HANDLING MEDICAL INSURANCE CLAIM DENIALS IN NEW YORK

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Mark Scherzer, Esq.

I. Benefit Issues Frequently Confronted for People with Serious or Chronic Illness

A. Health Claims:

1. Pre-existing condition exclusions / Portability
2. Coverage while on medical leave or disability claim
3. COBRA or state continuation of coverage
4. Person not covered or policy not in force
5. Denial of access to specialty care
6. Medical necessity of treatment
7. Experimental therapy
8. Off-label drug therapy
9. Treatments or conditions excluded from coverage
10. Treatments or conditions capped
11. Failure to obtain pre-authorization
12. Need or desire for out of network care
13. Coordination of benefits between several plans
14. Usual, customary and reasonable charges

B. Disability Claims:

1. Pre-existing condition exclusions / Portability
2. Rescission for misrepresentation
3. Person not covered or policy not in force
4. Definition of disability - does the person fit?
5. What was "regular" or "usual" occupation?
6. What were "material", "substantial" or "important" duties?
7. Can the client do those duties?
8. Can the client engage in a “reasonable occupation”?
9. Obligation to report activities while disabled
10. Can client be followed and observed?
11. Computation of benefits, offsets
12. Partial disability claims
13. Return to work: obligations, risks
14. Keeping other benefits dependent on disability

II. Establishing governing law: Is it a plan governed by ERISA, by state law, or by both?

A. ERISA, 29 U.S.C. §1001 et seq., governs most employer and union provided group benefit plans. ERISA does not, however, govern:

1. Church plans

2. Government plans

3. Plans provided to the employer (*e.g.*, to sole proprietor or partner). A plan issued to a sole proprietorship or partnership with no employees is clearly not governed by ERISA. Giardono v. Jones, 867 F.2d 409 (7th Cir. 1989); Kwatcher v. Massachusetts Employees Pension Fund, 879 F.2d 957 (1st. Cir. 1989); Robertson v. Alexander Grant & Co. 798 F.2d 898 (5th Cir. 1986); Ehrlich v. Howe, 848 F. Supp. 482 (S.D.N.Y. 1994); Pearl v. Monarch Life Ins. Co, 289 F. Supp. 2d 324 (E.D.N.Y. 2003). Even if the person is referred to as a "partner," however, one must analyze his or her rights to determine actual ownership interest. Ehrlich, *supra*; Simpson v. Ernst & Young, 100 F. 3d 436 (6th. Cir. 1996). A plan which covers both owner(s) and employees would be subject to ERISA, and the rights of an employer who participates in the plan along with the employees will be governed by ERISA. Yates v. Hendon, 541 U.S. 1 (2004).

4. Plans where employer is merely the conduit for employee to elect to purchase insurance, but employer does not "establish" or "maintain" plan. To constitute a plan, a reasonable person should be able to ascertain the source of financing, and the employer must establish or maintain the plan. Grimo v. Blue Cross/Blue Shield, 34 F.3d 148 (2nd Cir. 1994).

B. If plans are "self-insured" (not funded through an insurance policy), ERISA will be the source of regulation and will preempt state laws affecting benefit plans.

1. The statute (29 U.S.C. §1144) provides that ERISA preempts and renders ineffective state laws affecting employee benefit plans unless (under the "savings clause") those laws regulate insurance. Under an exception to the savings clause, the "deemer clause," self-insured plans cannot be considered insurance plans subject to state regulation.

2. An insurer may process the claims and send your client checks. This does not necessarily mean that the plan is insured. Often, self-insured plans contract with insurers to provide administrative services (sometimes known as "ASO" or administrative services only contracts).

3. Some insurers issue "stop-loss" policies to self insured plans. These policies

start to cover costs after the employer has covered a certain amount from its own funds, in a few cases as little as $5,000.00. While the temptation may be to argue that such policies are in effect insured and subject to state insurance law, the Second Circuit has rejected that argument. Travelers Ins. Co. v. Cuomo, 14 F.3d 708 (2d Cir. 1993), *rev'd other grounds*, NY State Conference of Blue Cross Blue Shield Plans v. Travelers, 514 U.S. 645, 655 (1995).

C. If plans are provided through insurance policies or through health maintenance organization contracts, state law may have some concurrent effect with ERISA.

1. The case law on ERISA preemption (under 29 U.S.C. §1144) is confusing, indeed almost impossible to reconcile into a coherent scheme. How do you determine if a state law regulates insurance? It clearly is not enough for a law or rule to appear in the state insurance code or to be a commonly articulated principle in the insurance case law. For years, the Supreme Court instructed that laws regulating insurance are those that (a) have the effect of transferring or spreading policyholders' risk, (b) are an integral part of the insurer-insured relationship, (c) are limited to entities within the insurance industry. Metropolitan Life v. Massachusetts, 471 U.S. 724 (1985) (state law mandating certain benefits in an insurance policy does regulate insurance and is not preempted); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (state common law rule providing for punitive damages in certain circumstances, including insurance disputes, does not regulate insurance and is therefore preempted).

2. In the last nine years, the Court has recently made application of the law considerably less clear by diverging from the Pilot Life rule. In UNUM Life Ins. Co. of America v. Ward, 119 S. Ct. 1380 (1999), the Court upheld a Ninth Circuit decision saving from ERISA preemption a California doctrine prohibiting use of late notice provisions to deny long term disability benefit claims if the insurer is not substantially prejudiced by the late notice. The Court endorsed the position of the U.S. Department of Labor (acting as *amicus curiae*) that the California law could be saved from preemption without satisfying each criterion of Pilot Life. The Pilot Life criteria, rather, are simply considerations for the court in arriving at a common sense determination of whether a law regulates insurance. It appears that the most important criterion in the Supreme Court's view is whether the state law in question is restricted in scope to insurance as opposed to state rules with more general applicability like the "bad faith" damages at issue in Pilot Life. Later cases have largely followed this trend of allowing state laws considerable latitude to be enforced. *See, e.g.*, Pegram v. Herdrich, 530 U.S. 211 (2000), upholding liability under state malpractice laws for physician employees of managed care organizations (*but see* Aetna Health Inc. v Davila, 542 U.S. 200 (2004), continuing to insulate the plans themselves from such liability); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002), upholding state

"external review" laws.

3. In addition to specific state laws regulating insurance, laws of very broad general application (*i.e.*, not particularly affecting employee benefit plans) such as tax laws are also saved from ERISA preemption event though they may have an incidental effect on employee benefit plans. NY State Conference of Blue Cross Blue Shield Plans v. Travelers, 514 U.S. 645, 655 (1995). Such a state law is not now likely to be held to be preempted if it does not conflict with ERISA or frustrate its purposes.

D. State law will be the sole source of law governing individually purchased insurance.

1. Be aware of choice of law questions, when the policy was issued for delivery in another state.

E. Gray areas:

1. Conversion coverage. Federal law requires that groups of 20 or more employees offer continuation coverage under COBRA for up 18, 29 or 36 months after termination of group eligibility, depending upon circumstances. New York extends this rule to the smallest groups. Many states, including New York, also require that insurers offer "conversion" health policies after group participation terminates. Federal circuits have differed on whether these sorts of coverage are subject to ERISA. Several courts have held that individual conversion policies purchased after termination of coverage are subject to ERISA (Painter v. Golden Rule Insurance Co., 121 F.3d 436 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 1516 (1998) (health insurance); Greany v. Western Farm Bureau Life Ins. Co., 973 F.2d 812, 817 (9th Cir. 1992) (health insurance); White v./Provident Life & Accident Ins. Co., 114 F.3d 26 (4th Cir. 1997), *cert. denied*, 422 U.S. 950 (1997) (life insurance); Logan v. Empire Blue Cross & Blue Shield, NYLJ, May 13, 1999 at 33, col. 6 (Sup. Ct. Westchester Co.) (health Insurance). Other courts, however, have held that while the group plan's right to convert is governed by ERISA, one's substantive rights under the resulting individual conversion policy are not. Demars v. Cigna Corp., 173 F.3d 443, 445 n.1, 448-50 (1st Cir. 1999); Waks v. Empire Blue Cross/Blue Shield, 263 F.3d 872, 874-76 (9th Cir. 2001); Ziperski v. First Unum Life Ins. Co., 2006 U.S. Dist. LEXIS 3116 (S.D.N.Y. Jan. 30, 2006); Vaughn v. Owen Steel Co., 871 F. Supp. 247 (D.S.C. 1994) (life insurance); Mimbs v. Commercial Life Ins., 818 F. Supp. 1556 (S.D. Ga., 1993) (life and health insurance). The Eleventh Circuit has reserved judgment on this issue, but held that if the policy to which one is converted consists of a group of former members of the same plan, ERISA governs. Glass v. United of Omaha Life Ins. Co., 33 F.3d 341 (4th Cir. 1994) (life insurance).

2. Multiemployer welfare associations. In recent years, some union plans in the metropolitan area have sold "associate memberships" to persons in entirely different industries, often self-employed or unemployed. In some cases the plans may purport to be self-insured, subject only to ERISA, and exempt from state regulations, although the associate members are really just individual purchasers of insurance and should be able to argue that the plan is neither established nor maintained by their employer or union. In other cases, the coverage is provided through insurance policies, but when non-union members are discovered to be enrolled, the insurer balks and claims they are not entitled to coverage.

F. Other important rules: If the plan through which the person is insured is a "federally qualified" HMO it may be legally obliged to cover any care which a participating physician has prescribed as medically necessary, Juliano v. The Health Maintenance Organization of New Jersey, Inc., 221 F.3d 279 (2d Cir. 2000). Federally qualified HMOs are listed on the website of HCFA. Be aware that HMOs may even operate as federal contractors, such as Medicare HMOs, without necessarily being "federally qualified." HCFA's listing distinguishes between federally qualified HMOs and those which have qualified as "Competitive Medical Plans" and are not subject to the same stringent requirements.

III. If a plan is governed by ERISA, how does that affect your client's rights? Although advocates for years bemoaned the apparent lack of substantive rules in ERISA protecting plan beneficiaries, the statute, 29 U.S.C. ' 1001 et seq., includes a number of beneficial rules which have been important underpinnings of a developing federal common law:

A. A requirement of accurate disclosure of plan benefits, limitations, and member obligations through a Summary Plan Description (SPD); identification of the plan administrator and those with authority to decide claims; and directions for obtaining further information and plan documents. 29 U.S.C. §§1022 and 1024.

B. Establishing a fiduciary duty upon those running the plan to operate it for the sole benefit of plan beneficiaries, as a prudent person would, with loyalty to plan terms and adherence to rules of fairness. 29 U.S.C. §1104. The breach of fiduciary duty theory has provided a fruitful vehicle for claims challenging a variety of insurer/employer actions. These include:

1. Failure to give full and complete information to plan participants in response to questions. Varity Corp. v. Howe, 116 S. Ct. 1065 (1996); Berlin v. Michigan Bell Tel. Co., 858 F.2d 1154 (6th Cir. 1988); Eddy v. Colonial Life Ins. Co. of America, 919 F.2d 747 (D.C. Cir. 1990); Ballone v. Eastman Kodak Co, 109 F.3d 117 (2d Cir. 1997).

2. Failure to explain a claim denial or to identify further information required for

approval. Booton v. Lockheed Medical Benefit Plan, 110 F.3d 1451 (9th Cir. 1997).

3. Misrepresentation to disabled employee that he is covered under a new group policy and failure to advise of the need to convert old group coverage. Fortune v. Medical Associates of Woodhull, 803 F. Supp. 636 (E.D.N.Y. 1992).

4. Failure to disclose physician financial incentives (e.g., penalties for excessive referrals for specialty care). Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997), cert. denied, 118 S. Ct. 297 (1997), *but see*, Weiss v. CIGNA Healthcare, Inc., 972 F. Supp. 748 (S.D.N.Y. 1997); Ehlmann v. Kaiser Foundation Health Plan, 20 F. Supp.2d 1008 (N.D. Tex. 1998), *aff'd*, 198 F.3d 552 (5th Cir. 2000). The holding in Shea may not be followed in light of Pegram, *supra*, which rejected a claim that the financial incentives themselves violated a fiduciary duty under ERISA, but the duty to disclose may still be sustained as a fiduciary function.

5. **CAVEAT 1:** An employer has no duty to maintain any particular kinds or levels of employee benefits, and is generally free to terminate benefits so long as it does so in an across-the-board, non-discriminatory manner. Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73 (1995); Lockheed Corp. v. Spink, 516 U.S. 1087 (1996); *See also*, Moore v. Metropolitan Life Ins. Co., 856 F.2d 488 (2d Cir. 1988).

6. **CAVEAT 2:** Great-West Life & Annuity Insurance co. v. Knudson, 534 U.S. 204 (2002) casts doubt on the continued availability to plan beneficiaries of monetary damages for breaches of fiduciary duty. The Court has since Great-West looked to the law which governed in the days of the divided bench to determine which remedies are "equitable." *See*, Sereboff v. Mid-Atlantic Medical Services, Inc., 126 S. Ct., 1869 (2006). As a result, while one might be able to recover on an equitable lien against specifically identified and segregated funds or obtain remedies like reinstatement or rescission, general monetary damages for breach of fiduciary duty are likely to be rejected.

7. **CAVEAT 3:** Be prepared for arguments that Pegram abolished any fiduciary duty type analysis for claims regarding medical treatment or "mixed" decisions (*e.g.*, whether a benefit is covered based on medical judgments). There are troubling broad *dicta* in that decision, although the Supreme Court did not purport to overrule Firestone. Keep in mind the distinction between suits for payment of benefits under the plan (where the Firestone rules should still apply) and suits for equitable relief based on alleged breaches of fiduciary duty.

C. Under Section 510 of ERISA, prohibiting discrimination intended to deprive a member of benefits to which s/he may become entitled. 29 U.S.C. §1140.

D. Requiring a procedure for full and fair internal review of denied claims. Department of Labor regulations adopted early in this decade provide a highly defined scheme for review. These review procedures include faster appeal time frames in cases of medical urgency and prohibit plans from requiring more than 2 levels of internal review. 29 C.F.R. ' 2560.503-1.

E. Providing a private right of action entitling aggrieved participants to sue to enforce their ERISA rights, ERISA Section 502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B), recover penalties and/or attorneys' fees in certain cases, to obtain declarations of their rights, and to seek other equitable relief. ERISA Section 502(a)(3), 29 U.S.C. §1132(a)(3).

F. In some cases, courts may apply ERISA federal common law. "In claims under [ERISA], we apply federal common law, not state law, in interpreting the beneficiary's entitlements[;] ... [h]owever, ERISA federal common law is largely informed by state law principles." Lifson v. INA Life Ins. Co. of New York, ___ F.3d ___, 2003 U.S. App. LEXIS 12842, at *8 (2nd Cir., Jun. 25, 2003). *See also*, Krishna v. Colgate Palmolive Co., 7 F.3d 11, 14 (2nd Cir. 1993) ("In developing federal common law, ... resort may be had to state law in a proper case"); Helms v. Monsanto Co., 728 F.2d 1416, 1421 n.6 (11th Cir. 1984) (in interpreting the plan definition of disability, court expressly relied on state insurance cases, observing that although these cases are "not applicable to plans covered by ERISA we are not using them as precedent but rather as examples of different courts' interpretation of these provisions"). For example, courts have resorted to federal common law to break an impasse resulting from mutually-repugnant "coordination of benefit" provisions in two applicable plans, *e.g.*, where an individual is covered as an employee or retiree under one plan, but is simultaneously covered as a dependent on a spouse's plan. McGurl v. Trucking Employees of North Jersey Welfare Fund, Inc., 124 F.3d 471, at 480-82 (3rd Cir. 1997) (adopting rule that plan covering participant as an employee should pay first); PM Group Life Ins. Co. v. Western Growers Assurance Trust, 953 F.2d 543, 546-47 (9th Cir., 1992).

G. A few provisions of federal law integrated with ERISA establish substantive rights to access to benefits. The most important are:

1. COBRA, 29 U.S.C. ' '1161-1168, permitting plan participants whose employer regularly employs twenty or more people to continue group health and dental benefits for up to 18, 29 or 36 months after losing group eligibility by paying premiums to their employer. The U.S. Department of Labor has technical assistance numbers with information about COBRA: 212.399.5191 or, in Washington, 202.219.4377. There is also an explanation on the DOL website, at http://www.dol.gov/dol/topic/health-plans/cobra.htm. [**NOTE:** New York has rules closely parallel to COBRA for continuation when

coverage in a group of 2 or more ends (Ins. L. 4305(e)).]

2. HIPAA, the Health Insurance Portability and Accountability Act of 1996, prohibiting health or genetic characteristic based discrimination in enrollment in group health plans, limiting use of pre-existing condition exclusions through portability rules, and guaranteeing the right of small groups and some individuals to purchase individual insurance policies when they have exhausted COBRA or conversion benefits. Lay summaries of many of these provisions may be found on the DOL website at http://www.dol.gov/dol/topic/health-plans/portability.htm [**NOTE:** New York has rules applicable to insured plans which are in several respects even more generous than HIPAA, including guaranteed open enrollment "direct pay" policies for individuals ineligible for employer or Medicare coverage, "community rating" (no premium differentials based on age, sex, health history, occupation) for individual and small group coverage, and portability of group disability benefits as well as health benefits.]

IV. If the plan is insured, how does that affect your client's rights? Insured plans will be subject to the numerous mandated benefits, eligibility rules and rating restrictions in the State's insurance code and regulations. In addition, for those in managed care plans, various state sources of regulation may come into play:

A. HMOs are regulated by Article 44 of the Public Health Law. Among other requirements of licensure, HMOs are required to provide a comprehensive set of health benefits which are sufficient to maintain enrolled members in good health. The State Health Department approves the benefit plans. However, only for individual purchasers buying standardized policies under Ins. L. ''4321 and 4322 or under state-subsidized programs like Child Health Plus, Family Health Plus and Healthy New York does the state establish all aspects of the benefit package.

B. New York's Managed Care Bill of Rights, enacted in 1996, applies to HMOs and other types of plans which may be considered managed care organizations for different purposes under the statute. It is codified in both the Insurance Law and the Public Health Law.

1. Article 44 of the Public Health Law has provisions for grievance procedures (for all managed care disputes other than those involving medical necessity decisions).

2. Article 49 of the public health law has provisions regarding utilization review (decisions based on medical necessity). Both Article 44 and 49 provide for internal review processes which are expedited (48 hour) appeal processes for urgent health situations.

3. Article 48 of the Insurance Law requires plans to have arrangements with

centers of excellence for treatment of life threatening, disabling or degenerative conditions or diseases, and to those so affected opportunities to obtain standing referrals to specialists, to have specialists as their primary care physicians, and to obtain treatment at centers of excellence. When adequate specialist expertise is unavailable in the network, plans must pay for it to be provided out of network on an in-network cost basis. Upon request, plans must reveal to their enrollees the criteria they use to determine whether a treatment is experimental.

C. Further managed care rights took effect in 1999. Article 49 of the Insurance Law provides for external review by state designated organizations of plan decisions about medical necessity of treatments and, for individuals with life threatening or severely disabling conditions, for review of decisions denying access to clinical trials, experimental treatments and off-label prescription drugs. The law establishes a favorable standard for approval of treatments denied on these bases. Of the hundreds of external reviews conducted in the first years of the program, almost half resulted in overturning plan decisions.

1. A sample external review letter is provided in the appendix to this outline. Note that unless the managed care plan is willing to agree to immediate external review, the external review request cannot be filed until the first level of internal appeal at the plan has been exhausted, and must be filed within 45 days of receipt of that decision. (This generally means that one cannot await the outcome of the second level of appeal at the plan, and that it may be prudent to file the external review and plan second level internal reviews simultaneously.)

2. As noted above, the U.S. Supreme Court has upheld state external review rules against challenges which claimed they were pre-empted by ERISA.

3. Be careful to obey deadlines for external review – 45 days from denial of first internal appeal to plan, plus 8 days for mailing. If the plan offers a second level of internal review, it will not extend the time to start an external review. The two, however, can proceed simultaneously.

4. **IMPORTANT RESOURCE:** Although state law still bars suits against HMOs themselves for damages for negligent or bad faith denials of care (other than vicarious claims for physician-employee negligence), New York's managed care rules are among the most comprehensive and complex in the country. An excellent guide to the Managed Care Bill of Rights and external review law for both lawyers and laypeople is: Kaplan, Laura, Consumer's Guide to New York's Managed Care Bill of Rights, Public Policy & Education Fund, (Ed. 2.1, September, 2001). You can view it on line at http://www.citizenactionny.org/press/reports/MC_consumer_guide.pdf. You can also order copies by calling 518.465-4600, faxing 518.465.2890, or from

the Citizen Action of New York website (www.citizenactionny.org). The first copy is free.

D. Many insurers and HMOs are now offering popular "point-of-service" plans, in which individuals can choose to stay in the network or go out of the network at any time they need a service. Despite the apparent freedom of choice, there may be internal "gatekeeper" requirements in these point-of-service plans that can become the subject of dispute.

V. Gathering Information to Pursue the Claim. While establishing what laws may apply to your situation, it is essential that you gather other information as quickly as possible.

A. Information available from ERISA Claim Administrators: ERISA regulations applicable to group plans provide, for claims decided after January 1, 2002, a period of 180 days from the denial of your client's claim to request review. That request must be comprehensive. The law guarantees broad access to information:

1. Summary plan description (SPD) of benefit plan in question. The plan administrator must supply the latest SPD to a plan participant within 30 days of a written request, or may be personally liable for a penalty. 29 U.S.C. ''1024(b)(4) and 1132 (c).

2. Underlying plan documents (*e.g.,* the full insurance policy, trust agreement, or administrative services agreement, not just the SPD), which must be made available for inspection on written request, 29 U.S.C. '1022(a)(1). Make your request clearly to the plan administrator and if you are not certain you've got everything persist and obtain clarification. Many human resources people have no idea what a plan document is despite their obligation to provide one. The U.S. Department of Labor has an enforcement office to pursue recalcitrant employers who do not share plan documents. (202) 219-8771. Or the plan participant may bring an action to force disclosure and to get penalties for failure to disclose.

3. All documents in the claim fiduciary's file "pertinent" to the claim denial. The plan must have a procedure to make these available for review. 29 C.F.R. '2560.503-1(g). The entire claim file may be too broad a request, Wilczynski v. Lumberman's Mut. Cas. Co., 93 F.3d 397 (7th Cir. 1996), but a substantial portion of it, including expert and investigative reports about the claim, can be obtained. Regulations make clear that documents consulted in claim processing, and guidelines, criteria and rules applicable to the claim must be produced whether or not the plan relied on them in making its determination. 29 C.F.R. '2560.503-1(m)(8). [**NOTE:** A sample records request letter is provided in the appendix to this outline.]

4. If the reasons for the plan determination are not clear, seek an explanation.

The plan must articulate its reasons for denying a claim in order to give the participant a meaningful opportunity for review. 29 C.F.R. '2560.503-1(f).

B. Information available from your client:

1. All documents exchanged between your client and the plan, including correspondence, claim forms submitted and explanation of benefit forms received.

2. If medical condition is relevant, the client's medical chart. A discussion with the client's physicians) is important, as clients do not always have a clear understanding of their medical condition. Detailed reports of their symptoms may be important, however.

3. If job responsibilities are relevant, an employment history, formal job description and your client's own detailed description of what his or her job entailed, with particular reference to different physical or mental activities required, hours worked, travel and the like.

VI. Reading the governing documents: What to look for to establish the status of the plan and assess your client's rights

A. What are the controlling provisions of the Plan?

1. Individual Insurance Policies as State Law Contracts: In general, individually purchased insurance policies are considered contracts, governed by state insurance and contract law. Insurance law will typically prescribe mandatory benefits and provisions. Contract law will govern matters such as interpretation and rules of construction with regard to policy provisions, choice of law, etc. Insurance policies are often considered by state common law to constitute a special breed of contract, and thus may give rise to special rules or treatment not applicable to contracts generally.

a. Contra Proferentem: When an insurance carrier drafts an ambiguously worded provision and attempts to limit its liability by relying on it, courts will construe the language against the carrier. *See, e.g.*, Breed v. Insurance Co. of North America, 46 N.Y.2d 351, 353, 413 N.Y.S.2d 352, 385 N.E.2d 1280 (1978); Sincoff v Liberty Mut. Fire Ins. Co., 11 N.Y.2d 386, 390, 183 N.E.2d 899, 901, 230 N.Y.S.2d 13, 16 (1962); 2 Couch on Insurance 3rd § 22:14; 7 Williston on Contracts § 900 (3d ed. 1963). This rule will also generally apply with regard to questions and answers on policy applications. Vella v. Equitable Life Assur. Soc. of U.S., 887 F.2d 388, 391-392 (2d Cir. 1989); Fanger v. Manhattan Life Ins. Co., 709 N.Y.S.2d 622 (2nd Dept. 2000); Botway v. American Int'l Assur. Co. of New York, 148 A.D.2d 302, 538 N.Y.S.2d 270 (1st Dept. 1989), *modified*, 151 App. Div. 2d 288, 543

N.Y.S.2d 651 (1989); Couch on Ins. 2d, §35:145 (1984).

b. Strict construction of exclusions: To exclude certain coverage from its policy obligations, an insurer must do so in clear and unmistakable language. Exclusions will not to be extended by interpretation or implication, but will to be accorded a strict and narrow construction, such that the insurer bears the burden of establishing that an exclusion applies to a particular case, and that the policy provisions are subject to no other reasonable interpretation. Seaboard Surety Co., v. Gillette Co., 64 N.Y.2d 304, 311, 476 N.E.2d 272, 486 N.Y.S.2d 873 (1984). *See also*, Continental Cas. Co., et al. v Rapid-Am. Corp., 80 N.Y.2d 640, 652, 609 N.E.2d 506, 593 N.Y.S.2d 966 (1993) ("To negate coverage by virtue of an exclusion, an insurer must establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case").

2. ERISA Summary Plan Descriptions and Other Plan Documentation. The SPD provided to your client should have a statement of ERISA rights. It will often indicate who maintains the plan and how it is funded (whether through an insurance policy or some other arrangement). It should have detailed instructions for how to request review.

a. Compare provisions of the underlying plan documents to the SPD. Most SPD's state that they are subject to the terms of these other documents, which must be available for the covered person's review. Some cases suggest that if the summary plan description mischaracterizes or is ambiguous with respect to provisions contained in the underlying plan document, the ambiguity may be read favorably to the covered person, superseding the plan documents. E.g., Heidgerd v. Olin Cor-Q., 906 F.2d 902 (2d Cir. 1990); Hansen v. Continental Insurance Co., 940 F.2d 971 (5th Cir. 1991). Don't count on this principle being universally applied in all circumstances. Check the plan documents.

b. Cases also establish estoppel against plans which misrepresent the plan terms orally to their covered members. *See* Kane v. Aetna Life Insurance, 893 F.2d 1283 (11th Cir. 1990). Again, while estoppel arguments may help in a pinch, you are better off if you have proceeded on a clear understanding of the rules applicable according to the plan terms themselves. In the Second Circuit, estoppel against an ERISA plan requires not just the usual elements of detrimental reliance but also "extraordinary circumstances". Devlin v. Transportation Communications Int'l Union, 173 F.3d 94 (2d Cir. 1999). On the other hand, this Circuit has readily found waiver of plan terms when a plan knowingly foregoes asserting a defense in responding to a claim, as long as it would not have the effect of creating additional coverage under the applicable policy. Lauder v. First Unum Life Ins. Co., 284 F.3d 375 (2d Cir. 2002).

B. **Effect of ERISA Discretionary Clauses:** Look for language in the plan which defines the scope of the plan administrator's discretion to interpret and apply its terms. This may seem like a matter of philosophical hairsplitting, but has major consequences. If the plan clearly gives such discretion to the administrator, then decisions about coverage will be reversible only if they are arbitrary and capricious. If no such discretion is reserved, decisions are subject to *de novo* review. Firestone Tire & Rubber Co. v. Bruch, 489 US 101 (1989).

1. Note that discretion is the exception, not the rule, and that the arbitrary and capricious standard does not apply unless there is a "clear grant of discretion to determine benefits or interpret the plan." Wulf v. Ouantum Chemical Corp., 26 F.3d 1368, 1373 (6th Cir. 1994), *cert. denied*, 115 S. Ct. 667 (1994). *See also*, Kirwan v. Marriot Corp., 10 F.3d 784, 788 (11th Cir. 1994); Baxter v. Lynn, 886 F.2d 182, 187 (8th Cir. 1989). Thus, in Rovira v. AT&T, 817 F. Supp. 1062, 1069 (S.D.N.Y. 1993), despite plan language that the plan administrator "shall serve as the final review committee" and that it "shall determine conclusively for all parties all questions arising in the administration of the Plan and any decision of such [administrator] shall not be subject to further review," de novo review was required because "[t]he Plan does not . . . expressly confer upon the [administrator] the power to interpret or construe the terms or provisions of the Plan." In Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243 (2d Cir. 1999), the Court of Appeals found that a plan's requirement of proof satisfactory to the decision-maker is not the equivalent of conferring discretion on that decision-maker.

2. When plan decisions are subject to *de novo* review, you may have the opportunity to import many common law concepts into the interpretation of the plan, such as the requirement that ambiguities be read favorably to the plan beneficiary (*see* Masella v. Connecticut Blue Cross & Blue Shield, 936 F. 2d 98 (2d Cir. 1991)), and that plans should be read to give effect to the reasonable expectations of the participants. Saltarelli v. Bob Baker Group Medical Trust, 33 F.3d 382 (9th Cir. 1994). Courts have made plain, however, that when discretion is granted to the plan administrator to interpret its terms, then the doctrine of *contra proferentem* will not apply. Winters v. Costco Wholesale Corp.)., 49 F.3d 550 (9th Cir. 1995), cert. denied, 116 S. Ct. 276 (1995).

3. Effect of Conflict of Interest: If decision-making or interpretive discretion is reserved, one should investigate conflicts of interest in the claim fiduciary which might have affected its determination; if such an effect can be shown, review is *de novo*. The Supreme Court recently held that the financial conflict of interest inherent in being the payer of claims as well as the decider should be taken into account, to reduce (in an unspecified way) the degree of deference accorded the plan administrator. Metropolitan Life Ins. Co. v.

Glenn, 128 S. Ct. 2343, 2008 U.S. Lexis 5030 (2008). That will chance the law in the Second Circuit, where showing a conflict of interest has heretofore not sufficed to obtain a less deferential standard of review. (See Whitney v. Empire Blue Cross & Blue Shield, 106 F.3d 475 (2d Cir., 1997), holding that one must show that the conflict of interest affected the determination, not just that the conflict existed.)

a. In determining whether a conflict of interest affected the decision, a court can look not only at structural conflicts but can also assess the credibility of the witnesses and can draw inferences about intention circumstantially. An excellent example of such fact finding can be found in Schwartz v. Oxford Health Plans, 175 F. Supp. 2d 581 (S.D.N.Y., 2001), in which a decision to change to a less generous reimbursement formula for "usual, customary and reasonable" fees was found tainted, based on the insurer's decision to make the change in the same year it began to experience losses, and after it failed to induce the insured to switch to an in-network provider.

4. *De Novo* review may be applicable, despite the existence of language sufficient to confer discretionary authority, under certain circumstances:

a. Failure to Make a Decision Within ERISA Time Deadlines/Deemed Denials. ERISA regulations provide that a plan administrator's failure to establish and follow a reasonable claims procedure, consistent with those outlined in the regulations, entitles a plan beneficiary to treat the administrator's actions (or non-actions) as a denial, and the "claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act." 29 CFR §2560.503-1(l).

(1) When a claim administrator fails to reach a decision regarding a claim within the timelines specified by ERISA regulations, and, therefore, its decision is deemed under ERISA regulations to be a denial, that denial may not be entitled to deference, even if a claim administrator is otherwise granted discretionary authority by the terms of the relevant plan. Nichols v. Prudential Ins. Co., 406 F.3d 98, 109-10 (2nd Cir. 2005); Gilbertson v. Allied Signal, Inc., 328 F.3d 625, at 631 (10th Cir. 2003); Jebian v. Hewlett Packard Co., 310 F.3d 1173 (9th Cir. 2002); Gritzer v. CBS, Inc., 275 F.3d 291 (3rd Cir. 2002).

(2) **NOTE:** Under the substantial compliance doctrine, small infractions of the deadline may be excused by the reviewing court. Bona v. MetLife Disability Ins. Co., 2004 U.S. Dist. LEXIS 754, at *12-13 (N.D. Cal., 2004) (decision issued 15 days after applicable deadline deemed "inconsequential" where claim administrator

appeared to be actively reviewing the claim during the relevant time period).

b. Decision Rendered by Party other than Entity on which Discretion Conferred. Even where a plan clearly confers discretionary authority, if the claim determination is made by an unauthorized party, *i.e.*, a party other than the claim administrator to whom discretion is conferred, that determination will be reviewed under the *de novo* standard. Sharkey v. Ultramar Energy, Ltd., 70 F.3d 226, 229 (2nd Cir. 1995); Rodriguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580, 584 (1st Cir. 1993); Baker v. Big Star Div. of The Grand Union Co., 893 F.2d 288, 291 (11th Cir. 1989) (as amended Jan. 29, 1990). Where there is no authorization, delegation to another party – even if a related corporate entity – may trigger *de novo* review. Anderson v. Unum Life Ins. Co. of Am., 414 F. Supp. 2d 1079, 1095-1100 (M.D. Ala, 2006) (where plan conferred discretionary authority on Unum Life and where there was no provision permitting delegation of that authority, claim denial would be reviewed *de novo* because it was made by UnumProvident, a related – but nonetheless wholly independent – corporate entity); Boyles v. Unum Life Ins. Co. of America, 2006 U.S. Dist. LEXIS 88581, at *14-15 (C.D. Cal., Nov. 20, 2006) (same).

c. State "No Discretion" Regulations. Some state regulators, concerned with the abusive use of ERISA discretionary authority, have sought to limit the use of clauses conferring discretionary authority. New York's Superintendent of Insurance issued a circular opinion in 2006, which banned discretionary clauses in health and disability policies, but later withdrew and replaced that opinion with one which merely "warned" insurers of the Superintendent's "belief" that such clauses were unlawful. Illinois, California, and Utah have issued regulatory bans on discretionary clauses. It remains to be seen whether such clauses would survive ERISA preemption. Saffon v. Wells Fargo & Co. Long Term Disability Plan, 2008 U.S. App. Lexis 334, at *6 (9th Cir., Jan. 9, 2008) ("It is an open question whether the states' efforts are preempted by ERISA, 29 U.S.C. § 1144(a), or (as is more likely) they are saved from preemption because they 'regulate[ ] insurance,' *id.* § 1144(b)(2)(A)") (sidestepping the question by finding that even if not preempted, California's regulatory prohibition could not be applied retroactively to the claim at issue).

C. Review under ERISA's Arbitrary and Capricious Standard. Even if a conflict of interest cannot be demonstrated, a claim administrator's decision may be successfully challenged as arbitrary and capricious.

1. The plan administrator must be loyal to the contract language. If it interprets the plan in a way that ignores relevant factors or is not based on substantial evidence, that is arbitrary and capricious. Miller v. United Welfare Fund, 72

F.3d 1067 (2d Cir. 1995); Zuckerbrod v. Phoenix Mutual Life Ins. Co., 78 F.3d 46 (2d Cir. 1996).

2. Inconsistent application of plan standards; that may also be strong evidence of arbitrary and capricious decision making. Egert v. Connecticut General Life Ins. Co., 900 F.2d 1032 (7th Cir., 1990); DeAngelis v. Warner Lambert Co., 641 F. Supp. 467 (S.D.N.Y. 1986); Sansevera v. E.I. DuPont de Nemours & Co., 859 F. Supp. 106 (S.D.N.Y. 1994). One may also in some circumstances want to argue that treating one disability differently from others may give rise to a discrimination claim under the Americans with Disabilities Act. Henderson v. Bodine Aluminum Inc., 70 F.3d 958 (8th Cir. 1995). Although most Courts of Appeal, including the Second Circuit, have rejected Henderson's notion that a plan which is written to provide different benefits for different illnesses would violate the ADA, a plan which as a matter of policy is interpreted differently for different diseases might still give rise to a claim.

3. Unsupported Reversal of Prior Decision. A claim administrator acts arbitrarily, in violation of ERISA, when it changes its position without receipt of any new evidence. Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130, 1146 (9th Cir. 2001); Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3rd Cir. 1997); Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556, 1569 (11th Cir. 1990), cert denied, 498 U.S. 1040 (1991).

4. Failure to Properly Credit Opinion of Treating Physician. Although the Supreme Court, in Black & Decker Disability Plan v. Nord, 538 U.S. 822, 123 S. Ct. 1965 (2003), held that Social Security's "treating physician rule" is inapplicable in the ERISA context, this does not mean that a beneficiary is defenseless when facing a plan's medical consultant. A claim administrator's preference for its own medical consultant may be arbitrary in a number of circumstances:

a. Where the treating physician is an expert in the beneficiary's medical condition, but the plan's medical consultant is not. Miller v. United Welfare Fund, 72 F.3d 1067, at 1073 (2nd Cir. 1995); Addis v. Limited Long-Term Disability Program, 2006 U.S. Dist. LEXIS 15325 (E.D. Pa., Mar. 30, 2006).

b. Where the claim administrator uncritically accepts the opinion of its medical consultant, even though that opinion is based on disputed, incomplete, or erroneous facts and/or stands against the weight of the medical evidence. Crocco v. Xerox Corp., 956 F. Supp. 129, 140 (D. Conn. 1997), *aff'd as to this holding*, 137 F.3d 105 (2nd Cir. 1998), Webber v. Aetna Life Ins. Co., 375 F. Supp. 2d 663, 673 (E.D. Tenn. 2005).

c. Where the medical consultant's opinion fails to address "particular circumstances" of the beneficiary's medical condition and thus ignores relevant factors, Zuckerbrod v. Phoenix Mutual Life Ins. Co., 78 F.3d 46, 50 (2nd Cir. 1996).

d. In general, Nord prohibits only "routine deference" which "automatically ... accord[s] special weight to the opinions of a treating physician." 123 S. Ct. at 1971-72. Consequently, "a plan administrator may not arbitrarily disregard reliable medical evidence proffered by a claimant, including the opinions of a treating physician." Evans v. Unumprovident Corp., 434 F.3d 866, 877 (6th Cir. 2006). *See, e.g.*, Addis v. Limited Long-Term Disability Program, 2006 U.S. Dist. LEXIS 15325 (E.D. Pa., Mar. 30, 2006) (unreasonable for claim administrator to credit its own non-specialist medical reviewer over claimant's treating specialist, particularly where the reviewer did not appear to have a specific understanding of the claimant's job requirements and where the reviewer did not deny that claimant had the alleged limitations, but only that he "is unable to substantiate" the limitations); Fordyce v. Life Ins. Co. of No. America, 2004 U.S. Dist. LEXIS 20135, at *34-35 (D. Minn., Jul. 22, 2004) (claim administrator's decision "to credit a non-examining, in-house physician, rather than relying on three examining physicians who rendered consistent opinions finding plaintiff could not return to work … [is] unreasonable and falls far below the 'substantial evidence' which might justify denial of plaintiff's claim").

D. Importance of Identifying Plan fiduciaries and Claim Administrators. Plan documents should be carefully reviewed to determine who is authorized to make decisions regarding claims and coverage. The documents should identify the "plan administrators" or "claim administrators," their respective roles and responsibilities, and whether they are accorded discretionary authority. The client should be carefully interviewed and the claim file closely reviewed to determine, in contrast, the parties actively involved in the decision-making. The plan authorizations, and any deviation therefrom, may have a number of consequences:

1. Only those who exercise discretion or who participate in a breach of fiduciary duty may be appropriate defendants. McManus v. Gitano Group, Inc., 851 F. Supp 79 (E.D.N.Y. 1994).

2. As previously noted, only those specifically authorized to exercise discretion may indeed exercise it. If others make decisions in their place the decisions may not be entitled to deference from a court, and the unauthorized party's decision may be reviewed *de novo*.

3. Requests for pertinent plan documentation must be directed in writing to the "plan administrator," as only the "plan administrator" may be subjected to penalties for any failure to provide such documentation within the statutory

30-day period.

E. Importance of Provisions Setting Forth the Procedures for Appealing Denied Claims. They will establish whether an internal review of a denied claim is required (exhaustion of internal remedies may not be required if the plan merely permits appeals, Osborne v. N.Y. State Teamsters Fund, 783 F. Supp 739 (N.D.N.Y. 1992)), but courts seem always at the ready to remand to the plan administrator and are reluctant to find that internal review is either not required or would be futile. Establish to whom to submit a request for review (it may be good practice to direct the request to the plan administrator named in the plan as well as to any individual to whom appeals are directed to be submitted) and the time within which to request review (ERISA mandates that you have no less than 180 days, and most plans only afford that minimum amount of time).

VII. Preparing the ERISA request for review

A. Put all information on which you rely in the request for review. Make your case for reversal as comprehensive as the case you would put on in court, including doctor's testimony (by letter) and medical records. I make legal arguments as well. *See* discussion in Locher v. Unum Life Ins. Co., 389 F.3d 288 (2nd Cir. 2004), allowing introduction of evidence beyond the administrative record only for good cause shown.

1. When the plan administrator's decision is reviewed on an "arbitrary and capricious" standard, some reviewing courts will not look beyond the information that was presented to the plan administrator. Jones v. Laborers Health & Welfare Trust Fund, 906 F.2d 480 (9th Cir. 1990).

2. When the plan administrator's decision is reviewed on a *de novo* basis, facts outside the record may, in the discretion of the court, be admitted with respect to interpretation of the plan.

3. The Second Circuit has joined the Third, Fourth, Seventh and Ninth in applying *de novo* review to factual determinations as well as plan interpretation. Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243 (1999). The Fifth Circuit has taken the opposite view. But the admissibility of new facts specific to the claimant's medical condition or similar situation-specific facts is in some doubt, and depends, as set forth in Locher, on showing good cause for such admission.

4. If your client has already done an internal appeal which you think creates an inadequate record, examine the plan's denial letter. If as often happens it invites further information for their consideration (or even if it does not) you may be able to reopen the internal review and make a better record for later court review.

VIII. Litigation Strategy

A. Where to sue?

1. If you seek injunctive relief, claim discrimination under ERISA '510, or are claiming breach of fiduciary duty, your ERISA claims are required to be brought in federal court.

2. If you are solely making claims for denied benefits under a plan, claims may be brought in state or federal court. In deciding which forum, take into account the usual criteria, including:

a. greater speed and supervision in federal court;

b. greater familiarity of federal court with ERISA;

c. practitioner's degree of comfort in each court.

3. Removal: It is almost standard practice for defendants in ERISA cases that have been brought in state court to remove them to federal court. If that happens and you have an argument against ERISA applying, make your motion for remand right away.

B. Jury trial?

1. The answer for many years was "Forget it." While the Second Circuit in Sullivan, joining most fellow circuits, found no right to jury trial in ERISA cases seeking benefits under ERISA's civil enforcement provisions, recent Supreme Court decisions like Great-West, which affirmed that claims for such damages do not implicate the fiduciary duties of directors, have undercut the theoretical underpinning for denying jury trials (that these are essentially equitable claims against fiduciaries for breach of their duties regarding a trust, and therefore not historically eligible for jury trial). Creative plaintiffs' counsel at Quadrino & Schwartz have a good argument for jury trial now in ERISA actions to recover benefits. *See*, Evan S. Schwartz and Michail Z. Hack, "Supreme Court Ruling Undermines Jury Trial Ban," N.Y.L.J., June 15, 2006, at p. 5, col. 1.

C. Remedies

1. "Contractual" damages, the benefits not paid, are generally available.

2. "Extracontractual" damages, such as consequential or tort-type damages, are generally not available to ERISA plan beneficiaries. This has been an area of

much ferment, with creative counsel trying to avoid this general rule by bringing traditional negligence claims, for negligent physician hiring and supervision, for vicarious liability for physician malpractice, for fraud in advertising plan benefits, for RICO violations, violations of New York General Business Law '349, and others. They have met with mixed success.

a. The most important inroad has been in malpractice type claims against health plans. An HMO, for example, may be vicariously liable for alleged incompetence of its employee physicians, even if it is not directly liable for its own negligent decision-making regarding treatment. Such claims are not preempted by ERISA, as Pegram established.

b. **NOTE** that in New York, however, overcoming the bar of ERISA preemption may not suffice. Although the Court of Appeals has recognized that ERISA is not a bar to malpractice claims against doctors who happen to be employed by HMOs, Nealy v. U.S. Healthcare HMO, 93 N.Y.2d 209 (1999), it has not extended that same liability to HMO medical directors or other utilization reviewers applying the terms of a plan. We still give HMOs statutory protection against medical malpractice claims, despite some initiatives in the last few years in the legislature to repeal that protection. A state determination to subject HMOs to malpractice claims would apparently not violate ERISA, as the Texas HMO liability law has been upheld. Corporate Health Insurance Inc. v. Texas Department of Insurance, 314 F.3d 784 (5th Cir. 2002).

3. As with general extracontractual damages, punitive damages are generally not recoverable by ERISA plan beneficiaries.

4. Attorneys' fees may be awarded in the discretion of the court, under a five factor test (in the Second Circuit) which looks not only to which party prevails but to issues such as deterrent effect, degree of bad faith, and benefits achieved for others beside the immediate parties. Chambless v. Masters, Mates & Pilots Pension Plan, 815 F.2d 869 (2nd Cir. 1987). No attorneys' fees may be awarded for the internal administrative review before a lawsuit is commenced, but that fees incurred before the plan administrator on a court ordered remand may be recovered. Peterson v. Continental Casualty Co., 282 F.3d 112 (2nd Cir. 2002).

5. Deceptive practices by insurers of individual insurance contracts may be remedied by limited punitive damage and attorneys fee awards under General Business Law '349, although the courts have not always welcomed such claims readily.

6. Be aware of other resources. The State Attorney General's Office now has a health care unit which is operating in a much more aggressively consumer

protective manner than the Insurance Department's Consumer Services Bureau. The Office of Managed Care within the State Department of Health may pursue violations by managed care plans.