

# The Waiver Doctrine, Alive And Well in ERISA Cases

By Robert J. McKennon

California courts have long applied the waiver doctrine in insurance cases, usually against insurers to afford coverage to insureds. But whether the waiver doctrine applies to group insurance claims under the Employee Retirement Income Security Act (ERISA) was resolved just last week by the 9th U.S. Circuit Court of Appeals in *Mitchell v. CB Richard Ellis Long Term Disability Plan*, 2010 DJDR 11532 (9th Cir. July 26). It was not a stretch to believe that the 9th Circuit, typically one of the most pro-insured circuits when deciding ERISA cases, would apply the waiver doctrine to afford coverage to plan participants. After all, most circuit courts that have considered the issue have adopted waiver in ERISA cases. See *Lauder v. First Unum Life Ins. Co.*, 284 F.3d 375, 382 (2d Cir. 2002) (holding insurer waived its right to rely on lack of disability as a defense when, upon becoming aware of the individual's disability, it failed to investigate or challenge it); *Rhorer v. Raytheon Eng'rs & Constructors Inc.*, 181 F.3d 634, 645 (5th Cir. 1999) (finding waiver available where insurer knew individual did not meet the eligibility requirements but nonetheless enrolled, accepted, and retained premiums from the individual); see also *Gaines v. Sargent Fletcher Inc. Group Life Ins. Plan*, 329 F. Supp. 2d 1198, 1222 (C.D. Cal. 2004) (holding insurer waived the right to require submission of a personal health statement when it enrolled and accepted premiums from plaintiff without giving any indication that plaintiff failed to comply with the precondition to obtaining coverage).



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Moreover, the 9th Circuit has recognized the similar equitable principle of estoppel in ERISA cases. See *Alaska Trowel Trades Pension Fund v. Lopshire*, 103 F.3d 881, 884 (9th Cir. 1996) (holding equitable estoppel available in ERISA action to recover trust fund contributions); *Pisciotta v. Teledyne Indus. Inc.*, 91 F.3d 1326, 1331 (9th Cir. 1996) (recognizing the availability of equitable estoppel in the context of ERISA, but finding estoppel unavailable because the terms of the plan were unambiguous).

It has been a long-standing requirement in ERISA that a long-term disability benefits insurer must disclose all of the reasons for the denial of a claim in writing at the administrative review level. The question became: Would the doctrine of waiver apply to prevent an insurer from relying on the new reason for the denial when it first asserted this basis

for denial in litigation and did not inform the insured of it in the claims and appeal process? The 9th Circuit answered this question in the affirmative in *Mitchell*.

Michael Mitchell had been a successful commercial real estate broker since 1983. Mitchell's employer, CB Richard Ellis, provided long-term disability benefits to its employees. From Jan. 1, 2000 until Dec. 31, 2003, Unum Life Insurance Co. of America provided long-term disability benefits to the plan's participants. MetLife replaced Unum as the insurer and claims administrator as of Jan. 1, 2004. In February 2001, Mitchell was diagnosed with restless leg syndrome. In October 2003, Mitchell was also diagnosed with major depression, chronic fatigue syndrome, sleep apnea, and hemochromatosis. Mitchell continued to work and his job performance was successful. In 2001, the year he was first diagnosed, his income was approximately \$180,000. In 2002, his income rose to \$250,000. But, by March 2004, Mitchell's disability interfered with his ability to earn income, which was solely based upon commission and bonuses. In 2003, his income dropped below \$30,000, and in 2004 it fell to under \$13,000.

Mitchell subsequently applied for long term disability benefits on April 15, 2004, only a few months after MetLife took over as benefits administrator and insurer of Ellis' employees. In the MetLife application for long term disability benefits, Mitchell provided the date of his first treatment as October 2003. He also stated that he was still working and that his disability began October 2003. MetLife denied Mitchell's claim based upon the definition of "disability" or "disabled" as defined in the certificate of insurance, since Mitchell was still able to work based on the doctor's reports and in fact, was still working.

In December 2004, Mitchell filed an appeal and submitted supporting letters from examining physicians, and additional medical records. On Jan. 18, 2005, MetLife upheld the original denial, although this time it based the denial on the ground that Mitchell did not meet the definition of disability as defined in the summary plan description. Under this definition, a plan participant must be "unable to perform the material and substantial duties of his/her regular occupation." During the initial claim and the administrative review processes, MetLife never specified, as a reason for denial, that it was not the provider of long term disability benefits at the claimed onset of Mitchell's disability in October 2003.

Mitchell filed suit against MetLife on Feb. 2, 2005, seeking long term disability benefits. MetLife then asserted for the first time it was not the provider of these benefits and Mitchell should have filed his benefit claim with Unum because the claimed disability predated its policy date. Mitchell filed with Unum in October 2005, but was denied. Mitchell requested a review of this decision on Nov. 13, 2006, and on Jan. 11, 2007, Unum denied his appeal because Mitchell continued to work. Mitchell then amended his complaint on Jan. 5, 2007, naming Unum as an additional defendant. Unum then filed a cross-complaint for indemnification against MetLife.

The District Court concluded MetLife had conflicting definitions of



disability and abused its discretion when it applied the more limiting definition of disability to deny long term disability benefits. The District Court also applied the waiver doctrine and found that MetLife could "not disavow that it was the administrator and insurer for Mitchell's claim when it never raised that reason during the administrative review."

The 9th Circuit affirmed. The court concluded MetLife abused its discretion by relying on an "unwritten and unexplained objective evidence requirement," and by failing to meet its own requirements for providing full disclosure when it denied benefits since it did not inform Mitchell of its claimed date of onset coverage defense. The court first stated that it need not address the waiver issue because MetLife was the "responsible insurer at the time Mitchell submitted his claim under the plain language of its policy." However, the court then explained in footnote 2:

"[W]e are not persuaded that the district court erred in concluding that MetLife waived its date of onset coverage defense. The purpose of ERISA's requirement that plan administrators provide claimants with the specific reasons for denial is undermined 'where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary.' These provisions 'afford the beneficiary an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial.' Requiring that plan administrators provide a participant with specific reasons for denial 'enable[s] the claimant to prepare adequately for any further administrative review, as well as appeal to the federal courts.' '[A] contrary rule would allow claimants, who are entitled to sue once a claim had been 'deemed denied,' to be 'sandbagged' by a rationale the plan administrator adduces only after the suit has commenced."

Even though one can argue that the 9th Circuit's discussion of the waiver issue in *Mitchell* is *dicta*, ERISA plan participants will rely on this decision to argue for application of the waiver doctrine where it could afford them benefits under an ERISA welfare benefit plan. Whether, and to what extent, this doctrine will apply in other contexts remains to be seen. However, it is a safe bet that the 9th Circuit is likely to expand its use of waiver in the future to grant benefits to ERISA plan participants.