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A Business Perspective on ERISA Claim Valuation

In its forty-fifth year, the Employee Retirement Income Security Act (ERISA) provides a comprehensive scheme for employers and employee organizations to establish and maintain employee welfare benefit plans. Employers are encouraged to establish such plans, and insurers to fund them, because of ERISA's uniform, cost-efficient set of standards, administrative requirements, and remedies. Predictability and consistency are hallmarks of ERISA, and they are likewise important to the business valuation of ERISA claims. How has ERISA fared in providing fiduciaries a predictable way to value claims?

This article will explore some practical aspects of valuing long-term disability claims by looking at the process of valuation and the factors that affect it. Valuation

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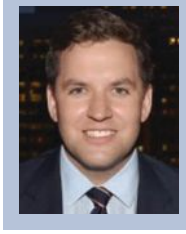

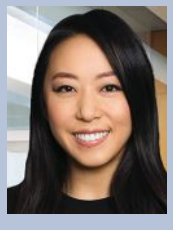

evolves at each stage in the life of a claim. During claim review, the fiduciary performs a full and fair review of the merits of a claim. Once litigation begins, collaborative analysis shifts focus to potential exposure and liability. During litigation and resolution, business risk analysis weighs external factors such as venue, the plaintiff and his or her counsel, regulatory matters, and the corporate client relationship. At each stage, and with each factor, predictability of result can play a key role in valuation.

Claim Valuation in Three Stages

ERISA provides little guidance on how to value claims. Claim valuation evolves in stages. Each carries its own focus area and set of priorities. A reasoned valuation results from collaborative analysis by claims, business, and legal professionals.

Stage One: Administrative Review Evaluates the Merits of a Claim

From a business perspective, claim valuation begins at claim intake. At this stage, the focus of the analysis is on the merits of the claim. The insurer of a funded plan—the claim administrator (administrator)—reviews the information pertinent to the merits of the claim according to the plan terms.

ERISA section 503 grants the participant the right to a "full and fair review" of a claim denial, and it requires denials to set forth the reasons for a denial in a manner "calculated to be understood by the participant." 29 U.S.C. §1133. The ERISA statute and U.S. Department of Labor regulations provide rules and guidance on claim processes. *Firestone v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989), guides toward an independent decision under the abuse of discretion standard.

The administrator reviews and adjudicates the claim in its capacity as an ERISA fiduciary under 29 U.S.C. §1002(21)(A), which provides:

> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any *discretionary authority* or *discretionary control* respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation direct or indirect, with respect to any moneys or other property of such plan, or has any authority or *discretionary responsibility* in the *administration* of such plan.

Case law interprets the nature and extent of discretionary authority and the circumstances under which one is considered a fiduciary. As a general matter, one is a fiduciary to the extent that he or she acts in a fiduciary capacity and exercises discretion under the plan. *See Varity Corp. v. Howe*, 516 U.S. 489, 116 S. Ct. 1065 (1996).

From a business perspective, claim valuation begins at claim intake. At this stage, the focus of the analysis is on the merits of the claim.

A fiduciary "shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—(D) in accordance with the documents and instruments governing the plan." ERISA, §504(a)(1)(D), 29 U.S.C. §1104(a)(1)(D). In a funded plan, the disability insurance policy is the written instrument governing the rights and duties of the claim fiduciary and participant. The policy (or "plan") specifies "the basis on which payments are made to and from the plan." ERISA, 29 U.S.C. §1102(a)(1) & (b)(4). *See* 29 C.F.R. §2560.503 (regarding claims procedure).

The relevant inquiry under the plan is whether the participant is eligible and disabled under the plan terms, conditions, and limitations. Claim specialists and managerial reviewers fully investigate and develop all medical, financial, and vocational information pertinent to the claim according to the policy language, including getting the necessary reviews. In the event of a denial and appeal, the claim undergoes full and fair review. The completion of administrative review concludes the first stage of claim valuation. The administrator has fully evaluated the merits of the claim, based on the administrative record.

Stage Two: With Lawsuit Initiation, Valuation Shifts to Analyzing Exposure and Liability Collaboratively

Now in litigation, claim valuation involves collaboration. The claims department is most familiar with the facts since it has worked diligently to harness all information and resources to understand the claim's substantive merit. While in-house counsel manages the litigation, the business side considers the effect of different aspects of the valuation approach on obligations to the policyholder, the plan, other participants, and shareholders.

Maximum Benefits Are Calculated to Determine the Parameters of Potential Exposure

Potential, maximum benefit exposure sets the outer parameters of claim valuation. Potential exposure does not account for the substantive merit of the claim, legal merit of the lawsuit, realistic duration of the disability, or mortality. The basic equation to calculate potential exposure is this:

> Past Benefits Sought + Net Present Value of Future Benefits Claimed = Maximum Exposure

Past benefits begin after expiration of the elimination or waiting period. Future benefits extend from the current date to the date that the plan terminates coverage.

The benefits calculation begins with the gross monthly benefit. Employee eligibility level and policy terms determine the gross monthly benefit amount. The gross amount includes any dependent coverage for which the participant is eligible.

Typically, the gross benefit is reduced by offsets for other income benefits stated in the policy. Offsets may include state disability income benefits (short term), Social Security disability income benefits (long term), earned income, or recovery from a third party. Courts hold that offset provisions are enforceable. *See Bacquie v. Liberty Mutual Ins. Co.*, 247 F.App'x. 296, 298 (2nd Cir. 2007), *See Carden v. Aetna Life Ins. Co.*, 559 F.3d 256, 263 (4th Cir. 2009).

The benefit calculation incorporates offsets as follows:

Gross Monthly Benefit - Offsets = Net Monthly Benefit

Under an assumed receipt provision, the insurer typically has the right to assume receipt of state and federal Social Security benefits, unless the insured participant has been denied benefits after exhausting all appeals. Repayment provisions obligate the participant to repay any otherwise offset benefits collected. Further, sufficient earned income may trigger a plan's residual or partial disability provision.

Once the net monthly benefit is determined, past and future claimed benefits are calculated. Interest may be applied to past benefits. Future benefits are discounted to reflect present value.

Benefits Are Reduced by Any Overpayments

In some cases, the maximum benefit calculation is reduced by overpayments. Overpayments occur when the administrator pays a monthly benefit that includes otherwise offset benefits, and the participant later collects the offset benefits. The participant has received a greater amount of benefits than the plan terms allow.

A fiduciary can seek restitution of overpayments by an action for equitable relief. ERISA provides that a participant, beneficiary, or fiduciary may bring an action "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." ERISA §502(a)(3), 29 U.S.C. §1132(a)(3). The Supreme Court has held that a fiduciary can seek recovery of overpayments through an action for equitable relief under section 502(a)(3). *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 358, 126 S. Ct. 1869, 1871, 164 L.Ed.2d 612 (2006).

A series of Supreme Court decisions between 2002 and 2016 define a plan's right to seek reimbursement of overpayments, and several circuit decisions have further developed the law in this area. *See Sereboff*, 547 U.S. at 358, 126 S. Ct. at 1871, 164 L.Ed.2d at 612 (2006); *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210, 122 S. Ct. 708, 713, 151 L.Ed.2d 635 (2002); *Montanile v. Bd. Of Trustees of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651, 662, 193 L.Ed. 2d 556 (2016) (not allowing recovery of a third-party asset that had been wholly disbursed on non-traceable items, such as services); *Weitzenkamp v. Unum Life Ins. Co. of Am.*, 661 F.3d 323, 332 (7th Cir. 2011) (permitting insurer to seek equitable lien for overpayment due to insured's receipt of social security benefits). For purposes of this discussion, suffice it to say that the central inquiry is whether the basis of the claim and the nature of the relief sought lies in equity and is permitted under ERISA, or whether the claim seeks a quintessentially legal remedy. *See Sereboff*, 547 U.S. at 356, 126 S. Ct. at 1869, 164 L.Ed.2d at 612; *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210, 122 S. Ct. 708, 713, 151 L.Ed.2d 635 (2002) (holding that a self-insured plan's action to recover plan benefits paid after the participant had recovered funds from a third-party tortfeasor did not lie in equity).

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Valuation Is Reassessed Based on the Legal Merits of Plaintiff's Causes of Action

In valuing the claim now in litigation, the fiduciary seeks to uphold plan terms and correctly apply ERISA's requirements. Valuation becomes more difficult when courts depart from ERISA's intent and uniform scheme, when circuits conflict, or when plaintiffs assert legal arguments contrary to plan terms and ERISA's purpose.

Valuation of the complaint depends first on the nature of the relief sought, primarily whether the participant seeks only benefits under ERISA, 29 U.S.C. 1132(a)(1)(B), or also seeks relief under ERISA, 29 U.S.C. 1132(a)(3). Section 1132(a)(3) provides that a participant can bring an action "to obtain other appropriate equitable relief." Claims may be premised on alleged violations of U.S. Department of Labor (DOL) regulations or other breaches of fiduciary duty. Courts will often consider these latter claims as essentially actions for benefits. However, if a court determines that a plaintiff properly states an (a)(3) claim seeking recovery beyond (a)(1)(B) benefits, claim valuation increases, which would include additional motion work and litigation cost.

Cost, valuation, and early resolution become less clear when the existence of an ERISA plan is an issue. The uncertainty of ERISA governance and preemption of state law claims for relief changes the equation to value a claim in litigation. Disputed issues such as whether a plan sponsor qualifies as an employer or employee organization, whether a plan was established or maintained, or whether the safe harbor regulation excludes coverage from ERISA, alter the fundamental valuation of whether exposure is limited to ERISA benefits or implicates extra-contractual damages. For example, circuits conflict in their treatment of coverage that continues for an individual when the plan may no longer exist as established and there has been no conversion to an individual policy. *See Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404 (9th Cir. 1995). *See Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872, 875 (9th Cir. 2001), *but see Finklestein v. Guardian Life Ins. Co. of America*, 2007 WL 1345228, at *5 (N.D. Cal. May 8, 2007) (discussing how *Waks* is distinguished). Uncertainty in the law can have a significant effect on valuation.

At this point, the valuation of claim and legal merits combine to arrive at an accurate estimate of potential exposure. The maximum exposure benefit amount is adjusted, based on the evaluation of the legal merits, evaluation of the administrative record, and other factors such as the expected duration of disability based on medical evidence and the participant's age.

Stage Three: Business Risk Analysis Weighs External Factors Influencing Valuation During Litigation and Resolution

Business risk analysis is an approach to value a claim in litigation based on a confluence of external factors that influence the core business service of providing disability coverage and that incorporate a claim's unique circumstances. In coordination with litigation management, business risk analysis identifies the specific costs and risks of particular strategies. Risk analysis is important to establishing a successful litigation and resolution strategy that satisfies the fiduciary's obligations to other plan participants and to its shareholders.

Circuit Trends Can Significantly Affect the Expected Legal Result

When circuits conflict, or outlier results begin to characterize ERISA law in a given circuit, the trend in a circuit becomes a factor and valuation may become more challenging.

For example, some courts may allow plaintiffs broader latitude in conducting discovery beyond the administrative record, thus raising litigation cost and increasing valuation. When a deferential standard of review applies, and the standard is undisputed, evidence of the merits of the claim is generally limited to the administrative record. Subject to limited exceptions, evidence extrinsic to the administrative record is inadmissible under de novo review. *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017, 1026–27 (4th Cir. 1993); *Opeta v. Nw. Airlines Pension Plan*, 484 F.3d 1211 (9th Cir. 2007). In short, "[a] district court should not take additional evidence merely because someone at a later time comes up with new evidence." *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 944 (9th Cir. 1995).

Plaintiffs may attempt to introduce, and courts may allow, new evidence, such as letters from physicians or family members, or documents relating to other participants, to attempt to expand the administrative record. *See Luby v. Teamsters Health, Welfare, and Pension Tr. Funds*, 944 F.2d 1176 1184-85 (3rd Cir. 1991) (holding that limiting review to the administrative record is contrary to the concept of de novo review). In these cases, additional briefing or motion work can increase litigation costs. The effect on other plans may become an issue when the standard of review is in dispute, and courts allow significant discovery, including corporate discovery, into the issue of whether an administrator has a conflict of interest.

> Mediation is often the first chance that the business representative, counsel, and plaintiff have to bridge understanding and expectations together.

Venue and Locality Affect Litigation Costs

Venue and locality also can raise cost issues such as attorney fee awards, and they may implicate regulatory concerns in states in which a regulatory settlement agreement is pending. Involving local counsel familiar with the development of ERISA common law in a given circuit, and by a particular court or judge, enables the company to forecast results better and more accurately assess valuation.

Attorney fee awards claimed under ERISA vary greatly from region to region and affect valuation. Under ERISA, a court has discretion to award attorney's fees to either party, as long as the fee claimant has achieved some degree of success on the merits. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 252, 130 S. Ct. 2149, 2156, 176 L.Ed.2d 998 (2010). In *Anderson v. Hartford Life & Acc. Ins. Co.*, a district court in the Seventh Circuit granted an award of $57,327 to the plaintiff, after reducing the hourly rate to a fee common to the community, rather than relying on the affidavits of out-of-state counsel to support a higher rate. 772 F.Supp.2d 1025, 1028 (S.D. Ind. 2011). In contrast, plaintiffs' counsel in the Ninth Circuit commonly seek more than $150,000 in fees in a garden variety ERISA claim. (The highest hourly fee approved is $900, as of this writing.)

The Expectations of a Plaintiff and the Approach of the Plaintiff's Counsel Affect Valuation

While litigation management assesses the dollar value of judgments and fee awards, business valuation also considers the human factor and maintains flexibility in valuation to accommodate changing circumstances. As the administrator is assessing its risks and their consequences, plaintiffs are also assessing their risks and level of tolerance. Plaintiffs can arrive to settlement discussions with unrealistic expectations, a lack of understanding of plan terms, and unfamiliarity with the legal system. Mediation is often the first chance that the business representative, counsel, and plaintiff have to bridge understanding and expectations together. Plaintiffs' counsel who are frequent filers can add an element of both understanding and predictability. Conversely, those unfamiliar with ERISA can increase costs by bringing motions or pursuing arguments that are beyond usual ERISA practice.

Conclusion

Both litigation management and business risk approaches contribute to claim valuation that reflects the claim merits, the legal merits, and external factors important to core business. Businesses prefer predictability and consistency in a landscape where there is risk. Insurers are in the business of underwriting risk in that they provide coverage to employees unable to work due to injury or illness, among other things. By its nature, litigation presents a host of risk factors at each stage in the life of a claim. To the extent that a fiduciary can forecast and prepare for those risks, claim valuation is more consistent and predictable. When aberrant case law, unpredictable legal argument by plaintiffs, or other factors skew direction or results, collaborative analysis can incorporate those factors to reach optimal claim valuation.