringing in additional parties who are outside of the court's jurisdiction. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Conflict of Interest/Standard of Review

The extent to which a conflict of interest motivates an administrator's claim decision is one of potentially many relevant factors that must be considered when determining whether an administrator abused its discretion. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

In reviewing an insurer's decision to terminate an ERISA plaintiff's disability benefits, the court erred when it assigned controlling weight to the conflict of interest factor where the evidence did not indicate the conflict tainted the entire administrative decision-making process. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

It was reasonable for an insurer not to believe a plaintiff's claim of disabling pain where she lacked credibility because video surveillance contradicted her complaints of disabling pain, and where her doctor's claims that she could not work were unsupported. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

Consideration of Objective Evidence in ERISA Cases

Requiring a claimant to prove her condition with objective data is arbitrary and capricious where no definitive objective test exists for the condition or its severity. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Where subjective symptoms of pain are not apparent in objective clinical data, plan administrators may require a certain degree of objectivity in terms of measuring the physical limitations observed in a functional capacity evaluation. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

The amount of fatigue or pain a claimant experiences is entirely subjective, however, the degree to which a claimant's pain or fatigue limits functional capabilities can be objectively measured. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Functional Capacity Evaluations may provide objective evidence of functional limitations amounting to total disability. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Consideration of Social Security Awards In ERISA Disability Cases

Although an ERISA claim administrator is not bound by a Social Security determination of disability, an administrator's failure to consider the Social Security determination when making its benefits decision suggests arbitrary decision-making. This is particularly true where the Social Security determination is made under a similar or stricter disability definition than contained in the ERISA plan. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Where an ERISA plan administrator insists a claimant apply for Social Security benefits and the claimant is awarded such benefits, which reduce the amount payable under the ERISA plan, the administrator must consider the Social Security's determination when evaluating whether the plaintiff is disabled under the plan. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Where an ERISA claim administrator never stated why it disagreed with the Social Security's disability benefits award to the plaintiff, it failed to consider the Social Security Administration's determination and acted arbitrarily and capriciously. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Consideration of Surveillance Videos In ERISA Cases

Where video surveillance showed a plaintiff performing activities greatly exceeded her claims of disabling pain and incapacity, it was not an abuse of discretion for the insurer to terminate disability benefits. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

Where video surveillance of a plaintiff performing activities greatly exceeded her self-reported limitations, it was not an abuse of discretion for the insurer to conclude she lacked credibility, to discount the value of her self-reported pain complaints and her doctor's assessments, and to give more weight to the surveillance video. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

Where an insurer provided its reviewing physicians with video surveillance of the plaintiff but instructed them not to rely on it too heavily or too little, an appropriate effort was made to reduce bias and consider all available evidence. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

Video surveillance of a plaintiff engaging in activities that greatly exceeded her self-reported limitations was properly considered by an ERISA disability insurer where the insurer did not distort the content of the video or overemphasize its importance when requesting medical reviews. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

An ERISA disability insurer's reviewing physicians properly considered video surveillance of a plaintiff where they did not mischaracterize the plaintiff's activities nor rely on the videos to the exclusion of all other evidence. *Finley v. Hartford Life & Accident Ins. Co.*, 2010 U.S. App. LEXIS 21509 (9th Cir. 2010).

Contract Construction

Standard rules of contract interpretation apply to disability insurance contracts, so the court first looks to the terms of the policy for resolution. *Martorello v. Sun Life Assurance Co.*, 704 F.Supp.2d 918 (2010).

Policy terms are construed in accordance with the context of the surrounding disability plan and an ambiguity results when plan language is susceptible to two reasonable interpretations. *Martorello v. Sun Life Assurance Co.*, 704 F.Supp.2d 918 (2010).

An ambiguity exists whenever two reasonable interpretations of a disputed provision are possible. *Martorello v. Sun Life Assurance Co.*, 704 F.Supp.2d 918 (2010).

Whenever there is an ambiguity in plan language it must be interpreted in favor of the employee/claimant. *Martorello v. Sun Life Assurance Co.*, 704 F.Supp.2d 918 (2010).

Where an insurance policy contains conflicting definitions of "disability," an insurer or plan administrator abuses its discretion if it denies disability benefits based on the policy's narrower definition when the insured qualifies as "disabled" under the policy's broader definition. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Where an insurance policy contains conflicting definitions of "disability," an insurer abuses its discretion in choosing to apply the more limiting definition of "disability" contained in the summary plan on review if the insurer initially denies the insured's claim based on a conflicting definition in the certificate of insurance. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

A policy clause stating, "If you become Disabled while insured," does not exclude disability predating coverage where the complete sentence states, "If you become Disabled while insured, proof of disability must be sent to Us." Such a clause, when read in context, does not limit coverage for disabilities beginning after the effective date, but instead merely requires that an insured submit a claim if she or he becomes disabled while insured. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

De Facto Appeal – *Rooker-Feldman*

Under the *Rooker-Feldman* doctrine (the rule based on two United States Supreme Court cases – *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923), and *District of Columbia Court of Appeals v. Feldman*, 460 U.S. 462 (1983)), federal district courts lack jurisdiction to hear "de facto appeals" from state court judgments. A "de facto appeal" is one where the federal plaintiff asserts as a legal wrong an allegedly erroneous state court decision and seeks relief from a state court judgment based on that decision. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

ERISA § 502(g)

The district court has discretion to award reasonable attorney's fee and costs to a prevailing party in an ERISA action under ERISA's fee statute section 502(g), but before applying the *Hummell* test, it must find that the litigant achieved some degree of success on the merits. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

ERISA: 60-Day Timeframe

An insurer must hear administrative appeals seeking coverage of accidental death and dismemberment benefits within sixty days of the administrative appeal being filed with the insurer pursuant to 29 C.F.R. section 2560.503. *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010).

ERISA: Abuse of Discretion

Where an insurance policy contains conflicting definitions of "disability," an insurer or plan administrator abuses its discretion if it denies disability benefits based on the policy's narrower definition when the insured qualifies as "disabled" under the policy's broader definition. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Insurer abused its discretion in denying the insured's disability claim by determining that he was not disabled on the basis of "an unwritten and unexplained objective evidence requirement" not specified in its policy. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Where an insurance policy contains conflicting definitions of "disability," an insurer abuses its discretion in choosing to apply the more limiting definition of "disability" contained in the summary plan on review if the insurer initially denies the insured's claim based on a conflicting definition in the certificate of insurance. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Where a disability policy does not contain an exclusion for disabilities beginning before the coverage effective date, an insurer could not deny coverage on that basis; and doing so would constitute an abuse of discretion. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

A disability insurer cannot justify its denial of benefits on the basis that an insured's claim lacks "objective evidence" that the insured's medical condition is "severe enough to warrant a finding of disability" if the policy does not include such an evidentiary standard; and, doing so would constitute an abuse of discretion because the denial would be based on "an unwritten and unexplained objective evidence requirement" not specified in the policy. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Where the plan contains inconsistent definitions of disability in the certificate of insurance and the summary plan description, the court found the insurer abused its discretion in applying the more limiting summary plan definition to deny a claim for benefits. *Mitchell. v. CB Richard Ellis Long Term Disability Plan,* 611 F.3d 1192 (9th Cir. 2010).

ERISA: Abuse of Discretion – Structural Conflict of Interest

Where the disability plan insurer both funds and administers benefit claims and there is plan language conferring discretion to the administrator's claim decision, a structural conflict of interest exists that must be considered by the court reviewing the claim decision. *Salz v. Std. Ins. Co.,* 380 Fed. Appx. 723 (9th Cir. 2010).

ERISA: Applicable Standard of Review

In an ERISA action for disability benefits, where the plan language clearly confers discretionary authority to the administrator or fiduciary's claim decision, the court's review is for abuse of discretion. *Rein v. Standard Ins. Co.,* 2010 U.S. Dist. LEXIS 77415 (E.D. Cal. 2010).

ERISA: Burden of Proof

There is no burden shifting in cases where the court conducts a de novo review of the claim administrator's decision. *Muniz v. Amec Constr. Mgmt., Inc.,* 623 F.3d 1290 (2010).

ERISA: Civil Actions

An ERISA-based retaliation or interference claim can be established through direct evidence, or in the absence of direct evidence, through the three-part burden-shifting framework common to Tile VII and Age Discrimination in Employment Act cases set forth in *McDonnell Douglas Corp. v. Green,* 411 U.S. 792 (1973). *Manning v. Am. Republic Ins. Co.,* 604 F.3d 1030 (8th Cir. 2010).

Under the framework set forth in *McDonnell Douglas Corp. v. Green,* 411 U.S. 792 (1973), if a claimant is able to establish a prima facie case of a violation of section 510 of ERISA (which makes it unlawful for an employer to discharge a participant for exercising any right to which he is entitled under plan (retaliation) for the purpose of interfering with the participant's rights under the plan (interference)), the burden shifts to the employer to articulate a legitimate, nondiscriminatory reason for its action. If the employer does so, then the burden shifts back to the claimant to prove that the proffered reason is pretextual. *Manning v. Am. Republic Ins. Co.,* 604 F.3d 1030 (8th Cir. 2010).

To establish a prima facie case of ERISA retaliation, a claimant must prove: (1) she participated in a statutorily protected activity (i.e., making a reasonable claim for ERISA benefits); (2) an adverse employment action was taken against her; and (3) a causal connection existed between her participation in a statutorily protected activity and an adverse employment action. A causal connection may be based upon circumstantial evidence. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

To establish a prima facie case of ERISA interference, a claimant must show that (1) the employer subjected her to an adverse employment action; (2) the claimant was likely to receive future benefits; and (3) a causal connection existed between the adverse action and the likelihood of future benefits. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

To establish a claim for interference with prospective benefits, a claimant must prove that the employer possessed a specific intent to interfere with her ERISA benefits. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

A plaintiff cannot prove an ERISA retaliation or interference claim through mere conjecture. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

ERISA: Conflict of Interest

A conflict of interest exists when a plan administrator holds the dual role of determining and paying benefits claims. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

If a conflict of interest exists, then a reviewing court should consider that conflict as a factor in whether the plan administrator abused its discretion in its benefits decision. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

The significance of a plan administrator's conflict of interest depends on the circumstances of the particular case. When an insurer has a history of biased claims administration, the conflict may be given substantial weight. When an insurer has taken steps to reduce the risk the conflict will affect eligibility determinations, the conflict should be given much less weight. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

An insurer's long-standing relationship with a medical reviewer is only one factor that is considered by the court in evaluating the affect the structural conflict of interest had on the claim decision. The relationship, alone is insufficient to show bias. *Gunn v. Reliance Std. Life Ins. Co.*, 2010 U.S. App. LEXIS 17436. (9th Cir. 2010).

ERISA: A Coverage Defense Is Waived If Not Asserted in the Initial Claim Denial

The insurer waived a coverage defense by failing to assert it in the initial claim denial where the policy required the insurer to "state the reason why [his] claim was denied and reference to the specific Plan Provision(s) on which the denial was based." *Mitchell. v. CB Richard Ellis Long Term Disability Plan*, 611 F.3d 1192 (9th Cir. 2010).

ERISA: Coverage is Determined Based on Meeting the Definition of Disability

The critical issue for determining coverage once the policy took effect was whether the plaintiff was "disabled" as defined in the plan documents. *Mitchell. v. CB Richard Ellis Long Term Disability Plan,* 611 F.3d 1192 (9th Cir. 2010).

ERISA: Date of Disability Can Occur Before Effective Date of Plan

The insurer's policy contained no exclusion or preclusion of coverage where the date of onset of disability occurred before the effective date of the plan. *Mitchell v. CB Richard Ellis Long Term Disability Plan,* 611 F.3d 1192 (9th Cir. 2010).

ERISA: Definition of "Plan"

In an ERISA action for disability benefits, the insurance policy may constitute the disability plan. *Rein v. Standard Ins. Co.,* 2010 U.S. Dist. LEXIS 77415 (E.D. Cal. 2010).

Where plan fiduciaries have offered a reasonable interpretation of disputed provisions, courts may not replace it with their own interpretation. *Manning v. Am. Republic Ins. Co.,* 604 F.3d 1030 (8th Cir. 2010).

ERISA: Failure to Follow Procedural Requirement

In an abuse of discretion case, the plan administrator's failure to provide claimant all relevant information to his claim for benefits constituted procedural error, giving the court discretion to consider evidence outside of the administrative record. *Prado v. Allied Domecq Spirits & Wine Group Disability Income Policy*, 2010 U.S. Dist. LEXIS 78837 (N.D. Cal. 2010).

ERISA: Future or Subsequent Spouse

The Ninth Circuit held ERISA did not contemplate reassignment of benefits for future or subsequent spouses, and noted Congress's silence as further support for the conclusion that the rights of a future or subsequent spouse did not exist in this context. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

ERISA: Inconsistent Bases for Denial of Benefits

Under an abuse of discretion standard of review, where there is a structural conflict of interest based on the insurer's dual role of funding and determining benefit claims, the court will review the claim decision with some skepticism where there is evidence the insurer provided inconsistent bases for the denial of benefits. *Mitchell v. CB Richard Ellis Long Term Disability Plan,* 611 F.3d 1192 (9th Cir. 2010).

ERISA: Limited Discovery into Structural Conflict of Interest

Despite collateral estoppel preventing plaintiff from re-litigating the abuse of discretion issue, plaintiff was entitled to conduct limited discovery into the nature, extent, and effect of plan administrator's conflict of interest on its decision-making process. *Prado v. Allied Domecq Spirits & Wine Group Disability Income Policy*, 2010 U.S. Dist. LEXIS 78837 (N.D. Cal. 2010).

ERISA: Occupation Standards

A plan administrator's reliance on the Department of Labor's *Dictionary of Occupational Titles* is appropriate as long as it is not unreasonable. Finding that a claimant's sedentary occupation requires sitting most of the time, accepting that a claimant cannot sit for prolonged periods of time, and then concluding that they have the flexibility to change positions and perform their occupation is unreasonable unless there is evidence in the record supporting the conclusion. *Salz v. Std. Ins. Co.*, 380 Fed. Appx. 723 (9th Cir. 2010).

ERISA: Plan Administration

It is not unreasonable for a plan administrator to deny benefits based on a lack of objective evidence. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

It is not an abuse of an ERISA plan administrator's discretion to ignore a medical opinion when the physician did not provide reliable, objective evidence of testing or other proof to support the finding of disability. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

A plan administrator is not required to order an IME when the claimant's evidence is facially insufficient to support a finding of disability. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

A plan administrator is entitled to seek and consider new evidence of a claimant's disability and if appropriate, terminate benefits. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Applying the abuse of discretion standard of review to a claim administrator's decision to terminate a plaintiff's long term disability benefits is a fact specific inquiry and the court may not consider an ERISA plan administrator's adverse judgments in other federal cases as evidence of a conflict of interest. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

Where an ERISA claim administrator terminated a plaintiff's long term disability benefits, the court held the plan administrator was not required to prove the plaintiff's condition had actually improved. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

ERISA: Preemption

The Ninth Circuit held a participant in an ERISA regulated Qualified Joint and Survivor Annuity may not change the surviving spouse beneficiary after the participant has retired and the annuity has become payable because these benefits irrevocably vest in the participant's spouse at the time of the participant's retirement. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

ERISA: Prevailing Party Attorney Fees

The five-factor *Hummel* test applies to determining whether attorney's fees should be awarded to a prevailing party in an ERISA case, and although a defendant could undoubtedly pay an award of attorney's fees, the Court nonetheless denied the plaintiff's motion for fees because no single factor is necessarily decisive. *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118 (9th Cir. 2010).

ERISA: Social Security Disability Benefits Award

An administrative review under the abuse of discretion standard must meaningfully analyze and discuss a claimant's award of Social Security disability benefits. *Salz v. Std. Ins. Co.*, 380 Fed. Appx. 723 (9th Cir. 2010).

ERISA: Standard of Review

The court of appeals reviews de novo a district court's grant of summary judgment regarding an ERISA plan administrator's benefits determination. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

When a plan confers discretionary review to the administrator to construe uncertain terms or make eligibility determinations, the administrator's decision is reviewed for abuse of discretion. Under the abuse of discretion standard, the court must affirm the plan administrator's interpretation of the plan unless it was arbitrary and capricious. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

To determine whether a plan administrator's decision was arbitrary and capricious, the court examines whether the decision was "reasonable." A decision is reasonable if supported by substantial evidence. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

Under the abuse of discretion standard of review, the claim decision will be viewed with skepticism by the court if the plan administrator's claim handling includes numerous procedural irregularities. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

In determining the reasonableness of a plan administrator's plan interpretation, the court should consider: (1) whether the administrator's language is contrary to the clear language of the plan; (2) whether the interpretation conflicts with the substantive or procedural requirements of ERISA; (3) whether the interpretation renders any language in the plan meaningless or internally inconsistent; (4) whether the interpretation is consistent with the goals of the plan; and (5) whether the administrator has consistently followed the interpretation. *Manning v. Am. Republic Ins. Co.*, 604 F.3d 1030 (8th Cir. 2010).

ERISA and Independent Medical Examinations

Where a plaintiff sought disability benefits under an ERISA plan and never underwent an independent medical examination ("IME"), and where both plaintiff and defendant contributed to the absence of an IME, the court would not hold the absence of an IME against the plaintiff. The court held the absence of an IME was nonetheless non-dispositive because the plan administrator did not base the denial of benefits on the plaintiff's failure to attend the IME. *Fagan v. Life Ins. Co. of North Am.*, U.S. Dist. Lexis 85413 (N.D. Cal. 2010).

Exclusions

Where a disability policy does not contain an exclusion for disabilities beginning before the coverage effective date, an insurer could not deny coverage on that basis; and doing so would constitute an abuse of discretion because the denial would be based on "an unwritten and unexplained objective evidence requirement" not specified in the policy. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

A policy clause stating, "If you become Disabled while insured," does not exclude disability predating coverage where the complete sentence states, "If you become Disabled while insured, proof of disability must be sent to Us." Such a clause, when read in context, does not limit coverage for disabilities beginning after the effective date, but instead merely requires that an insured submit a claim if she or he becomes disabled while insured. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Federal Rule of Civil Procedure 13(a)

In an action for wrongful denial of disability benefits, a successor insurer or plan administrator who fails to assert, in the same action, its indemnity claim against the preceding insurer waives its indemnity claim under FRCP 13(a) if the claim arises out of the same transaction giving rise to the benefits dispute and does not require bringing in additional parties who are outside of the court's jurisdiction. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Federal Rule of Civil Procedure 13(a): Purpose

The purpose of Federal Rule of Civil Procedure 13(a) is to prevent multiplicity of litigation and to promptly bring about resolution of disputes before the court. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Genuine Issue of Material Fact is Not Created by an Employee's Belief

An employee's belief about whether a plan is governed by ERISA is irrelevant and is insufficient to create a genuine dispute of material fact. *Gonzales v. Unum Life Ins. Co. of Am.*, 2010 U.S. Dist. LEXIS 96795 (S.D. Cal. 2010).

Qualified Joint and Survivor Annuity Benefits

The Ninth Circuit followed the reasoning and holding of the Fourth Circuit in *Hopkins v. ATT Global Info.*, 105 F.3d 153 (4th Cir. 1997), in which the court held Qualified Joint and Survivor Annuity benefits of pension plans cannot be changed after the retirement date, even with the spouse's consent. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

Impact of SSA Decision on Claims Decision

While ERISA plan administrators are not bound by a Social Security administrative law judge's determination regarding benefits eligibility, complete disregard for a contrary conclusion without explanation raises questions about whether an adverse benefit determination was reached without principled and deliberative reasoning. *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

Indemnity Claims: Waiver

In an action for wrongful denial of disability benefits, a successor insurer or plan administrator who fails to assert, in the same action, its indemnity claim against the preceding insurer waives its indemnity claim under FRCP 13(a) if the claim arises out of the same transaction giving rise to the benefits dispute and does not require bringing in additional parties who are outside of the court's jurisdiction. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Jurisdiction

There is no personal jurisdiction over an out-of-state insurer who does not conduct business within the forum state, but whose insureds seek urgent and emergency care in the forum state. *Choice Healthcare, Inc. v. Kaiser Found. Health Plan of Colo.*, 615 F.3d 364 (5th Cir. 2010).

Jury Trial is Not Available Under ERISA

ERISA does not expressly provide a right for a jury trial and the courts are divided on whether a jury trial is available to the beneficiary or participant. The recovery of benefits under 502(a) has generally been held to be an equitable action where a jury trial is not available. In *Gonzales v. Unum Life Ins. Co. of Am.*, 2010 U.S. Dist. LEXIS 96795 (S.D. Cal. 2010), * 15-16 (2010), plaintiff sought disability benefits under ERISA. Defendant filed a motion for partial summary judgment and requested the court strike plaintiff's demand for a jury trial. The court granted defendant's request to strike plaintiff's demand for a jury trial because "…there is no right to a jury trial on ERISA claims…" in the Ninth Circuit. *Thomas v. Or. Fruit Prods. Co.*, 228 F.3d 991 (9th Cir. 2000).

Limitations On Disability Benefits Based on Mental Disorders

Where defendants sought to limit a plaintiff's disability benefits based on an ERISA plan provision, limiting benefits caused or contributed to by a depressive or anxiety disorder, the court denied the defendants' motion for summary judgment, holding the defendants failed to clearly establish that a depressive or anxiety disorder was an objective source of the plaintiff's physical disability. *Fagan v. Life Ins. Co. of North Am.,* U.S. Dist. Lexis 85413 (N.D. Cal. 2010).

Where defendants sought to limit a plaintiff's disability benefits based on an ERISA plan provision limiting benefits caused or contributed to by a depressive or anxiety disorder, the court denied the defendants' motion for summary judgment, holding the plaintiff's depression was a reaction to his physical condition, which was distinct from a finding his depression was a contributing factor to his physical condition. *Fagan v. Life Ins. Co. of North Am.,* U.S. Dist. Lexis 85413 (N.D. Cal. 2010).

Meaningful Dialogue Between Administrator and Claimant

A claims administrator's decision to deny benefits was based on substantial evidence where it considered plaintiff's treating physician's opinions, the medical records were reviewed by three board-certified orthopedic surgeons and two vocational specialists and an independent medical examination was conducted. *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

"*Moench* Presumption" for Investments in Employee Stock Ownership Plans

The Ninth Circuit, with respect to the plaintiffs' claim of imprudent investment, joined the Third, Fifth, and Sixth Circuits by adopting the rebuttable "Moench presumption" (based on *Moench v. Robertson*, 62 F.3d 553 (3d Cir.1995)) that fiduciaries acted consistently with ERISA in their decisions to invest plan assets in employer stock. *Quan v. Computer Scis. Corp.*, 623 F.3d 870 (9th Cir. 2010).

Under the ERISA exemption, when investing in an ESOP, fiduciaries are not required to diversify their investments outside of company's stock to meet the prudent person standard. *Quan v. Computer Scis. Corp.*, 623 F.3d 870 (9th Cir. 2010).

To reconcile the conflicting ERISA provisions, the *Moench* presumption presumes that the fiduciary acted consistently with ERISA in its investment in employer's stock, and the participants are required to rebut the presumption by establishing that based on the circumstances the fiduciary abused its discretion by continuing to invest in the employer's stock. *Quan v. Computer Scis. Corp.,* 623 F.3d 870 (9th Cir. 2010).

The Ninth Circuit held that the presumption strikes the appropriate balance between the purpose of employer's stock ownership plans and ERISA's goal of ensuring proper management of the plans. *Quan v. Computer Scis. Corp.,* 623 F.3d 870 (9th Cir. 2010).

To rebut the presumption the Ninth Circuit held there must be evidence of an abrupt decline in the employer's stock combined with evidence of insider trading or that the company was on the brink of collapse. *Quan v. Computer Scis. Corp.,* 623 F.3d 870 (9th Cir. 2010).

Evidence of fiduciaries not making a prudent investment or deliberately ignoring a decline in stock prices is not sufficient to rebut the presumption. The Ninth Circuit recognized these factors would make the *Moench* presumption difficult to overcome. *Quan v. Computer Scis. Corp.,* 623 F.3d 870 (9th Cir. 2010).

Physical Impairments Constituting Disability under ERISA

The court granted plaintiff's motion for summary judgment seeking disability benefits under an ERISA plan based on the submission of objective evidence of a degenerative disc problem, and evidence from his treating physicians of significant manifestations of pain and the manner in which his pain prevented him from performing his material job duties. *Fagan v. Life Ins. Co. of North Am.,* U.S. Dist. Lexis 85413 (N.D. Cal. 2010).

The court granted plaintiff's motion for summary judgment seeking disability benefits under an ERISA plan where the defendant's physician testimony and the claim denial letters based on testimony, finding that plaintiff could simply perform light duty work, were conclusory and failed to engage in any detailed analysis demonstrating how he could do so. *Fagan v. Life Ins. Co. of North Am.,* U.S. Dist. Lexis 85413 (N.D. Cal. 2010).

The court granted a plaintiff's motion for summary judgment seeking disability benefits under an ERISA plan despite the defendant's reliance on well-supported evidence the plaintiff exhibited no neurological defects and that many of physical exam results were normal, because such facts were not determinative and did not materially counter the fact that the plaintiff's degenerative disc problem and pain, prevented him from performing his job duties. *Fagan v. Life Ins. Co. of North Am.,* U.S. Dist. Lexis 85413 (N.D. Cal. 2010).

The court granted a plaintiff's motion for summary judgment seeking disability benefits where the defendant's conclusions were not always based on an accurate reading of the claim record and defendant had mischaracterized one of the plaintiff's treating physician's reports. *Fagan v. Life Ins. Co. of North Am.,* U.S. Dist. Lexis 85413 (N.D. Cal. 2010).

Qualified Domestic Relations Orders

Labor 29 U.S.C. § 1056(d)(3)(F) permits Qualified Domestic Relations Orders ("QDROs") to reassign surviving spouse benefits, under certain circumstances, if the QDRO expressly assigns surviving spouse rights to a former spouse. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

Qualified Joint and Survivor Annuity: Irrevocability

The Ninth Circuit held a participant to an ERISA regulated Qualified Joint and Survivor Annuity ("QJSA") may not change the surviving spouse beneficiary after the participant has retired and the annuity has become payable because these benefits irrevocably vest in the participant's spouse at the time of the participant's retirement. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

Remedies Under ERISA are Limited

Extra-contractual and punitive damages are generally not permitted under ERISA. *Gonzales v. Unum Life Ins. Co. of Am.*, 2010 U.S. Dist. LEXIS 96795 (S.D. Cal. 2010).

Remedy/Reinstatement of Benefits

Plaintiff's disability benefits were terminated and the Court found that detailed medical data and consistent objective functionality testing indicated only a finding of total disability, retroactive reinstatement of ERISA plan benefits was appropriate. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758 (7th Cir. 2010).

***Rooker-Feldman* Doctrine**

Under the *Rooker-Feldman* doctrine (based on *Rooker v. Fidelity Trust Co.*, 263 U.S. 413 (1923), and *District of Columbia Court of Appeals v. Feldman*, 460 U.S. 462 (1983)), federal district courts lack jurisdiction to hear "de facto appeals" from state court judgments. A "de facto appeal" is one where the federal plaintiff asserts as a legal wrong an allegedly erroneous state court decision and seeks relief from a state court judgment based on that decision. *Carmona v. Carmona*, 603 F.3d 1041 (9th Cir. 2010).

Sixth Circuit Holds Beneficiary Designation Must Be "Signed" Under FEGLIA

A beneficiary designation must be "signed" to be effective under the Federal Employees Group Life Insurance Act. The Sixth Circuit held the district court properly concluded a former federal employee did not "sign" a beneficiary designation form when he printed his name in the box requesting "Print or Type Name" but failed to sign or mark the box requiring "Signature of Insured." The former employee's printed name on another part of the designation form did not create a triable issue of fact as to whether the form was "signed" as required by the Act. *Bonner v. Metro. Life Ins. Co.*, 621 F.3d 530 (6th Cir. 2010).

Standard of Review

An insurer's administrative appeal is not entitled to discretionary authority on review by the court of appeals when the administrative appeal was heard outside of the timeframe required by ERISA. *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010).

De novo review is used when an insurer fails to follow proper procedure in issuing a decision denying the beneficiary's administrative appeal because the insurer is divested of its discretionary authority to interpret the policy. *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010).

Standard of Review: Structural Conflict of Interest

Under a strict abuse of discretion standard that is not tempered by a structural conflict of interest, summary judgment is appropriate in favor of a claims administrator where the record establishes that plaintiff's medical records were reviewed and thoroughly considered. *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

Statute of Limitations: ERISA Benefits-Recovery Actions

A district court must apply only one statute of limitations per state for ERISA benefit-recovery actions under 29 U.S.C. § 1132 (a)(1)(B). *Wise v. Verizon Commc'n Inc.*, 600 F.3d 1180 (9th Cir. 2010).

A district court must apply the state statute that is most analogous to an ERISA benefits-recovery action. *Wise v. Verizon Commc'n Inc.*, 600 F.3d 1180 (9th Cir. 2010).

Under California law, the most analogous statute of limitations to an ERISA benefits-recovery claims is the four year statute of limitations for written contracts. *Wise v. Verizon Commc'n Inc.*, 600 F.3d 1180 (9th Cir. 2010).

Under Washington law, the most analogous statute of limitations to an ERISA benefits-recovery claims is the six year statute of limitations for written contracts. *Wise v. Verizon Commc'n Inc.*, 600 F.3d 1180 (9th Cir. 2010).

Statutory Interpretation

The purpose of Federal Rule of Civil Procedure 13(a) is to prevent multiplicity of litigation and to promptly bring about resolution of disputes before the court. *Mitchell v. Metro. Life Ins. Co.*, 611 F.3d 1192 (9th Cir. 2010).

Treating Physician's Opinions

A claim administrator is entitled to disagree with a plaintiff's treating physician's opinion if there is evidence in the record that provides a reasoned basis for doing so. *Holmstrom v. Metro. Life Ins.*, 615 F.3d 758, (7th Cir. 2010).

Texas Law

A claim for breach of fiduciary duty under ERISA Section 502(a)(3) was dismissed as improper, where relief was available based on plaintiff's claim for denial of benefits under ERISA Section 502(a)(1)(B). *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

While ERISA plan administrators are not bound by a Social Security administrative law judge's determination regarding eligibility for benefits, complete disregard for a contrary conclusion without explanation raises questions about whether adverse benefit determination was reached without principled and deliberative reasoning. *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

Under a strict abuse of discretion standard that is not tempered by a structural conflict of interest, summary judgment is appropriate in favor of a claims administrator where the record establishes that plaintiff's medical records were reviewed and thoroughly considered. *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

A claims administrator's decision to deny benefits was based on substantial evidence where it considered plaintiff's treating physician's opinion, the medical records were reviewed by three board-certified orthopedic surgeons and two vocational specialists and an independent medical examination was conducted. *Byrd v. Unum Life Ins.*, 2010 U.S. Dist. LEXIS 78974 (S.D. Tex. 2010).

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