The Colorado Lawyer

The Colorado Lawyer - May 2004/Vol 33/No 5

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This column provides information concerning current tort law issues and insurance issues addressed by practitioners representing either plaintiffs or defendants in tort cases. In addition, it addresses issues of insurance coverage, regulation, and bad faith.

This article provides a background of ERISA-governed long-term disability coverage. It addresses the benefits determination process, claim denials, administrative appellate review, and filing of suit against a plan administrator.

When an insurance carrier denies a claim for long-term disability ("LTD") benefits provided through a private employer's group plan, the Employee Retirement Income Security Act ("ERISA")1 is likely to govern the process. A practitioner's failure to understand the true impact of ERISA could result in simple mistakes with grave impact on the client's claim.

The internal appeal with the insurer is almost always the most critical stage of the entire process—including subsequent litigation, if suit must be filed. Thus, practitioners must understand the true importance of taking on such an appeal. Although the odds are heavily stacked in favor of the insurer in claims governed by ERISA, appropriate handling of the claim denial is vital.

ERISA reaches into all areas of employee pensions and other benefits. This article, however, focuses on the handling of LTD claims offered under an employer-provided group benefits package and the steps to be taken when the claim has been denied. This article also provides basic information on ERISA that should help the practitioner identify an ERISA case and avoid common mistakes. The ERISA-governed disability claim process and a response to a claim denial, as well as tips for submitting the administrative review, also are addressed. Finally, limited review of ERISA litigation issues is provided.

Basic ERISA Information

ERISA was passed by the U.S. Congress in 1974 to regulate employee benefits. Most people who participate in a pension or group insurance plan through a private employer or employee organization are covered by ERISA.
ERISA regulates "employee benefit plans." These plans exist in two forms: (1) "employee pension benefit plans"; and (2) "employee welfare benefit plans," which are established and maintained to provide health benefits, disability benefits, death or unemployment benefits, prepaid legal services, vacation benefits, day care centers, scholarship funds, apprenticeship and training benefits, and other similar benefits.2

When ERISA was first adopted, the legislation was hailed as a major success in advancing employee interests, at least regarding the overhaul of the private pension industry. However, in the thirty years ERISA has been in effect, many would argue that it has become better known as a shield against consumer interests in the administration of non-pension employee benefit plans, such as LTD benefits.3 ERISA is frequently used by the plan or plan insurer to prevent employees from having the legal redress and remedies they would have had under state laws existing before the adoption of ERISA.4

To complicate matters, a review of the statutes rarely provides a complete answer to a specific question. Further, the circuit courts are divided on interpretation of important issues, including the standard of review, scope of discovery, and admissibility of evidence.

Definitions of Key - ERISA Terms

It is essential to have a working knowledge of technical definitions of important ERISA terms.5 Commonly used terms follow in alphabetical order.

Group Policy: If LTD benefits provided by the plan are insured by the plan sponsor, the insurer issues a group insurance policy.

Pension Benefits: These benefits consist of payments to retirees, based in part on years of service.

Plan Administrator: According to most courts, this is the company or person responsible for making the decision to deny or pay benefits. It typically is the insurance company issuing the LTD group policy, if the plan is insured.

Plan Document: All of the plan’s rules and terms are spelled out in the complete employee benefit plan document. Often, the "plan" is the insurance policy itself. (See also definition of "summary plan description," below.)

Plan Participant: Typically, this refers to the employee enrolled in the plan. The plan participant also may be referred to as the claimant or insured.

Plan Sponsor: The employer or a union providing the plan is the plan sponsor.

Summary Plan Description: A summary of the "plan document" (defined above) explains the available benefits, claim procedures, permissible benefit offsets, how and when benefits are payable, and how to appeal if benefits are denied. The information often is provided in the form of an employee benefits booklet.

Welfare Benefits: These benefits include any benefit that is not a pension benefit, such as: disability, health, or life insurance; pre-paid legal services; or non-monetary benefits, such as day care services.

Elements of ERISA - Governed Plans

Most private sector employee benefit plans are governed by ERISA. Nonetheless, it is incumbent on a practitioner to verify that the benefit plan is truly governed by ERISA. The purchase of an insurance policy by an employer does not automatically establish the existence of an ERISA plan. If the plan benefit is insured, and the claimant questions the applicability of ERISA, the insurer has the obligation of establishing that this federal law governs the insurance policy.6
The threshold issue in determining whether the court has jurisdiction pursuant to ERISA is whether the employee's claim relates to insurance coverage he or she obtained through an "employee welfare benefit plan."7 By statute, there are five elements that must be met to constitute an employee welfare benefit plan.8 The plan must be (1) a plan, fund, or program (2) established or maintained (3) by an employer, employee-organization, or both (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, and other benefits (5) to participants or beneficiaries.9 If all elements are satisfied, the plan is governed by ERISA, as opposed to state common law.

Plans Not Covered by ERISA

Several kinds of plans are not governed by ERISA. These include: (1) group plans established or maintained by governmental entities or churches for their employees; (2) plans that are maintained solely to comply with applicable workers' compensation, unemployment, or disability laws; (3) plans maintained outside the United States primarily for the benefit of nonresident aliens; and (4) unfunded excess benefit plans.

In addition, there is a "safe harbor" that may exempt an established plan from ERISA.10 Relevant U.S. Department of Labor ("DOL") regulations provide that ERISA does not apply to group or group-type insurance programs where: (1) no contributions are made by an employer or employee organization; (2) participation in the program is voluntary; (3) the sole function of the employer is to permit the insurer to advertise the program to employees, and the employer only collects premiums through payroll deductions for the insurer; and (4) the employer does not profit from administration of the plan.11 If the insurance program meets the criteria set forth in the safe harbor regulations, or the benefit plan is otherwise not deemed an employee benefits plan, ERISA does not apply and state law governs.

Fiduciary Standards of Plan Administrators

The ERISA statutes set forth standards and rules governing the conduct of plan fiduciaries.12 In general, persons who exercise discretionary authority or control over management of a plan or disposition of its assets are "fiduciaries" for purposes of ERISA.13 Fiduciaries are required, among other things, to discharge their duties solely in the interest of plan participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan. Litigation may arise when a participant believes the administrator breached this duty in denying a benefit to which the participant believes he or she is entitled under the terms of the plan or policy.
Preemption Issues

In 1987, in Pilot Life Insurance Co. v. Dedeaux,14 the U.S. Supreme Court ruled that ERISA superseded a plan member's state law cause of action against a plan insurer for extra-contractual damages arising from the alleged bad faith denial of a disability claim. Applying ERISA's express preemption language, the Court held that the plaintiff's state law cause of action "related to" an ERISA plan, and was not "saved" from preemption as a law that regulates insurance.

Following the Pilot Life decision, with a few minor exceptions, each federal circuit court that addressed ERISA's preemptive effect on state law, bad-faith, or statutory unfair-settlement-practices claims filed against an ERISA plan insurer has held that ERISA superceded the state law remedies.15 In 2003, in Kidneigh v. UNUM Life Insurance Co. of America,16 the Tenth Circuit Court ruled that Colorado's common law claim of bad faith breach of insurance contract is preempted by this federal law, because such a claim conflicts with the statute's civil enforcement provision in that it would allow plan participants to obtain remedies not available under ERISA.

Overview of LTD Insurance

Disability insurance is either purchased by individuals through private insurance policies or provided by employers for the benefit of qualified employees. Group LTD coverage is a benefit of great value to employees and often can be provided at little cost to the employer. Employer-provided LTD benefits are specifically included in the "welfare benefits" plan definition and thus are covered by ERISA.

Disability insurance coverage is similar to the income replacement coverage provided by workers' compensation insurance and comes in both short- and long-term forms. In most states, including Colorado, employers are not legally required to provide disability insurance.17

LTD Benefits

LTD insurance programs typically begin after short-term benefits have been exhausted, usually three to six months after the onset of the disabling illness or injury. LTD benefits usually cover 50 percent to 67 percent of an employee's salary and are almost always

subject to a monthly maximum, usually $10,000. Some welfare benefit plans categorize the employee participants, with executives being entitled to higher benefit limits.

If the employee also is receiving other benefits, such as Social Security disability, the LTD benefits may be reduced proportionately, as designated by the policy language. Benefits generally end at the age of 65, or sometimes terminate within as short a time frame as five years after the disability begins. The age at which the participant becomes disabled also may determine the length of available disability coverage. It is extremely rare to find a group policy providing benefits for life.

"Own Occupation" and "Any Occupation" Eligibility

Most group LTD plans have a two-tiered disability definition for purposes of benefits eligibility. These definitions are often referred to as "own occupation" and "any occupation."

First, there is an initial period an individual must be disabled from his or her own job or regular occupation to receive benefits. Disability is usually defined as an inability to perform the material and substantial duties of a person's "own occupation."

Second, if approved for "own occupation" benefits, a transformation of the definition of disability occurs at a certain point in time in the future, commonly twenty-four months after the "own occupation" period begins. The participant's eligibility is then based on his or her inability to perform "any occupation." This new definition requires that the person prove both an inability to do the former job and an inability to perform any job for which he or she is capable or qualified, based on past work experience, education, and ability to retrain. If deemed disabled under the "any occupation" definition, the claimant may be entitled to benefits for only an additional three years or, more typically, until age 65.

To determine the eligibility of a plan participant, the practitioner must read the plan documents and the insurance policy itself. These provide information regarding the exact definitions used, the benefits available, and the duration of those benefits. Each group policy insurer uses different language and even the same insurer may use slightly altered language from one group policy to the next. The practitioner also should compare the language used in the plan documents with that contained in the group policy, because they sometimes differ.

LTD Claim Denial and Administrative Appeal

A participant's need for counsel may arise when he or she receives a denial letter. The letter must clearly inform the claimant of the denial, the specific basis for it, and the procedure for an internal review by the claim administrator. To achieve these requirements, the DOL has adopted regulations ("DOL Regulations") that set out the minimum requirements for employee benefit plan procedures and the specifics of the denial notice.18

Department of Labor Regulations

The DOL Regulations require the plan to establish and maintain reasonable claims procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations.19 These requirements should be reviewed in detail, inasmuch as they provide, among other things, that the claimant is entitled to be provided with copies of all documents, records, and other information relevant to the beneficiary's claim for benefits. The DOL Regulations also include a requirement for a description of "any additional materials or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary."20 Most important, the DOL Regulations are geared toward providing the claimant with a "full and fair review" of the decision denying the claim.21 This includes requirements that: (1) the claimant is informed as to what evidence the decision-maker relied on to make its decision; (2) the claimant has an opportunity to address the accuracy and reliability of that evidence; and (3) the decision-maker consider evidence presented by both parties prior to rendering its decision.

Under DOL Regulations that apply to all claims filed after January 1, 2002, ERISA disability claims must be decided within a reasonable period of time, but not later than forty-five days after receipt of the claim by the plan.22 The insurer may request two thirty-day extensions for reasons "beyond control of the plan," as long as the claimant is notified in writing prior to the expiration of the forty-five-day period.23

Deadline for Administrative Appeal

Following receipt of the denial letter, the participant must be given a reasonable opportunity to appeal the adverse benefit determination. The deadline and procedure for appealing must be clearly explained in the denial letter and must provide the denied claimant with a minimum of 180 days to submit the review request.24

Failure by the claimant to timely appeal the benefits denial will likely result in his or her failure to have complied with plan requirements, thereby resulting in a waiver of the claim by the participant. Conversely, a failure of the administrator to make a timely decision of the appeal will not result in an automatic requirement to pay the denied benefits. At best, the claimant can argue that the insurer's failure to render a timely decision results in a reviewing court in subsequent litigation applying a more flexible standard of review, as explained in more detail below.

If a client seeks legal help after submitting an appeal on his or her own, the practitioner should request an additional appeal opportunity, even if the denial was upheld. An additional appeal might be granted. In limited circumstances, the applicable policy may even provide the claimant with more than one appeal.

Administrative Appeal

The appeal from the denial letter is the most critical stage of the entire claims process. It is the client's best shot at reversing the insurer's denial. This is because a court's subsequent review of an ERISA-governed LTD claim will be limited to the administrative record (or "claim file") developed by the administrator-insurer.25 Such claim file typically is created long before litigation is commenced.

After the internal appeal is completed and a lawsuit is filed, a claimant almost certainly will be prevented from submitting additional evidence in support of the claim for benefits. Therefore, the claimant and his or her attorney must understand the importance of the pre-litigation steps that must be taken to increase the claimant's odds of success.

During the appeal process, the claimant should not hold back any evidence that supports his or her claim of disability. Instead, the claimant should take the opportunity afforded by the administrative appeal to load the claim file with as much evidence in favor of disability as possible. Doing so will provide the plan administrator with the grounds to pay the claimed LTD benefits. More important, this may be the claimant's only chance to submit such evidence, because acceptance of evidence concerning disability after the appeal has been exhausted and the client has filed suit is not likely.

Developing an Administrative Record: In the course of developing the administrative record, steps to be taken by the claimant's attorney should include: (1) immediately requesting the claim file; (2) requesting copies of the plan, the summary plan description, and a copy of the policy; (3) obtaining additional opinion letters from treating physicians; (4) providing pertinent medical literature that better explains the nature of the disability to the claims representative (and ultimately to the judge); (5) providing documentation from co-workers, the employer, and friends and relatives concerning the claimant's disability; and (6) generally "humanizing" the record (so it will document the impact of the claim on a real person's life). These records should be submitted to the claims representative, within the appeal deadline (180 days from the denial), along with a comprehensive letter from counsel.

Appeal Letter: A successful appeal generally includes a detailed letter from the claimant's attorney to the claims representative. The letter should point out all of the following that are relevant: (1) the insurer's misinterpretation of the policy; (2) non-compliance with federal requirements; (3) additional evidence submitted as part of the appeal; (4) the treating or consulting physicians' opinions concerning disability; (5) any deficiencies of the opinions obtained by the insurer from in-house or independent physicians; and (6) a general description of the plaintiff's disabled life.
The appeal letter should address all evidence not reviewed by the insurer and its importance to the determination of disability. Bias by the insurer that could be relevant might include the deliberate mischaracterization of medical evidence, mischaracterization of conversations with the claimant, an improper vocational assessment, and an improper or incomplete medical assessment. As explained below, a reviewing court likely will apply a highly deferential standard of review in favor of the insurance company, requiring that a claim denial be overturned only if the insurer's conduct is "arbitrary or

capricious." Thus, if there is any evidence in support of such conduct, it should be submitted during the appeal.

The claimant's attorney must take the opportunity of the appeal to load the claim file with any and all favorable evidence at his or her disposal. Importantly, the rules of evidence do not apply to the information and documents submitted to the insurer as part of this appeal process. Practitioners should note that the evidence in the appeal is not only addressed to the claims manager at this stage of the game, but also to the trial court judge if the appeal is unsuccessful.

Decision of Appeal: The appeal of the claim denial must be decided by the insurance company within forty-five days.26 The insurer may request a forty-five-day extension for reasons beyond control of the plan, as long as notice is provided to the claimant.27

ERISA Litigation Issues

If the claim and subsequent appeal are denied, the claimant may wish to pursue a lawsuit. A typical ERISA lawsuit is framed around declaratory or injunctive relief, seeking payment of benefits owed. A claim for relief is ordinarily pursued pursuant to 29 U.S.C. § 1132(a)(1)(B). That statute addresses a plan beneficiary who is seeking to recover LTD benefits due under the policy. It would apply if the policy at issue is clearly governed by ERISA. In contrast, with an individual disability policy, state law-based claims for breach of contract and bad faith could be asserted.
The federal and state courts hold concurrent jurisdiction. However, if a case is filed in state court, it will almost always be removed to federal court by the insurer and plan. Thus, as a practical matter, it is usually more expedient and cost-effective to file in federal court.

Many practitioners are surprised to learn that the right to a jury trial and the right to seek damages in cases where the insurer's conduct is negligent or even malicious have been removed by ERISA.28 A judge reviews the benefits decision, not a jury. ERISA gives the plan administrator (an insurance company) broad discretion to interpret the plan language and determine benefit eligibility. If suit is filed, the court is limited in the scope of its review of the administrator's decision and must generally uphold the denial, as long as there is some reasonable evidence supporting it.

Standard of Review

In ERISA litigation, it is necessary for the parties to agree on, or the court to determine, which standard of review the court will apply to the claim administrator's decision to deny LTD benefits. There are two types of review a court may use, depending on the language found in the plan document: (1) de novo; and (2) abuse of discretion (also called "arbitrary and capricious"). The Tenth Circuit Court treats the terms "abuse of discretion" and "arbitrary and capricious" as interchangeable in this context.29

Typically, claimants prefer to have their claims decided under the de novo standard. That allows an opportunity to introduce evidence beyond the administrative record; a greater chance of obtaining an order permitting discovery; and, most important, a non-deferential review by the judge of the administrator's benefits denial.

De Novo Review: In Firestone Tire and Rubber Co. v. Bruch,30 the U.S. Supreme Court established that a denial of disability benefits challenged under 29 U.S.C. § 1132(a)(1)(B) is to be reviewed under a de novo standard, unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Typically, the plan or the policy itself will grant discretionary authority to the claim administrator to interpret the plan and the insurance policy and to determine eligibility for benefits, thereby obviating the possibility of a de novo review.

"Arbitrary and Capricious" Review: When there is such a grant of authority to the insurer-administrator, the court must limit its inquiry to whether the insurer's decision was "arbitrary and capricious."31 The practitioner should scour the policy and plan for the existence or non-existence of discretionary authority. The standard of review to be applied will have significant impact on a claimant's chances of success.

If the plan is insured, the court may apply the so-called heightened abuse of discretion, which gives the administrator (insurance company) less deference because it has a conflict of interest. An inherent conflict of interest has been recognized by the courts when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company.32 In that situation, the insurer is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to plan participants. It is generally recognized that a conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries.33

Consistent with most other circuit courts of appeal, the Tenth Circuit Court has indicated that in applying the "arbitrary and capricious" standard,34 the level of deference to an administrator's decision diminishes "in direct relation to any conflict of interest the plan administrator has in making the challenged decision,"35 also known as the "sliding scale" approach.36

The Tenth Circuit Court recently substantially clarified how the arbitrary and capricious standard of review is to be applied. In Fought v. UNUM Life Insurance Co. of America,37 the Tenth Circuit Court adopted a two-tiered standard for reducing deference in instances in which a fiduciary has a conflict of interest because it: (1) adheres to ERISA common law; (2) promotes sound public policy; and (3) provides clearer guidance to lower courts, lawyers, and potential litigants.

Under the first tier, in every case in which the plan administrator operates under a conflict of interest, the plan administrator bears the burden of proving the reasonableness of its decision pursuant to the traditional arbitrary and capricious standard. Under the second tier, the court must determine whether the conflict of interest at issue is so severe as to

warrant an additional reduction in deference. In providing this two-tiered system of review, the Tenth Circuit Court modified the traditional arbitrary and capricious analysis to now require support for the administrator's decision to deny coverage by a preponderance of the evidence, rather than the traditional requirement of substantial evidence.38

As an aside, one exception to the applicability of the arbitrary and capricious standard might occur if the insurer fails to render a timely decision of the claim or appeal. Failure to timely render a decision may deem the claim denied by operation of law. In such circumstance, the reviewing judge may instead apply the de novo standard. The rationale is that because the claims administrator failed to apply its discretionary authority to make a final, reasoned (and timely) decision on appeal, it provided no actual exercise of discretion for application of reasoned judgment to which a court could defer.39

Limited Discovery

Once litigation is commenced, it is common for the claimant and insurer to disagree on the scope of discovery. The scope of permissible discovery may depend on which standard of review applies to the claim. Inevitably, the insurer will take the position that the court's review of the claim denial is entirely limited to the claim file and, thus, discovery is irrelevant. The claimant may assert that he or she is entitled to conduct discovery and to introduce evidence bearing on the extent of the conflict of interest question or whether the denial itself was arbitrary and capricious. The circuit courts are split. The Tenth Circuit Court has not directly ruled on the scope of permissible discovery in an arbitrary and capricious review.40

Recoverable Damages

Numerous ERISA cases have held that the participant's remedies are limited to appropriate equitable relief in the form of recovery of lost benefits. Given the preemption of state law-based claims for relief, extra-contractual damages are not recoverable in an ERISA LTD claim. The ERISA statutory scheme simply allows claimants to argue an entitlement to the denied benefits and for the case to be remanded to the administrator for future handling.41

Attorney Fees and Interest on Award

ERISA allows a court, in its discretion, to award reasonable attorney fees and costs of action to either party.42 The granting of attorney fees under ERISA is not to be done as a "matter of course," but is discretionary in nature.43
The Tenth Circuit Court has recognized a five-prong test in deciding whether attorney fees should be awarded to a "prevailing party" in an ERISA case. The court is required to consider the: (1) degree of the offending party's culpability or bad faith; (2) degree of the offending party's ability to satisfy an award of attorney fees; (3) degree to which such an award would "deter other persons acting under similar circumstances"; (4) amount of benefits conferred on all plan members; and (5) relative merits of the parties' positions.44

The determination of an award of pre-judgment interest is governed by a two-step analysis.45 The court must first determine whether the award of prejudgment interest will serve to compensate the injured party. Second, even if the award of prejudgment interest is compensatory in nature, the court still must determine whether the equities would preclude the award of prejudgment interest. Regarding the date from which the interest calculation should run, the Tenth Circuit Court has stated that prejudgment interest compensates participants as if the plan had paid benefits when the employee first filed the claim, not when it was denied.46

Tax Issues

Disability benefits are likely tax-free if the disabled insured paid premiums with after-tax dollars. However, if the disability policy was provided as an employer benefit, and the employer paid part or all of the premiums, any disability benefits received, including any lump-sum amount from a settlement, most likely will be taxable.

The full amount of the award of past due benefits or of a lump-sum settlement, and not just the net recovery following the deduction for costs and attorney fees, is subject to taxation.47 In general, according to the Internal Revenue Service, attorney fees paid to assert personal rights that are not related to any business or income-producing activity cannot be deducted.48

To reduce this taxable burden, the practitioner may want to recommend alternatives to the participant's immediate receipt of any settlement funds. One option would be to consider a structured settlement that would pay the settlement amount over a period of years. This may serve to slightly reduce the total amount of tax paid by the claimant.
Given the serious tax consequences of receiving these benefits or accepting a lump-sum settlement, a plan participant should consult with a tax advisor or other financial consultant. Such tax advisor also should be consulted as to the taxability of court-awarded attorney fees under ERISA.

Failure to advise a client on the taxability of a settlement or an award of benefits or attorney fees certainly could have malpractice implications for the practitioner. Therefore, it is important to advise the client in writing to obtain tax advice from a tax professional regarding the client's particular situation.

Conclusion

ERISA is an ever-evolving legal arena. It is complicated by a lack of interpretational uniformity among the various circuit courts on a wide variety of significant issues, including the standard of review, scope of discovery, and admissibility of evidence. The number of employees offered disability insurance as part of their employee packages has increased dramatically in recent years, resulting in a wave of litigation involving demands for LTD benefits under ERISA.

The two most crucial steps in handling ERISA LTD claims are: (1) determining whether ERISA applies; and (2) if there is still time, assisting the client with a thorough administrative appeal of the claim denial. However, even if the claimant hires an attorney after the appeal has been exhausted, counsel may still be able to help by seeking a second appeal or filing a lawsuit.

Handling ERISA cases can be difficult, but can be rewarding if approached properly. The ambiguities of the statutory scheme and unsettled law surrounding it can allow the practitioner to be creative in his or her approach to an ERISA claim.

NOTES

1. Employee Retirement Income Security Act of 1974 ("ERISA"), codified at 29 U.S.C. §§ 1001-1461 and in scattered sections of the Internal Revenue Code, 26 U.S.C. §§ 1-9722.
2. ERISA § 3(1), 29 U.S.C. § 1002(1).
3. For a detailed criticism of the U.S. Supreme Court's multiple decisions concerning the preemptive effect of ERISA, see Bogan, "ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption and State Law Remedies," 42 Santa Clara L.Rev. 105 (2001).
4. Id.
5. 29 U.S.C. § 1002.
6. See Baxter v. Life Ins. Co. of N. Am., 982 F.Supp. 1453, 1454 (D.Wyo. 1997) (denying insurer's motion to dismiss and granting plaintiff's motion to remand case to state court because ERISA did not apply to policy in question); Curtiss v. Union Central Life Ins. Co., 823 F.Supp. 851, 854 (D.Colo. 1993); Terry v. Protective Life Ins. Co., 717 F.Supp. 1203, 1205 (S.D. Miss. 1989).
7. The statutory definition of "employee welfare benefit plan" is found at 29 U.S.C. § 1002(1).
8. 29 U.S.C. § 1002(1).
9. See Gaylor v. John Hancock Mutual Life Ins. Co., 112 F.3d 460, 463 (10th Cir. 1997); Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982), cert. denied, 114 S.Ct. 140 (1984).
10. See Gaylor, supra, note 9 at 464.
11. 29 C.F.R. § 2510.3-1(j).
12. Part 4 of Title I of ERISA, 29 U.S.C. §§ 1101-1114.
13. ERISA defines "fiduciary" as a person who "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 . . . [or] has discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A).
14. Pilot Life, 481 U.S. 41 (1987).
15. See, e.g., Gilbert v. Alta Health & Life Ins. Co., 276 F.3d 1292, 1297-99 (11th Cir. 2001) (Alabama insurance bad faith statute preempted by ERISA); Swerhun v. Guardian Life Ins. Co. of Am., 979 F.2d 195, 199 (11th Cir. 1992) (Florida insurance bad faith statute preempted by ERISA).
16. Kidneigh, 345 F.3d 1182 (10th Cir. 2003); see also Conover v. Aetna U.S. Health

Care, Inc., 320 F.3d 1076, 1077 (10th Cir. 2003) (ERISA preemption of Oklahoma's bad faith laws); Moffett v. Halliburton Energy Servs., Inc., 291 F.3d 1227, 1237 (10th Cir. 2002) (preemption of Wyoming's bad faith laws).
17. A few jurisdictions require that employees be covered by short-term disability insurance through state-run programs or by private or self-insurance coverage that is equivalent to the state-run program. These include California, Hawaii, New Jersey, New York, Puerto Rico, and Rhode Island. The state programs provide minimal benefit levels and do not provide LTD coverage.
18. 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(j).
19. 29 C.F.R. § 2560.503-1(b)(1).
20. 29 C.F.R. § 2560.503-1(h)(3).
21. 29 U.S.C. § 1133.
22. 29 C.F.R. § 2560.503-1(f)(3).
23. Id.
24. 29 C.F.R. § 2560.503-1(h)(4).
25. Hall v. UNUM Life Ins. Co. of Am., 300 F.3d 1197, 1201 (10th Cir. 2002).
26. 29 C.F.R. § 2560.503-1.
27. Id.
28. Adams v. Cyprus Amax Minerals Co., 149 F. 3d 1156 (10th Cir. 1998).
29. See Chambers v. Family Health Plan Corp., 100 F.3d 818, 825 n.1 (10th Cir. 1996) ("Some circuit courts have recently distinguished between these two standards and have concluded that the abuse of discretion standard is more appropriate. Most courts, however, have held that this is a distinction without a difference. We agree and adhere to the arbitrary and capricious standard of review.").
30. Bruch, 489 U.S. 101, 115 (1989).
31. See Pitman v. Blue Cross & Blue Shield of Oklahoma, 217 F.3d 1291, 1296 (10th Cir. 2000).
32. Caldwell v. Life Ins. Co. of N. Am., 287 F.3d 1276, 1283 (10th Cir. 2002).
33. Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556, 1565 (11th Cir. 1990).
34. The Tenth Circuit Court treats the terms "arbitrary and capricious" and "abuse of discretion" as interchangeable in this context. See Fought v. UNUM Life Ins. Co. of Am., 357 F.3d 1173, 1184 (10th Cir. 2004), citing Chambers, supra, note 29 at 825 n.1.
35. Siemon v. AT&T Corp., 117 F.3d 1173, 1177 (10th Cir. 1997), citing Chambers, supra, note 29 at 825 n.1.
36. See Pitman, supra, note 31.
37. Fought, supra, note 34.
38. Id. at 1183, citing Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 380 n.4 (preponderance of the evidence "presents a higher standard of proof than substantial evidence.); id. at 382 (substantial evidence "is such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the [decisionmaker] . . . [and] requires more than a scintilla but less than a preponderance").
39. Gilbertson v. Allied Signal, Inc. and Life Ins. Co. of N. Am., 328 F.3d 625 (10th Cir. 2003).
40. See Hall, supra, note 25 (discussion of scope of admissible evidence in a de novo case). See also Caldwell v. Life Ins. Co., 165 F.R.D. 633, 638 (D.Kan. 1996) (allowing discovery under arbitrary and capricious review, including taking of depositions, to

determine whether: (1) plan fiduciary fulfilled duty to obtain information necessary to make determination to deny benefits; (2) plan fiduciary followed proper procedures in reviewing and denying plaintiff's claim; and (3) record was complete).
41. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a) (1)(B).
42. 29 U.S.C. § 1132(g)(1).
43. Gordon v. U.S. Steel Corp., 724 F.2d 106 (10th Cir. 1983), citing Iron Workers Local No. 272 v. Bowen, 624 F.2d 1255, 1265-66 (5th Cir. 1980).
44. Id.
45. Caldwell, supra, note 32.
46. Id. at 1287.
47. In 2004, the U.S. Supreme Court granted certiorari in Freeman v. Comm'r of Internal Revenue, No. 03-660; Comm'r of Internal Revenue v. Banks, No. 03-892; and Comm'r of Internal Revenue v. Banaitis, No. 03-907.
48. See, e.g., Alexander v. Internal Revenue Serv., 72 F.3d 938 (1st Cir. 1995).

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