Fiduciary's Obligation to Credit Subjective Complaints of Pain

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Body

ERISA-governed group long-term disability claims are frequently litigated in both the Eastern and Southern districts of New York. To make a successful claim under a group long-term disability plan, an employee generally has to provide proof that an injury or sickness prevents her from performing either her own occupation or any occupation for which she is reasonably suited. In the end, the proof in every long-term disability claim boils down to "subjective complaints." For example, while cancer can be "objectively" proven, its disabling sequelae, pain and fatigue, are entirely subjective. Although an X-ray can verify a spinal fracture and an MRI can often verify a herniated disk, the disabling pain and numbness flowing from them cannot be objectively confirmed, only clinically correlated. Quite simply then, all disability claims require claimants to explain how sickness or injury subjectively disables them in order to establish a valid claim in the first instance.

The U.S. Court of Appeals for the Second Circuit's recent decision in Miles v. Principal Life Insurance[1] recognized this reality and in so doing, set forth proper procedural parameters to guide claimants, fiduciaries, and district courts through the proof-of-disability process. Thus, the success or failure of nearly all Employee Retirement Income Security Act-governed long-term disability claims depends on how a long-term disability claim administrator (typically an insurance company) weighs and evaluates a disabled individual's subjective complaints.

Key Cases

The seminal case establishing the need to credit a disabled claimant's subjective complaints is Connors v. Conn. Gen Life Ins.,[2] where the Second Circuit held that a district court may not discount an ERISA beneficiary's subjective complaints of pain as legally insufficient evidence of disability, and that "the

subjective element of pain is an important factor to be considered in determining disability."[3] Subsequent to its proclamation in Connors, the Second Circuit seemed to retreat, however, from its strong position that a claim fiduciary must consider subjective complaints of pain. For example, in Maniatty v. Unum Provident,[4] the court affirmed the district court's determination that a disability claim arising out of back pain required objective "proof" of that pain. The district court held that the very notion of "proof" connotes "objectivity."[5] Further, in Hobson v. Metropolitan Life Ins.,[6] the court held that a plan administrator may require a disappointed ERISA-plan beneficiary to provide objective evidence of disability to prevent fraud or unsupported claims of disability.[7]

After the Second Circuit's decisions in Maniatty and Hobson, district courts began to read objective proof requirements into ERISA-governed long-term disability policies in direct contravention of Connors. For example, based on Hobson, one district court reasoned that it "[i]s reasonable for the administrator to require an objective component to proof of disability."[8]

'Miles' Case

The Second Circuit's most recent decision in Miles v. Principal Life Insurance[9] reaffirms the vitality of its earlier decision in Connors and provides a very strict and desperately needed road map dictating how claim fiduciaries and district courts are to weigh and evaluate subjective complaints of disability.

Ralph Miles, the claimant in Miles, was a senior equity law firm partner and head of his firm's commercial real estate practice. Although Miles suffered from senso-neural hearing loss, vertigo and tinnitus, his tinnitus was one of his primary disabling conditions.[10]

Miles filed a claim under his ERISA-governed long-term disability policy administered by the defendant, Principal Life Insurance Company. Miles provided Principal with all relevant claim forms and attending physician's statements and medical records, including an EEG, MRIs and hearing examinations.

On his claim forms, Miles indicated that the high frequency sound resulting from his tinnitus would wake him up at night and rendered him disabled, because it rendered him unable to read or concentrate due to his pain and disorientation. Miles' primary treating physician provided that Miles' hearing issues and head pain made him unable to perform his occupation due to his fogginess and inability to concentrate.

Principal hired two separate physicians to evaluate Miles' claim. While acknowledging that Miles suffered from hearing loss, vertigo and tinnitus, one physician opined that no "objective" findings existed to support impairment from a neurological perspective and thus, no restrictions and limitations were supported by the information provided. Another physician hired by Principal echoed that Miles "lacked observable, objective information confirming that [he] was disabled."[11]

Based on the reviews of two physicians, Principal denied Miles' claim primarily relying on an absence of objective clinical documentation that clearly sets out Miles' limitations.

As required by Miles' long-term disability benefit plan, he administratively appealed Principal's initial adverse benefit determination. In support of his appeal, Miles submitted the statement of his primary treating physician. In relevant part, that physician's statement plainly stated that Miles' roaring tinnitus was his truly disabling condition, and although no objective tests for tinnitus exists, Miles' complaints of tinnitus completely correlated to his degree of hearing loss and his reported symptoms.

Principal hired two more physicians to review the information submitted by Miles in his administrative review. Both of these physicians acknowledged Miles' tinnitus symptoms, but stated that no physical restrictions or limitations existed based on "objective" medical data, and that his severe symptoms were all "self reported." Principal denied Miles' claim for the final time.

Miles then brought an action in the District Court which ruled, after a bench trial on a stipulated record pursuant to FRCP 52, that Principal's initial adverse benefit determination was neither arbitrary nor capricious, and that Principal afforded Miles a full and fair review of his denied claim. The District Court relied on Maniatty v. UnumProvident,[12] ruling that Principal's request for objective proof of Miles' disabling tinnitus was reasonable.[13]

Second Circuit Sets Road Map

The Second Circuit reversed and set out a road map for district courts to follow when evaluating whether a claim fiduciary has properly evaluated subjective complaints. First, the court ruled that "[s]ubjective complaints of disabling conditions are not merely evidence of a disability, but are 'important factors to be considered in determining a disability.'"[14] Indeed, the court held that it is per se arbitrary and capricious for a claim fiduciary to disregard evidence simply because it is subjective.

Next, if the claim fiduciary chooses to disregard a claimant's subjective complaints, the court held that ERISA requires that it provide the specific reasons for its decision to discount them.[15] Simply pointing out that the evidence of a disability is "subjective" is not a proper basis to reject that evidence. Thus, the court held that a claim fiduciary's failure to provide a basis for the rejection of subjective complaints is "arbitrary."[16] The court reasoned that a claim fiduciary may afford lower weight to subjective complaints if it identifies other objective findings that it would reasonably have expected to see in conjunction with the subjective complaints.[17]

The Miles court further held that a claim fiduciary may not require a claimant to obtain an objective test for a disabling condition where no such test exists.[18]

Finally, in assessing the weight to provide a claimant's subjective complaints, the Second Circuit noted that a claim fiduciary should rely on collateral evidence, such as tertiary diagnoses commonly associated with the subjective complaints, or a positive work history that supports the credibility of a claimant's subjective complaints.[19]

The guidance provided by the Second Circuit in Miles will significantly streamline the process for proving ERISA-governed disability claims, both to claims administrators and the courts tasked with evaluating the propriety of those determinations. These guidelines are crucial in the ERISA-governed claims arena, an arena where an insurance company's claim file is typically denominated the "administrative record," often the only evidence the federal courts will ever see in one of these cases. It is also a world where sick, injured, out-of-work claimants are struggling with proper diagnoses, care and treatment while in financial crisis and while simultaneously trying to prove they cannot work-a daunting situation to say the least. The Miles court has properly and plainly defined the scope of an administrator's obligation to rebut proof of disability to the greater benefit of courts, claimants and fiduciaries alike.

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Endnotes:

1. Miles v. Principal Life Insurance, -F.3d-, 2013 WL 3197996 (2d Cir. 2013).

2. Connors v. Conn. Gen Life Ins., 272 F.3d 127 (2d. Cir. 2001).

3. Id. at 136.

4. Maniatty v. Unum Provident, 62 Fed. Appx. 413, 2003 WL 21105390 (2d. Cir. 2003).

5. Maniatty v. UnumProvident, 218 F.Supp.2d 500, 504 (S.D.N.Y., 2002).

6. Hobson v. Metropolitan Life Ins., 574 F.3d 75 (2d Cir. 2009).

7. Id. at 88.

8. Pava v. Hartford Life and Accident Insurance, 2005 WL 2039192, 11 (E.D.N.Y. 2005).

9. Miles v. Principal Life Insurance, 2013 WL 3197996 (2d Cir. 2013).

10. Id. at *2.

11. Id. at *5.

12. Maniatty v. UnumProvident, 218 F.Supp.2d 500, 504 (S.D.N.Y. 2002).

13. Miles v. Principal Life Insurance, 831 F.Supp.2d 767, 778 (S.D.N.Y. 2013).

14. Miles v. Principal Life Insurance, 2013 WL 3197996, * 11 (2d Cir. 2013).

15. Id. at * 12.

16. Id. at * 12.

17. Id. at * 14.

18. Id. at *13.

19. Id. at *13.

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