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ERISA Disability Plan Insurers Score Important Circuit Court Victories

September 03, 2020

In recent months, circuit courts across the country have supported insurers' discretion to deny long-term disability benefits (LTD) under ERISA. Since the beginning of the year, disability plan insurers have prevailed in the majority of disability claim disputes to reach the First, Third, Seventh, Ninth, Tenth, and Eleventh Circuit Courts of Appeals. Below is an overview of some of the appellate wins for disability insurers so far this year.

Even if one doctor finds a participant disabled, an insurer can reasonably credit other doctors who examine the participant and disagree with that finding. The **Third Circuit** so held when it upheld a company's decision to discontinue LTD benefits to a plan participant under a policy provision that disability benefits would end after two years unless the participant's disability prevented her from doing any job for which she was reasonably fitted by training, education, or experience.

Upon review of the participant's file, four health care professionals concluded that the participant could perform work in her field. During an administrative appeal, the insurer's in-house reviewer found that the participant's headaches, arthritis, Crohn's disease, and fibromyalgia did not prevent her from doing light or sedentary work, a view shared by some of the participant's own doctors. Only one of the participant's doctors found that she had limited functional capabilities that prevented her from working. Based on the totality of the medical records, the participant was denied continuing LTD benefits. Both the district court and the court of appeals concluded that the insurer's decision was reasonable, and not arbitrary and capricious.

In another case, the Third Circuit also affirmed judgment for the insurer, finding that the insurer did not abuse its discretion in denying a claim for LTD benefits submitted by a participant based on complaints of migraine headaches.

In a **Seventh Circuit** decision, the participant was denied continuing LTD benefits because she did not satisfy the "any occupation" definition of disability that would have allowed her benefits to continue after two years. During the two-year review, her primary physician reported that some of the participant's endometriosis symptoms that had resulted in the commencement of LTD had subsided, but her Lyme disease specialist noted that the participant was still experiencing fatigue and other symptoms. The specialist ultimately informed the insurer that the participant could not work at all, for fear of stress exacerbating her symptoms. The participant herself told the insurer that she was improving and had engaged in certain activities. Two consulting physicians concluded that her reported activities were disproportionate to her complaints, and there was no evidence that she could not perform the duties of her regular occupation. The insurer subsequently terminated her LTD benefits. Then, during an administrative appeal, additional physicians were consulted, but the participant declined to submit to an independent medical examination, and her appeal was denied.

Notably, neither party addressed whether the participant satisfied the definition of "any occupation" disability in the district court. Because the plan did not give the insurer discretion, the district court appropriately reviewed the administrative record de novo and ruled in the insurer's favor. Given the participant's burden to prove entitlement to benefits, her failure to prove that she met "any occupation" definition was fatal to her claim, and the Seventh Circuit affirmed.

The **Fourth Circuit** found that an insurer did not abuse its discretion in denying a participant continued LTD benefits. The court reiterated its long-held view that it will not disturb a plan administrator's decision provided that it is reasonable, even if the court would have come to a contrary conclusion independently.

The **Ninth Circuit** reviewed the denial of "any occupation" disability benefits under a de novo standard of review, finding that neither of the participant's treating physicians certified his disability during the "any occupation" period, and contemporaneous medical records suggested that his complaints were opportunistic.

In a **Tenth Circuit** decision, the court grappled with choice-of-law issues, which impacted whether the denial of benefits was subject to abuse of discretion or de novo review. The participant worked in Colorado, but the policy was governed by Pennsylvania law, where the insured employer was incorporated and had its principal place of business. The court concluded that Pennsylvania law — and the abuse of discretion standard — applied. Applying this standard, the Tenth Circuit reversed the district court and held that the insurer's denial of benefits for alleged neurological impairments must be affirmed. In so holding, the court rejected the participant's claim that the insurer operated under a conflict of interest as both the insurer and claims administrator.

The **Eleventh Circuit** affirmed the denial of an LTD benefits claim because of a preexisting condition related to the participant's substance abuse and drug dependency. During an administrative appeal,

the participant asserted that his disability was the result of substance abuse/dependency that had commenced outside the applicable six-month look-back period. An independent physician who reviewed the pertinent records concluded, however, that the participant's disability was a preexisting condition during the look-back period. The Eleventh Circuit found that the insurer reasonably proved that substance abuse/drug dependency was a preexisting condition under the policy and that the insurer's determinations deserved deference.

Disability insurers have not fared as well in the **Sixth Circuit**. That court reversed judgment for the plan administrator and ruled in favor of the participant in at least three separate opinions since the beginning of the year, and found in favor of the insurer only once.

Conclusion

These decisions reflect that, in evaluating claims under ERISA, courts generally continue to follow the deferential constructs for review and will affirm decisions that are based on reliable evidence — even if that evidence may be conflicting — provided the insurer's decisions are reasonable. Courts, however, may still be expected to reject benefits decisions that appear to be based on cherry-picked evidence or the insurer's willful disregard of unfavorable facts.

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