Arkansas Association of Defense Counsel

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"ERISA-FICATION": THE APPLICAITON OF ERISA TO INDIVIDUAL DISABILITY POLICIES

By David Donovan

The defense of a lawsuit seeking benefits under an individual disability insurance policy can be challenging. As we all know, defending an insurance company as the named defendant presents unique difficulties. Let's face it, insurance companies are generally not well liked by the public (unfavorable ratings probably worse than both Donald Trump and Hillary Clinton), and jurys (some anyway) may relish the opportunity to stick it to the insurer. Throw into the mix a Plaintiff with a physical or mental impairment to some degree who may assert a bad faith claim, and the deck is often stacked against the defendant. Such cases remind us of how hard our job can be at times.

The litigation dynamics are different when a disability claim is governed by the Employee Retirement Income Security Act (ERISA): there are no jury trials; the record is restricted to the evidence presented in the administrative proceeding; and, depending on plan language and other factors, the review of the claim decision may be based on abuse of discretion. Most important, ERISA preempts state law. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987). The defendant has no exposure to the state statutory penalty or extra contractual bad faith claims. ERISA recovery is limited to the benefits due, prejudgment interest, and attorneys fees.

Generally, ERISA applies only to employer sponsored plans. For an employee who is a participant in his employer's long term disability plan, insured by a disability insurance company, his claim is governed by ERISA.

If an insured purchases an individual policy, and there is no employer involvement in the administration of the policy, his claim is generally governed by state law.

Defense counsel should not automatically assume that ERISA does not apply to what appears to be a simple individual policy. The law does recognize that, under some circumstances, policies purchased in the name of an individual, and insuring only that individual, may still be ERISA policies.

Consider for example, this hypothetical case. A surgeon in Little Rock purchases an individual disability policy through the agency which writes all of the coverage for his practice. The surgeon is the named insured. He submits a disability claim contending that an arthritic condition prevents him from performing surgery. The insurer denies the claim based on medical reviews that conclude the arthritis is not disabling. He files suit in Arkansas state court and alleges bad faith, claiming that the insurer improperly manipulated the medical evidence. The insurance company removes to federal court asserting federal jurisdiction based on diversity, and alternatively federal question jurisdiction based on ERISA.

Discovery reveals the following facts. The doctor's practice was conducted through a professional association incorporated under Arkansas law. All of his insurance policies (disability, life, malpractice, health, general liability) are purchased though the P.A., with all premiums paid by the P.A. The employees of the P.A., a nurse practitioner, a physician assistant, two clerical staff, and an office manager, each have health insurance coverage and a life policy paid for by the P.A. All of the policies, the doctor's and the staff's, are written through the same insurance agency. The office manager handles all the paper work for all the policies and writes checks for the premiums. She coordinates the submission of claims with the insurance agent.

The insurance company moves for summary judgment on the bad faith claim, arguing that the policy is governed by ERISA and the tort claim is preempted by federal law. The brief is based on the following legal analysis.

ERISA, 29 U.S.C. § 1001, governs any "employee welfare benefit plan" which is defined as "any plan, fund, or program which was . . . established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . benefits in the event of . . . illness." 29 U.S.C. § 1002. ERISA therefore requires the following elements, by statutory definition, for an employee welfare benefit plan: (1) A plan, fund, or program; (2) that is established or maintained; (3) by an employer; (4) for the purpose of providing benefits; and (5) to participants or their beneficiaries. See, Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982). These five criteria are referred to as the Donovan factors (no relation, and, no, the case name was not the inspiration for this article) which have been embraced by the federal circuits, including the Eighth Circuit. Nw. Airlines, Inc. V. Fed Ins. Co., 32 F.3d 349, 354 (8th Cir. 1994); Harris v. Ark. Book Co., 794 F.2d 358, 360 (8th Cir. 1986).

Taken together, the Donovan factors mean that an ERISA plan must embody "a set of administrative practices" by the employer. Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 11-12, 107 S. Ct. 2211 (1987).

In Johnston v. Paul Revere Life Ins. Co., 241 F.3d 623 (8th Cir. 2001), an employee sought disability benefits from an insurer. The employer had purchased 12 separate disability insurance policies for its employees which included certain "own occupation" coverage. The employees met with an independent insurance agent retained by the employer who explained benefits and completed the necessary enrollment forms. Employees were given the choice of paying the premiums themselves or having the employer make the payments through payroll deduction. The insurance company billed the employer for monthly premiums which paid the insurance coverage in a lump sum, adding the amount it paid for the employees' individual premiums to the employees' W2 form at the end of the tax year. The district court held that this constituted an ERISA plan and the Eighth Circuit affirmed. The "court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." (Quoting Harris v. Ark. Book Co., 794 F.2d 358, 360 (8th Cir. 1986)). In concluding that the employer's role in administering the plan, transmitting premium, and explaining policies satisfied the criteria for an ERISA plan, the court ruled:

"[W]e hold that a reasonable person could conclude that Western Pathology did establish a plan within the meaning of ERISA that offered disability benefits to its employees. Also, a reasonable person could further ascertain the intended benefits, beneficiaries, the source of financing, and procedures for receiving benefits of the disability plan at issue. Because Western Pathology engaged in the ongoing administration of the plan by assisting in the application process, by maintaining the policy of premiums, the plan embodied a set of administrative practices. We, therefore, hold, in agreement with the district court, that "a reasonable person [could] conclude that Western Pathology did establish a plan that offered benefits to its employees, as evidenced by the offering of retirement and disability insurance policies to employees[.]"

Johnston, 241 F.3d at 629.

In the hypothetical case outlined above, this author believes it will be a very close question for the district court. The role of the office manager and the insurance agent may "embody a set of administrative practices." The defense will argue that the policies of all the employees of the P.A., including the surgeon who receives his salary draws through the P.A., constitute a plan established and maintained by the employer. Depending on the testimony of the surgeon and the office manager, however, the disability policy may be administered entirely separately. The difference in the coverages for the surgeon and the employees of the P.A., will be a factor relied on

by the Plaintiff in arguing that the individual disability policy was not part of a "plan or program" established or maintained by the P.A., and that no administrative procedure was established for his disability policy. "The pivotal inquiry is whether the plan requires the establishment of a separate, ongoing administrative scheme to administer the plan's benefits." Kulinski v. Metronic Bio-Medicus, 21 F.3d 254, 257 (8th Cir. 1994).

Ultimately, whether an individual policy is part of an ERISA plan is a mixed question of law and fact. Harris, 794 F.2d at 360. A recent case from the District of Minnesota distinguished Johnston and provides a good example of the mixed legal / factual analysis of this issue. Lanpher v. Unum Life Ins. Co. of Am., 2015 U.S. Dist LEXIS 116892 (D. Minn. 2015). In that case the administration was conducted primarily by the insurance company, and the employer simply provided the insurer access to its employees to sell policies. The employer did not have enough control over administration to create an ERISA plan.

In the defense of any individual disability policy claim, consideration should be given to potential "ERISA-fication" of the policy. This will require detailed discovery into the insured's policies, business organizations, and the policies of employees within that business organization. The focus should be on the administration necessary for all of those policies.

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