An ERISA Litigation Primer
(Or, What to Do When an ERISA Case Walks In the Door)

I. Why do I care whether this is an ERISA case or not, I never plan on handling one?

A. If not going to handle ERISA cases, have to recognize one when it comes in the door.

B. Have to make sure one of three applicable limitations periods doesn't run while the file is sitting on your desk.

C. An ERISA's Plan's ability to recover overpayments is important to many non-ERISA practitioners.

This comes up a lot in personal injury cases. The client's health plan pays for your injured client's treatment, and when the other side settles the health plan tries to jump in and grab the settlement for itself. Can it?

II. The first question is whether it is an ERISA case.

Under federal law, any "plan, fund or program" which is "established or maintained" by an employer or employee organization for the purpose of providing certain types of employee benefits (life, health, accident, disability, pension) will be governed by ERISA. 29 U.S.C. § 1002(1).

There are a number of issues wrapped up in this .

- Is there a plan?
- Is the plan established or maintained by an employer?
- Is the employer the right kind of employer?
- Does the plan cover any employees?
- Does the plan provide the right kind of benefits?

B. Is There a Plan?

In order for something to be governed by ERISA, it has to be a plan. And for there to be a plan there has to be some sort of administrative scheme for paying benefits.

For example, Maine passed a law requiring companies to pay employees a one time severance payment if it closed its business. The employer sued, claiming that the state law was governed by ERISA.

The Court said no, that requiring an employer to make a one time payment did not create a plan:

> To do little more than write a check hardly constitutes the operation of a benefit plan. Once this single event is over, the employer has no further responsibility. The theoretical possibility of a one-time obligation in the future simply creates no need for an ongoing administrative program for processing claims and paying benefits.

Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 12 (1987).

The area of "payroll practices" are a corollary to the issue of whether there is a plan. 29 C.F.R. § 2510.3-1(b) excludes from ERISA a swath of payments the employee receives from his or her employer. A lot of these are what you would expect, things like overtime pay, pay received during jury duty, or while on sabbatical.

However, one of these listed payroll practices is routinely mistaken for an ERISA disability claim. The regulations defining "payroll practices" include "payment of an employee's normal compensation, out of the employer's general assets, on account of periods of time during which the employee is physically or mentally unable to perform his or her duties.. . . " 29 C.F.R. § 2510.3-l(b)(2).

This looks a lot like an employer-funded plan providing disability benefits that would normally be subject to ERISA. And, in spite of the language of the regulation, it can still be a payroll practice if the employee gets less than his normal compensation, *Bassiri v. Xerox Corp.*, 463 F.3d 927, 933 (9th Cir. 2006), which makes it look even more like an employer sponsored, self-funded ERISA disability plan.

It turns out that the key to whether the employer sponsored payments constitute a "payroll practice" depends on the source of the payments. "The Department of Labor has chosen to define 'normal compensation' broadly and focus on the source of the funding, rather than its amount." *Bassiri*, 463 F.3d 927, 932 (9th Cir. 2006). So if there is a trust set up to pay the benefits then ERISA governs. If the benefits come out of the employer's bank account like wage payments, it is likely a payroll practice.

C. Is the plan "established or maintained" by an employer or employee organization?

The next question is whether the Plan is "established or maintained" by an employer or employee organization. The law at this point is clear that even minimal involvement by an employer will be sufficient to meet the "established or maintained" test.

> It is not difficult for an employer to establish an ERISA plan, even if it does no more than arrange for a 'group-type insurance program,', unless it is a mere advertiser who makes no contributions on behalf of its employees.

Kanne v. Connecticut General Life Ins. Co., 867 F.2d 489, 492 (9th Cir. 1988) (as amended, 1989)

In determining whether an employer "established or maintained" the benefits program, Courts generally follow the Department of Labor's "safe harbor" regulations. These regulations set forth four specific criteria, all of which must be met if a group insurance program is to be exempt from ERISA coverage:

> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation in the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

Kanne, 867 F.2d at 492. In other words, if any one of these factors is not met the plan created is subject to ERISA as a matter of law. *Stuart v. UNUM Life Ins. Co. of America*, 217 F.3d 1145, 1153 (9th Cir. 1999).

D. **Is employer one that is excluded from ERISA?**

1. **Plans where the government or a church is the employer are (usually) excluded from ERISA**.

ERISA exempts government plans and some church plans from its scope:

> (b) The provisions of this subchapter shall not apply to any employee benefit plan if--
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> (1) such plan is a governmental plan (as defined in section 1002(32) of this title);
>
> (2) such plan is a church plan (as defined in section 1002(33) of this title) with respect to which no election has been made under section 410(d) of Title 26;

29 U.S.C.A. § 1003(b).

2. **What is a government plan?**

A government plan is defined under statute as:

> a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality any of the foregoing.

29 U.S.C. § 1002(32).

It is easy to determine whether the plan sponsor is the United States or a state or a sub-division (i.e a city or county). The difficulty is in determining whether the sponsor might be an agency or instrumentality of a governmental organization.

In addressing this issue, in *Rose v. Long Island Railroad Pension Plan*, 828 F.2d 910 (2nd Cir. 1987) the Court adopted the IRS's definition of "agency or instrumentality" under 26 U.S.C. § 414(d). This section is used to determine those governmental plans exempted from certain requirements for advantageous tax treatment. *Id.* At 917. Here, six factors are considered in determining whether an entity is a governmental instrumentality:

> (1) whether it is used for a governmental purpose and performs a governmental function;
>
> (2) whether performance of its function is on behalf of one or more states or political subdivisions;
>
> (3) whether there are any private interests involved, or whether the states or political subdivisions involved have the powers and interests of an owner;
>
> (4) whether control and supervision of the organization is vested in public authority or authorities;
>
> (5) if express or implied statutory or other authority is necessary for the creation and/or use of such an instrumentality, and whether such authority exists; and
>
> (6) the degree of financial autonomy and the source of its operating expenses.

3. **What is a church plan?**

The first question here is "what is a church?" Fortunately ERISA provides an easy answer, if the IRS thinks it is a church, then for your purposes it is a church:

> The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their

> beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of Title 26.

29 U.S.C. § 1002 (33)(A).

However, unlike in the case of a government plan, the Church can decide to "opt in" to pension vesting requirements contained in ERISA:

> If the church or convention or association of churches which maintains any church plan makes an election under this subsection (in such form and manner as the Secretary may by regulations prescribe), then the provisions of this title relating to participation, vesting, funding, etc. (as in effect from time to time) shall apply to such church plan as if such provisions did not contain an exclusion for church plans.

26 U.S.C. § 410(d)(1).

E. **Does the plan cover employees**?

Given that we are talking about the **Employee** Retirement Income Security Plan, what if the insured is a business owner, who obtains his insurance through the business? Is that covered by ERISA?

The answer is, it depends on whether there are also some common law employees who are also covered by the plan:

> The regulations implementing this section provide that a plan "under which no employees are participants" does not constitute an ERISA employee benefit plan. 29 C.F.R. § 2510.3-3(b). Neither an owner of a business nor a partner in a partnership can constitute an "employee" for purposes of determining the existence of an ERISA plan.

Peterson v. American Life & Health Ins. Co., 48 F.3d 404, 407 (9th Cir. 1995).

There are a lot of potential issues here, and the law is a bit unclear. For example, if a single plan covers both employees and owners, then it is governed by ERISA. But in *Peterson* the Ninth Circuit held that two medical plans, one covering only owners and another covering only employees were both governed by ERISA.

Subsequently, in *LaVenture v. Prudential Ins. Co. of America*, 237 F.3d 1042, 1044 (9th Cir. 2001) the Ninth Circuit held that a company's disability plan that covered only owners was not governed by ERISA just because the company also had a health plan that covered employees. And in *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872 (9th Cir. 2001) the Ninth Circuit held that when an employee left her employment and her group coverage was converted into individual coverage, it was no longer governed by ERISA.

If you have a case where it is unclear if the plan at issue covers actual employees, it might be time to call an expert.

F. **Are They the Right Type of Benefits**?

In order for a Plan to be an ERISA Plan, it has to dispense the right type of employee benefits. The list of potential ERISA benefits can be pretty extensive. They include:

> medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services

29 U.S.C. § 1002(1)(A).

In practice, however, this is not as broad as it seems. For example, the courts have balked at treating accrued vacation benefits within ERISA's scope. *Massachusetts v. Morash* 490 U.S. 107, 116 (1989) ("It is unlikely that Congress intended to subject to ERISA's reporting and disclosure requirements those vacation benefits which by their nature are payable on a regular basis from the general assets of the employer and are accumulated over time only at the election of the employee."). In addition, regulations exclude "payroll practices" from ERISA, which are defined to mean holiday pay, sick pay, overtime pay and the like. 29 CFR § 2510.3-1(b).

G. **The Good News is that Most of the Time the Question Whether ERISA Governs a Client's Claim is Pretty Simple**

The good news is that in 90% of the cases the answer to whether a case is governed by ERISA is pretty clear. The major benefits people fight about, medical, life and long term disability, will be ERISA. The vast majority of plans cover at least some employees, and most of the time it is pretty clear whether the employee works for a private employer or the government. The difficult cases are those at the margins.

III. **A Warning on Statute of Limitations and the Time to Appeal**

After you have determined that your client's claim is governed by ERISA, now you have to both protect the client and yourself by not missing any deadlines. This is a very tricky and dangerous area of ERISA, and it was made trickier and more dangerous by some recent Supreme Court meddling in an area that it obviously failed to properly understand.

There are three potential limitations periods you have to worry about:

- One is a basic four year (in California) limitation period that runs from the date of the final denial. ERISA allows plans to set a shorter limitations period, so you

need to check the plan document to see whether this limitation is four years or some shorter period;

- There is also a time limit on when appeals are allowed from the initial clam denial. If this isn't done timely, the claimant loses all rights to further challenge the denial; and

- Recently, the Supreme Court has interpreted an archaic three year limitations period contained in many disability plans, which is based on insurance code language that nobody really understands. Unfortunately, the Supreme Court held that this three year period can (and usually will) begin accruing before his claim is actually denied.

B. The Statute of Limitations is Normally Four Years, But Plans Can Mandate Shorter Periods

In California the federal courts have borrowed the four year statute of limitations from Cal. Code Civ. Proc. § 337. *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643, 648 (9th Cir. 2000) (en banc). This four year statute of limitations begins to accrue when the claimant knows or should know that his claim has been denied:

> We hold that under federal law, an ERISA cause of action accrues either at the time benefits are actually denied, *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1501 (9th Cir.1984), or when the insured has reason to know that the claim has been denied.

Wetzel, 222 F.3d at 649.

That seems straightforward. However ERISA plans are allowed to place alternative limitation periods in the plan documents. Limitations periods as short as 90 days have been upheld as "reasonable" by the Courts. *Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301, 1304 (11th Cir. 1998). So you need to get a copy of the plan or Summary Plan Description and see if it contains a time period in which to file suit.

C. The time to appeal and exhaust the claim can be much shorter than the limitations period.

The limitations period isn't all you need to worry about. An ERISA denial is a multi-step process; there is an initial denial, an appeal, and then a decision upholding the appeal before the administrative remedies are exhausted. And, if the client fails to appeal in a timely manner, he loses his right to challenge the denial in Court.

How long do you have from the initial denial to file an appeal? The Plan is permitted to set the time period, although ERISA's regulations set out minimum periods.

- For a health plan or a disability plan, the minimum period for an appeal is 180 days. 29 CFR § 2560.503-1 (h)(3)(i); (h)(4).

- For all other plans, the minimum time period for an appeal is 60 days. 29 CFR § 2560.503-1 (h)(2)(i).

You can count on it that the Plan will adopt the minimum time period. So, first thing you do is get the most recent denial letter from the client. The letter will show whether this is the initial or the final denial. If it is the initial denial it will also provide the time to appeal.

Now, if the file lands on your desk and the time to appeal has been blown, all is not necessarily lost. First, you need to look at the actual plan to see if it contains the same time limitations. Sometimes it doesn't. And just because the SPD has the appeal limitation, it arguably doesn't count unless the language is repeated in the actual binding plan document. *Merigan v. Liberty Life Assur. Co. of Boston*, 826 F.Supp.2d 388, 395 (D.Mass.,2011) ("It is undisputed that the Policy does not incorporate any time limit within which an appeal from a negative decision must be taken. In these circumstances, Liberty acted improperly in refusing to consider Merigan's appeal of the termination of his LTD benefits on the grounds that the appeal was untimely.").

D. ***Heimeshoff*** **holds that a statutorily mandated three year limitations period can begin running before the claim for benefits is actually denied.**

Most disability plans or policies contain a provision that looks something like this:

> Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

This is based on a "model" insurance code provision setting out required policy language that has since been adopted by most states. In California this language is at Cal. Ins. Code § 10350.11.

According to this language, the claimant has only three years to bring suit from when "proof of claim is required." Most policies have language requiring "proof of claim" 60 or 90 days from the disability date so, read strictly, this language creates another limitations period of three years and two or three months from the disability date.

In the ERISA context most courts haven't been willing to apply this language as written, for the obvious reason that–as we will discuss in a little bit– ERISA involves a fairly lengthy administrative process, and it can be six months or a year or even more before a final denial is issued. So giving literal impact to this provision would mean that this three year limitations period would start running for a claimant before her claim was actually denied.

Nonetheless, in *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 134 S. Ct. 604 (2013) the Supreme Court interpreted the statute in just this manner. It recognized that exhausting the claimant's appeal rights might take a year or so, but reasoned that this still left two years, which it decided was plenty of time.

What the *Heimeshoff* Court failed to account for was that, in a lot of cases, the insurer pays benefits for a period of time before terminating them. For example, suppose, as often happens, the insurer paid disability benefits for 24 months, and then stopped when the definition of disability changed from "own occupation" to "any occupation." The policy has a six month elimination period before any benefits are due, and maybe after "any occupation" benefits were denied the insured took another six months exhausting the appeal, and then spent two months finding a lawyer willing to handle an ERISA claim. Well, guess what? The client just walked in the door, the denial is two months old, and maybe the statute of limitations runs tomorrow. Or maybe it ran yesterday.

In a case like this, I don't doubt that the courts will try hard to craft an exception to the *Heimeshoff* rule, but I wouldn't want to be the guy litigating that issue.

IV. **Before Filing the Claim**

When the claim comes to you, it will be in one of two forms. It may come to you after the initial denial. In that case, you will have to exhaust the appeal rights before you can file a lawsuit. Alternatively, the claimant might have already exhausted the appeal, in which case you can go ahead and file suit.

You would rather get into the case before the final denial. A key problem with ERISA litigation is that you can't (generally) introduce evidence outside the "Administrative Record," which is a fancy name for the insurance company's claim file. So the appeal might be your last chance to submit evidence that is favorable to your client's claim.

A. **Make Sure You Exhaust Your Client's Right to Appeal**

Under the federal scheme set up by Congress, it was contemplated that an administrative review process would be established, and that claimants would be required to exhaust their administrative remedies prior to seeking judicial relief. 29 C.F.R. § 2560.503-1. What this means is that ERISA plans are required to have an "appeal" mechanism for review of denied benefit claims. Persons who have their claims denied are required to go through this process before they can file a lawsuit:

> Quite early in ERISA's history, [the Ninth Circuit] announced as the general rule governing ERISA claims that a claimant must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court.

Diaz v. United Agricultural Employee Welfare Benefit Plan and Trust, 50 F.3d 1478, 1483 (9th Cir. 1995) (citing *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980)).

The exhaustion requirement is discretionary, meaning the district court can disregard it with proper grounds:

> Federal courts have authority to enforce the exhaustion requirement in ERISA actions, and as a matter of sound policy they should usually do so. That said, we have made it clear that there are exceptions to the general rule, and that when a district court determines that one of these exceptions applies, we review that determination for an abuse of discretion.

Dishman v. UNUM Life Ins. Co. of America, 269 F.3d 974, 984 (9th Cir. 2001) (attributions and footnotes omitted). In *Dishman* the Ninth Circuit found that the insurer gave "inadequate notice of both the denial of his claim and the available appeals procedure" which justified excusing the exhausting requirement.

Based on my own experience, I would not count on the district court doing the claimant any favors. The judges all have busy dockets (or they think they do), and if they can clear a case by sending it to the insurer for further review, generally they will. So you should exhaust, unless you have a good reason not to.

B. **During the Appeal, Make Sure You Get Your Evidence Into the Record**

In the course of the claim or appeal process, make sure that you get all your evidence into the Record. This is because, as a general rule, the district court will refuse to consider any evidence that the claims fiduciary (generally the insurance company) did not have when it decided its case.

You non-ERISA lawyers should think of this as building a record on appeal, with the claims process as the trial. If you plan to use the evidence on appeal, you have to "make a record" at the trial court.

There are three major exceptions to the rule against extrinsic evidence at an ERISA trial, as I will explain a bit later. But you shouldn't count on a favorable court ruling, instead you should make sure that the evidence will be admissible by getting it to the claims fiduciary before it makes its decision.

In doing so, make sure that you meet whatever time restraints the fiduciary gives you. In *Alford v. DCH Foundation Group Long Term Disability Plan*, 311 F.3d 955 (9th Cir. 2002) the Ninth Circuit held that an ERISA fiduciary may properly disregard information submitted after a reasonable deadline has passed. "To the extent that Ms. Alford relies on documents allegedly submitted to UNUM on October 23, 1998 [i.e. after the deadline to submit documents had passed], to bolster her claim of abuse of discretion, we agree with UNUM that these documents were not part of the record it was required to consider." *Alford*, 311 F.3d at 960.

V. **Proper Parties**

There is some confusion as to the identity of the proper parties in an ERISA benefits suit. In the typical case the employer funds the benefits through a policy of insurance. In such a case, the insurer is responsible for paying benefits, and also decides whether to pay the claim. One would think it obvious that a lawsuit to recover benefits wrongfully withheld would be against the insurer

Not so fast. Until recently the Ninth Circuit mandated that the only proper defendant in an ERISA benefits lawsuit was the plan entity. According to 29 U.S.C. § 1132(d), "an employee benefit plan may sue or be sued under this title as an entity . . . [and] [a]ny money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity . . .". Subsequent case law in the Ninth Circuit has strictly applied this statutory authority, holding that the plan is the only proper entity in a claim for plan benefits. "It is true that ERISA permits suits to recover benefits only against the plan as an entity" *Riordan v. Commonwealth Edison Co.*, 128 F.3d 549, 551 (7th Cir. 1997).

Given this, even where a plan was fully insured the claim had to be brought against the plan itself. So if the employee was denied long term disability benefits under a plan sponsored by, say, Bank of America, the suit would be against the "Bank of America Long Term Disability Plan."

Recently, in *Cyr v. Reliance Standard Life Ins. Co.*, 642 F.3d 1202 (9th Cir. 2011) (*en banc*), the Ninth Circuit modified this rule, holding that the insurer of a fully insured plan that actually made the decision to deny benefits could also be a proper party in an ERISA case:

> Reliance [i.e. the Reliance Standard, the insurer] denied Cyr's request for increased benefits even though, as the plan insurer, it was responsible for paying legitimate benefits claims. Reliance is, therefore, a logical defendant for an action by Cyr to recover benefits due to her under the terms of the plan and to enforce her rights under the terms of the plan, which is precisely the civil action authorized by § 1132(a)(1)(B).

Cyr, 642 F.3d at 1207.

So now, if you are absolutely sure that the Plan is fully insured, just go ahead and sue the insurer. However, in a lot of cases it is hard to tell whether a plan is fully insured; from the outside a self-funded plan with an insurer as the third party administrator looks an awful lot like an insured plan. In cases like this, sue both the Plan and the insurer and let them sort out the identity of the proper defendant.

VI. **ERISA causes of action.**

A. **Overview**

ERISA causes of action are statutory in nature, and are set out in 29 U.S.C. § 1132(a). In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-6 (1987) the Supreme Court held that these provide the exclusive remedies available to enforce rights under ERISA. The Supreme Court has repeatedly rejected any attempt to add common law claims to the list supplied by Congress in section 1132(a). *E.g. Mertens v. Hewitt Associates*, 508 U.S. 248, 249 (1993).

The most common ERISA claim brought is by a claimant under 29 U.S.C. § 1132(a)(1)(B) "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." This section is straightforward and means exactly what it says; a participant can use this claim to challenge a denial of benefits or to enforce his right to future benefits. This is the statutory basis for the overwhelming majority of ERISA litigation.

Another, less common, claim arises under 29 U.S.C. § 1132(a)(1)(A), which permits a cause of action against the "plan administrator" for failure to supply certain information pursuant to a written request. The nuts and bolts of this claim are complicated, and beyond the scope of this talk.

There are also two equitably based claims available for an ERISA participant. These are pursuant to 29 U.S.C. § 1132(a)(2) or 29 U.S.C. § 1132(a)(3). Both of these claims have specific limitations and requirements.

B. **Benefits claims under Section 1132(a)(1)(B)**

As noted above, the vast majority of ERISA litigation is brought under 29 U.S.C. § 1132(a)(1)(B), which states:

> A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> * * *
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. § 1132(a)(1)(B). Just as it says, under this section a claimant can recover benefits due under the plan.

Two things you want to keep in mind here. First, this section is the sole and exclusive mechanism by which a claimant can challenge a denial of benefits. Any state law claims, such as for breach of contract or for bad faith or for improper business practice, are preempted by ERISA. As the Supreme Court held in *Pilot Life*:

> The six carefully integrated civil enforcement provisions found in § 502(a)[1] of the statute as finally enacted provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.

Pilot Life, 481 U.S. at 54.

The corollary to this is that, since the statute makes no mention of consequential damages, they are not allowed. So, if the plan's failure to pay for a health treatment caused the patient's death, or the denial of disability benefits caused the claimant to lose her home, ERISA provides no remedy. All you are entitled to under this section are the unpaid benefits.

C. **Fiduciary duty claims under Section 1132(a)(2)**

ERISA recognizes a cause of action for breach of fiduciary duty under 29 U.S.C. § 1132(a)(2) which states that a civil action may be brought "by a participant . . . for appropriate relief under section 409 [as codified, 29 U.S.C. § 1109]." However claims allowed by this section are limited to those that seek to benefit the plan as a whole. The Supreme Court interpreted § 1109 in just this fashion:

> Petitioner contends . . . that recovery for a violation of § 409 [29 U.S.C. § 1109] inures to the benefit of the plan as a whole. We find this contention supported by the text of § 409, by the statutory provisions defining the duties of a fiduciary, and by the provisions defining the rights of a beneficiary.

Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 140 (1985). In *Amalgamated Clothing & Textile Workers Union, AFL-CIO v. Murdock*, 861 F.2d 1406, 1414 (9th Cir. 1988) the Ninth Circuit took this to its logical conclusion, stating that this cause of action does not apply to the mishandling of an individual claim.

So unless the participant is seeking relief flowing to the plan (rather than to her), this is not the cause of action to use.

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[1] One of the ways the Courts make ERISA even more confusing is the practice of referring to ERISA's provisions by their pre-codified nomenclature. The § 502(a) referred to by the *Pilot Life* Court is codified as 29 U.S.C. § 1132(a).

D. Claims for appropriate equitable relief under Section 1132(a)(3).

1. Introduction.

The scope of 29 U.S.C. § 1132(a)(3) is, at this point, somewhat uncertain. Both ERISA claimants and plan entities have been trying to use this section to fill some of the gaps left in ERISA's statutory structure. Up until recently the courts have resisted those attempts. Some more recent decisions, however, have significantly expended what is allowed under § 1132(a)(3).

The statute itself states as follows:

"(a) ...A civil action may be brought-

. . . . .

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of [ERISA Title I] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan."

29 U.S.C. § 1132(a)(3). The statute plainly sets out two requirements for "appropriate equitable relief". First, the relief sought must be "equitable" rather than legal. Second, the statute requires that the equitable relief be aimed at redressing a violation of ERISA or the terms of the Plan. "Thus, under the plain language of § 502(a)(3) [i.e. 29 U.S.C. § 1132(a)(3)], the relief sought must be equitable in nature, and the claim for relief must be predicated on either a violation of ERISA or the enforcement of a plan provision or an ERISA provision." *Green v. Holland*, 480 F.3d 1216, 1224 (11th Cir. 2007).

The two major areas where this statute is used is (1) by insurers or plan entities attempting to recover overpayments, and (2) by claimants trying to obtain relief that is impossible under the actual plan documents themselves. Let's take them both in turn.

2. Use of ERISA's equitable relief provision by plan entities to recover overpayments.

You read the cases and they talk about ERISA as being comprehensive, "reticulated," and thoughtfully crafted out. For anyone who actually practices in this area, that is so much nonsense. At least with respect to welfare benefits (i.e. non pension benefits), ERISA is mistake ridden and wildly incomplete. In point of fact, all it does is sweep away the protections of state laws, leaving essentially no substantive provisions in their place, and leaves it to the courts to try to sort things out.

One such area where ERISA's drafters left a hole in the statute is with respect to a plan's right to collect overpayments. This comes up primarily in two contexts. The first is an area of

extreme importance to many non-ERISA practitioners, for example personal injury specialists. Often, the injured party's employer sponsored health plan pays for his medical care. The health plan usually has a provision requiring the beneficiary to repay this from any third party recovery. So, after a personal injury specialist has obtained a recovery for his injured client, the health plan steps up and says it wants some (or sometimes all) of that recovery.

The other area where this commonly comes up is in the disability context. Sometimes after the insurer has been paying disability benefits, the insured qualifies for Social Security disability, or perhaps a disability pension. This allows the insurer to offset benefits, meaning that it has probably been overpaying benefits, and wants the overpayment back.

Well, the people who brought us ERISA failed to provide a remedy for recovery of overpaid benefits in the "comprehensive" remedies provided in 29 U.S.C. § 1132. So plans tried to shoehorn their claims for overpayment into the closest fit, a § 1132(a)(3) claim for "appropriate equitable relief."

Initially, the Supreme Court balked. In *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) it held that what the plan was seeking here was legal damages, not within the scope of the equitable relief allowed in § 1132(a)(3).

More recently, however, in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), the Court changed course to allow a plan to collect overpaid medical benefits from the beneficiary, where the beneficiary had promised to repay any overpayment. To do so it reached back to a 92 year old case for the proposition that an equitable "lien by agreement" had been created when the claimant received the funds that created the overpayment.

In *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013), the Court took this a step further, holding that equitable doctrines such as unjust enrichment or the "common fund" doctrine didn't apply to this new equitable claim. As such, depending on the specific nature of the plan language, the Plan can claim the entire amount of the settlement, including the attorney fees expended to obtain the settlement, even if this leaves the beneficiary with no compensation for his lost income or pain.

Fortunately, in the more recent case of *Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651 (2016) the Court, in the person of Justice Thomas, tossed the plaintiffs' bar a bone. In *Montanile* the beneficiary was injured by a drunk driver, and his lawyer obtained a settlement. The lawyer held the funds in trust and attempted to negotiate a settlement with the health plan, with no success. The lawyer then informed the plan that he was distributing the funds unless the Plan objected within 14 days. When the Plan interposed no objection the funds were distributed.

The Plan filed suit, seeking a recover out of the beneficiary's general assets. The Supreme Court held that "equitable relief" applied only to an identifiable res, and that what the Plan was seeking here was legal damages not allowed by the statute.

So personal injury specialists can take some heart from the following language:

> The Board protests that tracking and participating in legal proceedings is hard and costly, and that settlements are often shrouded in secrecy. The facts of this case undercut that argument. The Board had sufficient notice of Montanile's settlement to have taken various steps to preserve those funds. Most notably, when negotiations broke down and Montanile's lawyer expressed his intent to disburse the remaining settlement funds to Montanile unless the plan objected within 14 days, the Board could have—but did not—object.

Montanile, 136 S. Ct. at 662.

3. On the plaintiffs' side, the *Amara* decision expanded (somewhat) the concept of equitable remedies.

On the plaintiffs' side, §1132(a)(3) limitation to equitable relief caused similar problems. In a number of cases, such as *Mertens v. Hewitt Associates*, 508 U.S. 248, 255 (1993), the Court held that it could not include money damages.

However, in *CIGNA Corp. v. Amara* 131 S.Ct. 1866 (2011) the Supreme Court appeared to create broad new equitable remedies under § (a)(3) for the courts to reform plans and bind employers to the terms of their misstatements. In addition, the *Amara* Court has dusted off the old equitable remedy of "surcharge" which, in direct contrast to prior holdings, can be used to require the payment of money damages as a result of a Plan's breach of its fiduciary responsibilities.

What all of this means in practice is, as noted above, somewhat uncertain, as the lower courts are still sorting out the scope of § 1132(a)(3). Unfortunately, the Ninth Circuit appears to take a very narrow view of these new equitable remedies, for example in *Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945 (9th Cir. 2014) it grafted on a number of very restrictive requirements to obtaining equitable relief.

VII. Evidence and Discovery

A. With Three Exceptions, Evidence in ERISA Cases Is Limited to the Administrative Record

The general rule in ERISA cases is that the court will limit the admissible evidence to the record the plan had when it issued its final denial. The reasoning is that, otherwise, the courts would be acting as substitute plan fiduciaries, deciding issues in the first instance rather than performing their task of reviewing plan decisions:

> Nothing in the legislative history suggests that Congress intended that federal district courts would function as substitute plan administrators, a role they would

> inevitably assume if they received or considered evidence not presented to administrators concerning employees' entitlement to benefits.

Taft v. Equitable Life Assurance Soc'y, 9 F.3d 1469, 1472 (9th Cir. 1993) (attribution omitted). As such, the Ninth Circuit has held that, subject to some exceptions, evidence outside the Administrative Record[2] is inadmissible on the issue of whether the claim was properly denied:

> [T]he district court may not consider "new evidence," i.e., evidence which was not part of the administrative record. Under the abuse of discretions standard, the district court may review only evidence which was presented to the plan trustees or administrator.

McKenzie v. General Telephone Co. of California, 41 F.3d 1310, 1316 (9th Cir. 1994).[3]

As noted above, there are three exceptions to the general rule excluding extrinsic evidence in ERISA cases. First, according to *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan,* 46 F.3d 938, 943-44 (9th Cir. 1995) extrinsic evidence may be admissible in a *de novo* case. Its use is limited, however, to cases "when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefits decision."

In a case where the abuse of discretion standard applies, the court is permitted to "consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc). As a result, a claimant is permitted to introduce evidence from outside the record showing that plan fiduciary's dual role as claims decider and claims payer has influenced its fiduciary obligations to fairly decide a claim.

The third exception comes into play where the fiduciary engages in a procedural irregularity which causes the record to be incomplete on some significant point. Where the fiduciary takes some action which prevents a claimant from having an opportunity to address an issue in the record, *Abatie* states that the district court must allow her to introduce evidence on that issue in litigation:

> When a plan administrator has failed to follow a procedural requirement of ERISA, the court may have to consider evidence outside the administrative record. For example, if the administrator did not provide a full and fair hearing, as required by ERISA, 29 U.S.C. § 1133(2), the court must be in a position to assess

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[2] For reasons outside the scope of this lecture, the insurer or plan's claim file is commonly called the Administrative Record.

[3] Both *Taft* and *McKenzie* have been limited on this point by *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc), as was pointed out by the panel in *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 873, n. 2 (9th Cir., 2008).

> the effect of that failure and, before it can do so, must permit the participant to present additional evidence.

Abatie, 458 F.3d at 972 -973.

B. **Discovery is Allowed in ERISA Cases to the Extent It is "Reasonably Calculated" to Produce Admissible Evidence**

Rule 26(b)(1) of the Federal Rules of Civil Procedure defines the scope of discovery. There is no exception for ERISA cases. According to Rule 26(b)(1) discovery is allowed into "any matter, not privileged, that is relevant to the claim or defense of any party" so long as it is "reasonably calculated to lead to the discovery of admissible evidence."[4] In other words, allowable discovery in ERISA cases should be tied to the scope of admissible evidence, described above.

So, as noted in *Crosby v. Louisiana Health Service and Indem. Co.*, 647 F.3d 258 (5th Cir. 2011), a party has a right to discovery in ERISA cases whenever she seeks evidence that–given the scope of admissible evidence in those cases–is "reasonably calculated to lead to the discovery of admissible evidence:"

> Here, Crosby sought to discover evidence that would indicate whether the administrative record was complete, whether Blue Cross complied with ERISA's procedural requirements, and whether Blue Cross had previously afforded coverage for claims related to the jaw, teeth, or mouth. Her discovery request was at least reasonably calculated to lead to the discovery of some admissible evidence.

Crosby, 647 F.3d at 263 -264. *Also*, *Self v. The Prudential Ins. Co. of America*, 2010 WL 996503, 1 (N.D.Fla.,2010) (in ERISA case, "Rule 26 provides that 'unless otherwise limited by court order,' parties to a civil action may conduct discovery regarding any matter that is not privileged and relevant to a claim or defense in the case. Fed.R.Civ.P. 26(b) (1)"); *Mulligan v. Provident Life and Acc. Ins. Co.*, 271 F.R.D. 584, 593 (E.D.Tenn.,2011) ("While the discovery requests at issue are overbroad, the Court finds that they appear, in part, reasonably calculated to lead to the discovery of admissible evidence.").

In *Barker v. Life Ins. Co. of North America*, 265 F.R.D. 389 (S.D.Ind.,2009) the Court set out the following analysis for determining the scope of discovery in ERISA cases:

> The Federal Rules of Civil Procedure provide for liberal discovery by requiring disclosure of any relevant matter. *Hughes v. CUNA Mutual Group*, 257 F.R.D. 176, 177 (S.D.Ind.2009). "Relevant" matter, in the discovery context, extends

[4] Unfortunately, this useful language was deleted in the 2015 revisions to Rule 26. It is unknown as of this date whether this impacts the scope of discovery in ERISA cases, which largely hinges on this phrase.

> beyond information properly admissible at trial to include anything that "appears reasonably calculated to lead to the discovery of admissible evidence." Fed.R.Civ.P. 26(b)(1); see *Hughes*, 257 F.R.D. at 177. Here, this court must determine what is "relevant" in cases where a plaintiff challenges a denial of benefits under an ERISA plan.

Barker, 265 F.R.D. at 393. *Also*, *Adams v. Hartford Life and Acc. Ins. Co.*, 589 F.Supp.2d 1366, 1368 (N.D.Ga.,2008) ("the court concludes that the plaintiff is entitled to pursue any discovery that is relevant in itself or [that] appears reasonably calculated to lead to the discovery of admissible evidence."); *Hogan-Cross v. Metropolitan Life Ins. Co.*, 568 F.Supp.2d 410, 414 (S.D.N.Y.,2008) ("The question here, as in all cases, is whether the discovery sought is relevant in itself or "appears reasonably calculated to lead to the discovery of admissible evidence.").

VIII. **The Standard of Review**

A. **ERISA cases are decided under either the *de novo* or abuse of discretion standard of reviews**

There are two possible standards of review in ERISA cases, abuse of discretion or *de novo*. Review will be abuse of discretion where language "granting the power to interpret plan terms and to make final benefits determinations" is included in the Plan. *Abatie v. Alta Health & Life Ins. Co.,* 458 F.3d 955, 963 (9th Cir. 2006) (en banc).

The Ninth Circuit has held that the grant of discretion must be "unambiguous" to be effective:

> If an insurance company seeking to sell and administer an ERISA plan wants to have discretion in making claims decisions, it should say so. It is not difficult to write, "The plan administrator has discretionary authority to grant or deny benefits under this plan." When the language of a plan is unambiguous, a company purchasing the plan, and employees evaluating what their employer has purchased on their behalf, can clearly understand the scope of the authority the administrator has reserved for itself.

Ingram v. Martin Marietta Long Term Disability Income Plan for Salaried Employees of Transferred GE Operations, 244 F.3d 1109, 1113-1114 (9th Cir. 2001). Moreover, in the absence of an explicit grant of discretion review will be *de novo*:

> Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

Whether *de novo* or abuse of discretion review applies can be case determinative. The plaintiff faces a daunting standard under abuse of discretion review:

> An ERISA administrator abuses its discretion only if it (1) renders a decision without explanation, (2) construes provisions of the plan in a way that conflicts with the plain language of the plan, or (3) relies on clearly erroneous findings of fact.

Boyd v. Bert Bell/Pete Rozelle NFL Players Retirement Plan, 410 F.3d 1173, 1178 (9th Cir. 2005).

The claimant's attorney therefore has an incentive to reduce the standard of review to *de novo*. There are, fortunately, a number of ways to accomplish this.

B. **Reducing the standard of review to *de novo*.**

1. **Recent California law prohibits discretionary clauses in insurance policies**.

California has enacted a statute making discretionary clauses illegal in insurance policies. According to Cal. Ins. Code § 10110.6(a):

> If a policy, contract, certificate, or agreement offered, issued, delivered, or renewed, whether or not in California, that provides or funds life insurance or disability insurance coverage for any California resident contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the policy, contract, certificate, or agreement, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

This law, however, only applies to insured plans, not self funded plans. Moreover, insurers are attempting to avoid this and similar laws from other states by putting discretionary language in a document which is outside the policy.

This tactic has been rejected by a number of district court opinions, that have broadly upheld the California law. *I.d.Gonda v. The Permanente Medical Group, Inc.*, 10 Fed. Supp. 3d 1091, 1095 (N.D. Cal. 2014). The district court in *Polnicky v. Liberty Life Assurance Company of Boston*, 999 F. Supp. 2d 1134, 1149 (N.D. Cal., 2013) and *Cerone v. Reliance Standard Life Ins. Co.*, 9 F. Supp. 3d 1145, 1149 (S.D.Cal.,2014).

There is one outlier, *Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan*, 2014 WL 979191 (C.D. Cal., 2014), where the district court held that the California ban on discretionary clauses did not apply because there was no evidence that the plan document containing the discretionary language "renewed" after the statute's effective date. That case is

on appeal, and the insurer is swinging for the fences, arguing that the California law is preempted by ERISA, in spite of the fact that the Ninth Circuit had already pretty much resolved the issue in *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009). So stay tuned.

2. **The plan cannot be modified by the summary plan description**.

To be effective, a grant of discretion must be in the Plan Document. In *CIGNA Corp. v. Amara*, 131 S.Ct. 1866, 1878 (2011) the Supreme Court held that language in the Summary Plan Description ("SPD") cannot be used to modify or interpret the Plan. Courts have used this to hold that the actual grant of discretion must be in the plan to be effective.

For example, in *Eugene S. v. Horizon Blue Cross Blue Shield of New Jersey*, 663 F.3d 1124 (10 Cir. 2011), the Court held that a grant of discretion in the SPD is not effective unless the SPD is incorporated into the Plan:

> However, an insurer is not entitled to deferential review merely because it claims the SPD is integrated into the Plan. Rather, the insurer must demonstrate that the SPD is part of the Plan, for example, by the SPD clearly stating on its face that it is part of the Plan. A contrary decision would undermine *Amara*.

Eugene S., 663F.3d at 1131. *Also*, *Prichard v. Metro. Life Ins. Co.*, 783 F.3d 1166, 1170 (9th Cir. 2015) (grant of discretion not effective where not incorporated into the plan).

3. **The Discretion Must Be Exercised by the Entity Granted Discretion by the Policy**

Often, the plan grants discretion to one entity and the decision is made by a different entity. This happens, for example, when a plan hires a third party administrator to decide claims, but neglects to modify the plan to reflect this.

In such a case, the law is clear that a plan's grant of discretion is ineffective where the decision is not made by the entity granted discretion. This was the ruling of *Jebian v. Hewlett-Packard Co. Employee Benefits Organization Income Protection Plan*, 349 F.3d 1098 (9th Cir. 2003) which held that a grant of discretionary authority only applies where the decision is made in accordance with Plan terms:

> [A]lthough *Firestone* directs courts to defer to the decisions of plans in which their language grants discretionary authority, that deference applies only when the decision is made by the body vested with discretion.

Jebian, 349 F.3d at 1105.

4. The Grant of Discretion May be an Illegal Plan Amendment

If the insurer or plan attempts to grant discretion in a document outside the plan, an argument exists that this is an unauthorized plan amendment. The plan almost certainly has an integration clause and strict procedures for its amendment. If the document which purports to grant discretion does not comply with the plan procedures for amendment or delegation of discretionary authority, the courts will not enforce it.

For example, in *Shane v. Albertson's Inc.*, 504 F.3d 1166 (9th Cir. 2007) the Plan granted authority to "the Plan Trustees." However a different body, the "Medical Review Committee" ("MRC") issued the benefits denial. There was a delegation of authority to the MRC, but the *Shane* Court held that this was only effective if the Plan authorized the delegation. "When considering and applying the delegation clause in conjunction with the relevant evidence regarding the transfer of discretionary authority to the MRC, it is apparent that the delegation to the MRC was not in compliance with the 1993 Disability Plan's stated requirements." *Shane*, 504 F.3d at 1171.

C. Evidence of Conflict Can Reduce the Extent of Discretion

In *Abatie v. Alta Health & Life Ins. Co.* 458 F.3d 955 (9th Cir. 2006) (*en banc*) the Ninth Circuit held that, where the entity paying benefits is the fiduciary who decides whether benefits should be paid, the District Court must take the fiduciary's level of conflict into account in deciding cases under the abuse of discretion standard:

> We read Firestone to require abuse of discretion review whenever an ERISA plan grants discretion to the plan administrator, but a review informed by the nature, extent, and effect on the decision-making process of any conflict of interest that may appear in the record.

Abatie, 458 F.3d at 967. As such, where plaintiff presents colorable evidence of conflict, *Abatie* requires the court to weigh the level of conflict–on a case by case basis–in order to determine how much discretion to give the fiduciary's decision:

> A district court, when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's reason for denying insurance coverage. An egregious conflict may weigh more heavily (that is, may cause the court to find an abuse of discretion more readily) than a minor, technical conflict might.

Abatie, 458 F.3d at 968. *Abatie* was clear that procedural irregularities by the fiduciary, as well as actions taken by the fiduciary that detracted from the insured's right to "full and fair review" of her claim were factors that could be taken into account in determining the level of conflict. *Abatie*, 458 F.3d at 972-73.

IX. **ERISA trials are short to non-existent.**

The section on ERISA trials will be short, because ERISA trials themselves are short. In *Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir. 1999) (en banc) the Ninth Circuit authorized ERISA trials to take place by the judge just reading the record on which the claim was denied:

> Although Rule 43(a) requires that "testimony" be taken in open court, the record should be regarded as being in the nature of exhibits, in the nature of documents, which are routinely a basis for findings of fact even though no one reads them out loud. We have affirmed bench trials on records in other cases. See *Adair v. Sunwest Bank (In re Adair)*, 965 F.2d 777, 779 (9th Cir.1992). A majority of us conclude that, in its discretion guided by *Mongeluzo*, the district court may try the case on the record that the administrator had before it.

Kearney, 175 F.3d at 1094-1095.

What this means in practice is that the Court will usually set a briefing schedule for arguing the case on the papers. Sometimes the Court will schedule oral argument, and sometimes the Court just decides the case in the absence of counsel.

X. **A plaintiff achieving success on the merits is presumptively entitled to attorney fees.**

The good news in ERISA cases is that plaintiffs who achieve success on the merits are entitled to an award of attorney fees. The standard for whether fees are appropriate is set forth in *Hummell v. S.E. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir.1980), which sets out the following factors:

> 1. the degree of the opposing party's culpability or bad faith,
>
> 2. the ability of the opposing party to satisfy an award of fees,
>
> 3. whether an award of fees would deter others from acting in similar circumstances,
>
> 4. whether the party requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA, and
>
> 5. the relative merits of the parties' positions.

Cline v. Industrial Maintenance Engineering & Contracting Co., 200 F.3d 1223, 1235 (9th Cir. 2000) (footnote omitted) (quoting from *Hummell v. S.E. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir.1980)).

Practically speaking, however, a plaintiff who achieves success on the merits is presumptively entitled to an award of fees, unless there are "special circumstances" which would make a fee award unjust:

> Because of the absence of such special circumstances, the district court abused its discretion in denying plaintiff attorneys' fees. We therefore reverse and remand that portion of the district court's decision denying plaintiff attorneys' fees.

McConnell v. MEBA Medical and Benefits Plan, 778 F.2d 521, 525-26 (9th Cir. 1985). By the same token, a prevailing defendant is only entitled to attorney fees where there is evidence the plaintiff brought the litigation in bad faith.

Are you entitled to fees if, after filing suit, the insurer or plan concedes and pays benefits. The answer is "probably yes," although the judge does have discretion to deny a fee award. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242 (2010).

A. **Timekeeping issues.**

Make sure you write down your time. Write it with the understanding that you are going to have to disclose your time records. The description of the work done should support the amount of time you put down for each task. The records may be extensive, and you don't want to spend hours redacting them, so avoid including privileged or otherwise sensitive material.

B. **No fees for administrative appeals.**

In *Cann v. Carpenters' Pension Trust Fund for N. Cal.*, 989 F.2d 313 (9th Cir. 1993) the Ninth Circuit held that fees expended on appeal aren't compensable. So, all that work I said you had to do exhausting the administrative appeal? You can't get paid for it, so plan accordingly.