

Special Report

Why Your Long-Term Disability Company Love ERISA

And Why You Should Be Screaming to Your Congressman About ERISA

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A Law To Protect Your Pension is Turned on Its Head To Be Used Against You

The Employee Retirement Income Security Act was passed in 1974 to protect the cash in your pension fund. Today it protects the insurance companies more than it does the employees. Nowhere is this more evident than in the long-term disability insurance policy that you hold through your employer.

Ninety-nine percent of all disability insurance plans offered to employees are governed by ERISA. Under ERISA, you have the right to file suit in federal court if your claim for benefits is denied. But, unlike almost any other legal proceeding, one side goes into court with all of the “good cards.” That side is the insurance company.

The Insurance Company’s “ACE”

The most important card held by the insurance companies is something called a “reservation of discretion.” Don’t bother looking in the ERISA statute for this “ace” – it’s not there. The reservation of discretion is something that the courts have given to the insurance companies – for free! Here is what this “special card” means:

If your claim for benefits is denied, you will lose your lawsuit against the insurance company, even if you are right and it is wrong, if there is any evidence that supports the insurance company’s decision. In any other legal proceeding, you can only win if you have a preponderance (*i.e.* more than 50 percent) of the evidence in your favor. Under ERISA, however, the claimant can have 85 percent of the evidence, and the insurance company can have 15 percent of the evidence, and if the insurance policy contains a “reservation of discretion,” they win!

The 8th Circuit Court of Appeals recently put it rather bluntly:

...a beneficiary claiming procedural irregularities must show that the plan administrator, in the exercise of its power, acted **dishonestly**, acted from an **improper motive**, or **failed to use judgment** in reaching a decision.

WOW!! This court said that these cases are only winnable if you can prove that the insurance company acted dishonestly!

Quick. Call the police. This is robbery without a gun.

We Are Not Kidding About this Terrible Law!

Think we exaggerate? Here are some examples:

- Ivan Kimber suffered from insulin-dependent diabetes. After he lost vision in one eye, he was transferred from his job as a heavy equipment operator to a desk job. Over the next three years, his condition worsened. After suffering several incidents of diabetic shock, his doctors recommended that he take medical leave and apply for disability under his company's long-term disability plan.

At first, the plan granted him benefits "indefinitely." Later, the plan changed its mind and terminated those benefits. Kimber submitted reports from three doctors. The plan again started to pay, but stopped after Kimber reached 24 months of benefits, citing the 24-month Mental and Nervous provision in the policy.¹

The Court began its opinion by pointing out the low level of evidence necessary to uphold the disability insurance plan's decision to deny benefits. It said, "The administrator's decision need not be the only logical one, nor even the best one. It need only be sufficiently supported by facts within his knowledge to counter a claim that it was arbitrary or capricious." The Court said that when a court reviews an administrator's decision, it "need only assure that the administrator's decision falls somewhere on a continuum of reasonableness – even if on the low end."

The Court looked at all of the facts in the case and said that "although we might have come to a different conclusion, the plan administrator acted within his discretion in [denying the claim]."

Under almost every other law governing insurance contracts, any ambiguity in the insurance contract will be construed against the insurance company and in favor of the claimant. The Court said that this disability plan was ambiguous, but that it did not have to apply the standard law and read the ambiguity in favor of the claimant. It said that under ERISA, the insurance company or plan administrator may interpret the plan in its own favor, as long as the interpretation is merely rational.

The insurance company has both the legal power to deny your claim and the unilateral power to interpret your policy—even if the policy is ambiguous

¹ Most group insurance policies offered through employers contain a limitation of benefits if the disability is caused by a mental illness. Although this discriminates greatly against those suffering from mental illness, courts have said that it is perfectly all right for an insurance to limit benefits to two years if the cause of the disability is a mental illness.

Contrary to All Other Insurance Law, in a Disability Case It Does Not Matter What the Reasonable Expectation of the Claimant Is

Finally, the Court looked at the standard “reasonable expectation doctrine.” This doctrine means that a written disability plan should be interpreted in a way which matches the reasonable expectations of a claimant or an insured. The Court said that under ERISA, this doctrine did not apply and that, again, the plan administrator or insurance company could interpret the policy in a way most favorable to it.

- Bradley Bingham was a paraplegic who was paid benefits for five years by Sun Life Insurance Company of Canada. After five years, his policy provided that he would only be eligible for benefits if he was totally disabled from working at any occupation.

After reviewing the evidence from Bingham’s treating physicians (which supported the claim) and numerous affidavits from people who knew him (all of which supported the claim), the Court said that because of ERISA, “The question we face in this appeal is not which side we believe is right, but whether the insurance company had substantial evidentiary grounds for a reasonable decision in its favor.” The Court said that the case was difficult because of “the obvious courage the claimant has shown in facing his disability.”

When the case goes to court the question for the judge is not, as in most cases, whether the insurance company was right or wrong. The question for the judge is whether or not the company’s decision had a little bit of evidence to support it.

The Insurance Company Won Even After the Court Decided That it Took a *Minimalist* View of the Medical Records

The Court said that it was counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. The Court also said that it seemed clear that Sun Life had taken a minimalist view of the record.

One court has stated that if one doesn't break out into a "loud" guffaw when reviewing an administrator's decision, that decision must be upheld.

Because Sun Life did not have to prove that it was right, only that it had not acted arbitrarily, the Court found in favor of Sun Life. It pointed out that even though the Social Security Administration had found Bingham to be disabled, that under this policy, establishing his inability to perform any occupation for which he could be trained, was a very high one. The Court ruled in favor of the insurance company.

In a dissent filed by one of the other Appellate Court judges, the judge said that there was significant and un rebutted evidence that Bingham, in his current condition, was unable to work consistently. He said that Bingham was not a malingerer, and that the affidavits submitted by his family demonstrated that if he engaged in much activity on one day, he would be in pain or discomfort on subsequent days, making it difficult for him to leave his bed. This judge also said that one would think that the Social Security finding, coupled with the affidavits from his family and the reports from his doctors that he was totally disabled, would have at least prompted the insurance company to seek an independent examination of his condition before denying benefits.

The Worst Disability Decision of All Time Took Place Right In Our Own Backyard

In perhaps the worst disability decision of all time,² Patrick Gallagher was denied disability benefits under an insurance policy issued by Reliance Standard Life Insurance Company.

Goodwill Publishing Simply Had Bought a Terrible Disability Policy

(and you should check your employer's policy before you have a claim)

The problem for Gallagher was that the policy that he had through his employer, Goodwill Publishing, Inc., provided almost no coverage whatsoever. Benefits were payable only if the employee could not perform each and every material duty of his regular occupation. The Fourth Circuit Court of Appeals found, contrary to general insurance law, that this meant exactly what it said: If there was one material duty of his job which he could perform, then he would not be entitled to benefits. Gallagher's disability was based upon chronic back pain. Surgery and extensive rehabilitation programs have offered him no comfort. He had severe nerve pain in his neck and left arm, and had been diagnosed with diffuse degenerative disk disease, disk herniation and spurring, on all facets throughout his lumbar spine.

The Social Security Administration had found him to be totally disabled but that did not matter!

Gallagher was an editor. Obviously, part of his material duties included reading and marking edits on pages. One of Gallagher's physicians had noted that he could read and evaluate material, review final proofs, and approve or make changes.

² Unfortunately, this decision came from the Fourth Circuit Court of Appeals. This court governs disability claims in Maryland, West Virginia, Virginia, North Carolina and South Carolina.

Two Decades of Severe Back Pain Did Not Matter, Either

The Court said that it was clear from the record that due to his chronic back condition, Gallagher had endured significant pain and discomfort for over two decades. Nevertheless, because Gallagher could perform at least one of the material duties of his job, the Court found that he was not eligible for benefits.

Under this court decision, paralyzed actor Christopher Reeve would not have been eligible for benefits under this policy. Christopher Reeve was an actor. One of the material duties of acting is to be able to read. Since Reeve, a severe quadriplegic, can still read, he would not have been eligible for benefits under this policy.

The law of ERISA will not change until enough people educate enough lawmakers about these injustices. Talk to your Congressman. Get all of our reports and mail them to as many people as you can. You can make a difference for the next claimant.

One small change in ERISA—the Elimination of the power of the insurance companies to “reserve discretion” to themselves would level the playing field again and put you on even footing with the insurance company if your claim is denied.

If You Are Even Thinking of Making A Disability Claim, Talk to An ERISA Experienced Disability Attorney First

The cases above only go to prove why, if you have a claim, you need to consult with an experienced ERISA long-term disability attorney.

Benjamin W. Glass, III is the author of “**14 Ways to Guarantee That Your Long Term Disability Claim is Denied and You Lose in Court.**” Contact Mr. Glass for your copy of this important free book.