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Outside Counsel

Second Circuit Broadens Disability Insurance Remedies

BY KEVIN SCHLOSSER & ROBERT C. ANGELILLO

The U.S. Court of Appeals for the Second Circuit has recently expanded the rights and remedies for disabled individuals seeking to obtain insurance benefits under employer-sponsored policies. As a result, actions challenging the denial of disability insurance benefits should be easier to prosecute and prove, and the remedies available - including attorneys' fees and prejudgment interest - are likely to be awarded more frequently.

Employer-sponsored disability insurance policies are governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. (ERISA), which preempts state contract law principles "insofar as they may now or hereafter relate to" covered disability plans. See 29 U.S.C. §§1144(a) & 1144(c)(i). Under ERISA, there is a mandatory "administrative review" of claims, requiring the claimant to "appeal" any denial to the plan administrator before bringing an action.

In any action seeking to challenge a denial, the court must determine whether to apply the "arbitrary and capricious" (also called the "abuse of discretion") standard of review or the de novo standard. Under *Firestone Tire & Rubber Company v. Bruch*, 489 U.S. 101 (1989), de novo review will apply unless the disability insurance plan reserves "discretionary authority" to determine benefits to the administrator.

In describing the factors to be considered under the "abuse of discretion" standard, the Supreme Court in *Firestone* stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion." *Firestone*, 489 U.S. at 115 (citation omitted).

However, notwithstanding this language in *Firestone*, courts often disagreed as to how to consider this conflict, what impact it would have and what weight to give it in determining whether to uphold a claim denial.

A common conflict of interest is where the administrator both determines benefits under the policy and is responsible for paying a claim. In *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343 (2008), an important decision likely to have significant impact on ERISA disability insurance litigation, the Supreme Court found that courts must consider this conflict in determining whether the administrator had abused its discretion in denying a claim, even under the limited "arbitrary and capricious" standard. In guiding the lower courts on the amount of weight to place on this conflict, the Court continued that, although it was not creating a fixed standard to be applied in all situations, certain factors should influence the reviewing court's decision.

Thus, the Court explained that this conflict of interest would be important "where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration" or where the insurance company has emphasized medical reports and evidence that favor a denial while de-emphasizing contrary evidence. Id. at 2351. On the other hand, the conflict might be given less weight "where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision-making irrespective of whom the inaccuracy benefits." Id.

Before *Glenn*, the standard of review was likely to be dispositive in determining whether the insurance company's denial of the claim would be upheld in court. As discussed below, because *Glenn* has significantly liberalized the level of review even under the "arbitrary and capricious" standard, the issue of which standard applies no longer has the same importance.

In its first substantive application of *Glenn*, in *McCauley v. First Unum Life Insurance Company*, 2008 WL 5377680 (2008), the Second Circuit provided guidance on the critical factors that the courts must consider in determining whether insurance benefits have been properly denied.

In *McCauley*, the plaintiff was a tax attorney who suffered from colon cancer. Although the condition itself had been successfully treated, the treatment was so debilitating that it became impossible for plaintiff to continue to work. The plan administrator, defendant First Unum Life Insurance Company (First Unum) - which was also responsible for paying the claim if it had been granted, and therefore suffered from the precise conflict noted by *Glenn* - denied the claim. First Unum subsequently upheld its denial during its "administrative review." After exhausting his administrative remedies, plaintiff instituted an action in the Southern District contesting the denial of his claim.

The district court applied the "arbitrary and capricious" standard to the claim, concluded that First Unum's decision was "reasonable" and, therefore, awarded it summary judgment dismissing the case. On appeal, the Second Circuit applied *Glenn*, reversed, and remanded the case for the sole purpose of entering judgment in favor of plaintiff and awarding him his benefits under the policy, with attorneys' fees.

Kevin Schlosser *is a partner and chairman of the litigation department at Meyer, Suozzi, English & Klein in Garden City.* **Robert C. Angelillo** *is a member of the firm's litigation department. Both also are members of the firm's disability insurance practice group. They can be reached at kschlosser@msek.com and rangelillo@msek.com, respectively.*

The court first noted: "Following *Glenn*, a plan under which an administrator both evaluates and pays benefits claims creates the kind of conflict of interest that courts must take into account and weigh as a factor in determining whether there was an abuse of discretion" - even though this factor does not require a de novo review.

The court held that while this conflict of interest under the pre-*Glenn* Second Circuit case law could have led to a change of the standard of review from "arbitrary and capricious" to de novo if the conflict affected the administrator's determination of the claim, now, this conflict is to be considered directly in determining whether the administrator in fact acted unreasonably and thereby abused its discretionary authority in denying the claim. It is no longer necessary, therefore, for courts to impose the more liberal de novo standard to consider the conflict in determining whether the claim denial will be upheld.

The court then reviewed a series of inappropriate and deceptive acts by First Unum in denying and then upholding that denial of the claim: First Unum (1) ignored the "clear proof" of plaintiff's eligibility for total disability benefits, asserting without basis that this information was duplicative of evidence it already reviewed; and (2) misrepresented the purported reason why it rejected the newly submitted medical information on appeal, claiming that it was because it was not signed by a physician. The court observed that if First Unum had so advised plaintiff during the administrative review, he could have easily remedied it by having the physician sign.

The court then observed that these acts were "exacerbated" by First Unum's conflict in both determining the claim and being responsible for paying the claim, concluding that this conflict must have "influenced" First Unum's wrongful denial of the claim in the absence of other evidence. The court also emphasized that First Unum failed to rebut evidence of its history of abusive claims procedures.

McCauley indicates that plan administrators will need to offer evidence that they have taken preventive measures to mitigate the overall affect of their conflict of interest to counteract the important weight placed upon this conflict in determining whether it influenced the claim decision and thereby resulted in an impermissible "arbitrary and capricious" decision.

Courts are now required to consider the insurer's past history as well as the mechanisms it implemented, if any, to insure that the potential for any bias that may arise due to the conflict is mitigated or avoided. As a result, courts cannot limit their review strictly to the administrative record, which would not contain any of this additional information. Thus, in addition to liberalizing the substantive review process, *McCauley* and *Glenn* will also prevent insurance administrators from limiting discovery solely to the administrative record.[1]

Attorney's Fees

In *Slupinski v. First Unum Life Insurance Co.*, 2009 WL 159165 (2d Cir. 2009), the Second Circuit broadened the grounds upon which attorney's fees and prejudgment interest may be awarded to a prevailing claimant under ERISA.

In *Slupinski*, the claimant, an attorney, suffered serious injuries in a car accident. The combination of severe pain in his arm and the effects of the pain medication he was required to take to cope with it rendered it impossible for him to continue to practice as an attorney. After paying benefits for a number of years, First Unum terminated his benefits. After exhausting his administrative remedies, Mr. Slupinski obtained judgment in the Southern District, but his claim for attorneys' fees and prejudgment interest was denied. Slupinski appealed that denial.

Under ERISA, a district court may award attorneys' fees and expenses to a prevailing party in an action to recover benefits. 29 U.S.C. §1132(g)(1). In *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 871 (2d Cir. 1987), the Second Circuit held that district courts must evaluate "(1) the degree of the offending party's culpability or bad faith, (2) the ability of the offending party to satisfy an award of attorney's fees, (3) whether an award of fees would deter other persons from acting similarly under like circumstances, (4) the relative merits of the parties' positions, and (5) whether the action conferred a common benefit on a group of pension plan participants."

The Second Circuit in *Slupinski* found "considerable difficulty with the district court's rulings on the first and fourth *Chambless* factors, i.e., the degree of culpability - or of bad faith, if any - on the part of First Unum and the relative merits of the parties' positions," noting that "while the degree of culpability and the relative merits 'are not dispositive under the [*Chambless*] five-factor test,' they do 'weigh heavily.'" Id. (citing *Anita Foundations Inc. v. ILGWU National Retirement Fund*, 902 F.2d 185, 189 (2d Cir. 1990)).

The court continued that "'culpability' and 'bad faith' are distinct standards" and, therefore, "to win an award of attorney's fees under ERISA a party need not prove that the offending party acted in bad faith." The Second Circuit further noted that the award of attorney's fees in disability benefits cases is not the equivalent of a sanction, but instead is remedial.

Accordingly, the claimant need not show the defendant's conduct was "frivolous," but instead need only show "culpable" conduct, a far lower standard that the Court defined as, inter alia, "involving the breach of a legal duty or the commission of a fault." The court also noted that First Unum's initial payment of benefits did not minimize its culpability for failing to do so later.

The Second Circuit in *Slupinski* also explained the circumstances under which prejudgment interest should be paid to a prevailing claimant. After noting that the decision to award prejudgment interest lies in the discretion of the district court, the court explained that, like attorneys' fees, prejudgment interest is an element of compensatory damages.

It continued that the award of prejudgment interest is generally appropriate to prevent a windfall to the defendant, relying on employment law cases holding that it is an "abuse of discretion" not to award prejudgment interest to plaintiffs in lost compensation cases insofar as it would amount to an "interest-free loan" to the defendant.

In fact, the court enumerated only limited instances where an award of prejudgment interest may not be appropriate, including dilatory conduct by the plaintiff or when the funds in issue had already been placed in an interest-bearing account and the entire amount, plus interest, is awarded to the plaintiff.

These recent decisions of the Second Circuit show a rather compelling trend towards expanding the rights of disability insurance claimants in an effort to level the playing field against insurance carriers and to provide fair and adequate compensation to disabled claimants who have been wrongfully denied benefits.

Endnotes:

1. See, e.g., New York Law Journal, "Liberalizing Discovery in ERISA Disability Insurance Cases," K. Schlosser, Sept. 23, 2008.