Several Mistakes by the Claim Administrator Lead to an Award of Disability Benefits

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The Ninth Circuit overturned the denial of benefits by a plan administrator in a case that provides a useful "reverse weathervane," showing several mistakes that a plan administrator should ***not*** make when reviewing a benefits claim. In *Salomaa v. Honda Long Term Disability Plan*, No. 08-55426 (9th Cir. Mar. 7, 2011), the Ninth Circuit held that plaintiff Samuel Salomaa met his burden of showing that the Honda Long Term Disability Plan ("the Plan") abused its discretion in denying his claim for long-term disability benefits. Because the Plan made numerous errors in denying Salomaa's claim for benefits and failed to provide the "full and fair review" that ERISA requires, the Ninth Circuit reversed the district court's affirmance of the claim denial and remanded the case with instructions to award disability benefits to the plaintiff.

Salomaa suffered from chronic fatigue syndrome, a condition difficult to diagnose using objective medical tests. As stated by Salomaa's treating physician, "usually there were no physical findings for chronic fatigue syndrome except that the patient looked fatigued." Despite having previously been a model employee with no psychiatric history, Salomaa apparently was unable to function normally on most days. Eliminating other possible diagnoses, his doctors diagnosed chronic fatigue syndrome. However, when Salomaa applied to the Plan for benefits, his initial claim and claim appeal were denied.

Reviewing the record, the Ninth Circuit found many serious errors in the Plan's claim review.

- The initial claim denial erroneously asserted that Salomaa had no weight loss, when in fact he had lost 14% of his body weight over a six month period. The final denial noted the weight loss but then said there was "no underlying condition, such as cancer or HIV disease", that might explain Salomaa's fatigue or weight loss. The Ninth Circuit found such reasoning illogical, since such objective measures are not used to establish the existence of chronic fatigue syndrome.

- The initial claim denial misconstrued the process by which his physicians attempted to diagnose

and treat Salomaa's symptoms of depression. The final denial did not even mention either depression or lack of it as a basis for the decision to deny benefits.

- The claims manager initially denied Salomaa's claim on the basis that "Salomaa had no positive objective physical findings" supporting his diagnosis, and invited him to supplement the medical record. In response, Salomaa submitted a supplemental report by his treating physician, documenting significant functional limitations. Notwithstanding that new report, the claims manager found an insufficient basis for the claim.

- The Plan had Salomaa's record reviewed by two consulting physicians, who said that Salomaa was not disabled. Neither of their reports was provided to Salomaa's lawyer despite his request for the Plan's file on the claim. Salomaa thus had no opportunity to respond to those reports during the claim review process.

- Every doctor who personally examined Salomaa found him to be disabled. However, the Plan did not take advantage of Salomaa's offer for the Plan's own consulting physicians to examine him.

- Salomaa submitted evidence of his award of disability benefits from the Social Security Administration. That award was not binding on the Plan, but the Plan's claim denial did not even note, much less attempt to distinguish or refute, that award.

Significantly, the Plan's grounds for claim denial shifted as Salomaa refuted each of the Plan's stated reasons. As Salomaa developed and supplemented his medical records in support of his claim, only the denial of the claim remained constant.

Based on these circumstances, the Ninth Circuit held that the Plan's claims manager abused its discretion and did not provide Salomaa a "full and fair" review of his claim as required by ERISA.

The court also addressed the conflict of interest in Salomaa's case in light of the Supreme Court's decisions in Metropolitan Life Insurance Co. v. Glenn, 128 S. Ct. 2343 (2008), and *Conkright v. Frommert*, 130 S. Ct. 1640 (2010). The Ninth Circuit observed that, in applying those recent decisions, "the administrator's decision cannot be disturbed if it is reasonable," but a reversal would be appropriate where the court is "left with a definite and firm conviction that a mistake has been committed," and that "a higher degree of skepticism is appropriate where the administrator has a conflict of interest." The Ninth Circuit reached that conclusion in this case, where the Plan's claim manager both administered the claims process and paid the benefits, a conflict of interest. The Ninth Circuit found that the repeated errors of the claims manager did not provide Salomaa a full and fair review, and that increased judicial skepticism was warranted.

Salomaa demonstrates that companies administering employee benefit plans should carefully evaluate all of the evidence in the claim record, acknowledge all evidence in denial letters, even if such evidence is not thought to carry much weight, and be careful to avoid factual errors that may provoke skepticism by a reviewing court.

For more information about this topic, please contact the authors or any member of the Williams

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