



Social Security NEWS

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Message From the Chair

Hon. James D. Wascher

Thank you for your membership in the Social Security Law Section of the Federal Bar Association. The Board of Directors of the Section is committed to maximizing the value that you receive from your membership. Please contact me at james.wascher@ssa.gov, or any of the other Board members, if you have any suggestions for how we can serve you better.

This is a time of transition for the Section Board. Within the past few months, two of our past Chairs, Larry Auerbach and Rick Waitsman, have retired as Administrative Law Judges and resigned as Board members. Larry was my immediate predecessor as Section Chair, and offered me indispensable counsel as I made the transition from Section member to Board member to Board Chair within about a six-month period in 2012. The Board valued Rick's wise perspective, which was enriched by his encyclopedic knowledge of past Section positions and activities. We thank Larry and Rick for their leadership in the FBA and for their service to our country, and wish them well in retirement.

The remaining directors hope to fill Larry's and Rick's vacancies, and perhaps also to grow the Board in the near future. The Board meets by conference telephone call about three times a year, usually in the mid-afternoon on a weekday. Individual directors also take on special assignments for the Board, such as draft-



Hon. James D. Wascher

James D. Wascher is the Chair of the Social Security Law Section and an Administrative Law Judge serving in the Chicago Hearing Office of the Social Security Office of Disability Adjudication and Review. The views expressed in this message are solely his, and do not necessarily reflect the view of the Social Security Administration, the Federal Bar Association or the Social Security Law Section.

ing position papers, presenting webinars and editing our newsletter. If you are interested in becoming a Board member, please contact me at the email address above. I look forward to hearing from you.

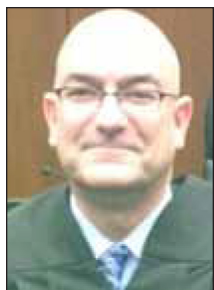
This is the third edition of *Social Security News* under the leadership of newsletter editor N. David Kornfeld. He is anxious to review and publish that article on Social Security disability law that you've always wanted to write. Please contact Nat at ndksocialsecuritylaw@gmail.com.

ALSO IN THIS ISSUE

| | |
|--|---|
| <i>Letter from the Editor</i> | 2 |
| <i>Federal Case Law Update</i> | 3 |
| <i>Developing the Record in Disability Cases: A Conundrum for Lawyers and Judges</i> | 4 |
| <i>Long Term Disability Claims: A Primer for Social Security Attorneys</i> | 6 |
| <i>Anecdotal Evidence of the Suicide Epidemic Among Social Security Disability Applicants (Reports from the Field)</i> | 9 |

Letter from the Editor

N. David Kornfeld



N. David
Kornfeld

For the past three decades N. David Kornfeld has practiced Social Security Disability Law in the Chicago area, representing both adults and children before the Social Security Administration as well as in Federal Court.

This issue as hoped for features Senior District Court Judge Robert Pratt's updated perspectives on Social Security cases generally. Judge Pratt writes of the goal that all participants in the adjudicative process should share, whether you are a lawyer or an administrative law judge. Judge Pratt cites the long ago, fundamental aspirational goal from the Eighth Circuit *Battles* case which states the common sense imperative, "that deserving claimants who apply for benefits receive justice." Judge Pratt writes that the system works best towards this goal when ALJs and lawyers work together to fully and fairly develop the record. We are truly honored to be able to share Judge Pratt's perspectives and thoughts and we will always be open to further articles from him should he ever wish to grace our newsletter again in the future.

We are also honored to feature an article written by attorneys Martina Sherman and William Reynolds, a primer on Long Term Disability (LTD) issues as they relate to Social Security generally. Attorneys Sherman and Reynolds are associates at the nationally respected LTD firm led by Federal Bar Association member Marc DeBofsky with main offices in Chicago, Illinois. This interesting and informative article is a must read. Also, special thanks again to board member Casey Saunders for his federal court update.

Given the fact that this is the third issue which I have edited, I am in the privileged position to revisit some of the matters that I have written about previously. In that vein, a year ago in the Spring 2014 issue I wrote about the controversial dispute regarding the cost of living adjustment to the hourly rate cap under the Equal Access to Justice Act (EAJA), and I suggested that further clarification from the Seventh Circuit would be on the horizon given the disparate district court interpretations of the requirements for establishing the adjustment following the Court's prior ruling in the *Mathews-Sheets* case. Indeed, clarification has come in the case of *Sprinkle v. Colvin*, No. 13-3654 (7th Cir. Jan. 23, 2015). In order to prove that a cost of living adjustment is justified,

the Seventh Circuit stated in *Sprinkle* that, "an EAJA claimant may rely on a general and readily available measure of inflation such as the Consumer Price Index, as well as proof that the requested rate does not exceed the prevailing market rate in the community for similar services by lawyers of comparable skill and experience." The Court clarified that a plaintiff is not required to prove the effect of inflation on their individual attorney's costs. Instead, the Consumer Price Index (CPI) now "suffices as proof of an increase in the cost of living," and the court "should generally award the inflation-adjusted rate according to the CPI, using the date on which the legal services were performed." The Court reiterated however that under the EAJA there is no "automatic entitlement to fee enhancements" and that "satisfactory evidence that the rate they request is in line with those prevailing in the community for similar services by lawyers of comparable skill and experience." The evidence required could simply be affidavits from other attorneys, and the Court indicated that a district court in its discretion could find "a single sworn statement from a claimant's attorney, setting forth the prevailing market rate, to be sufficient ..." The Court vacated the judgment of the district court which limited the Plaintiff's attorney to \$125 per hour and remanded the case back to the district court judge for further proceedings consistent with the opinion. The end result of *Sprinkle* is that reasonable cost of living adjustments under the EAJA should generally be something that the government should not contest, nor should it be something that courts should deny. The *Sprinkle* case was handled by respected Federal Bar Association, Social Security Section Member, Attorney Barry Schultz. Congratulations to my good friend Barry for fighting the good fight in the Seventh Circuit once again, something which he has done so often and so well over many, many years.

In the Winter 2015 issue, I wrote about what I perceived to be the neglected suicide epidemic among Social Security Disability ap-

LETTER CONTINUED ON PAGE 19

Federal Case Law Update

Casey L. Saunders

The Ninth Circuit finds that a limitation to simple, routine tasks is inconsistent with the requirements of Level 3 Reasoning. *Zavalin v. Colvin*, 778 F.3d 842 (9th Cir. 2015).

Preliminary Statement

In *Zavalin*, the Ninth Circuit Court of Appeals spoke for the first time on whether an apparent conflict exists between the residual functional capacity (RFC) to perform simple, repetitive tasks, and the demand of Level 3 Reasoning. After looking at decisions from other courts and the definitions of Level 2 and Level 3 Reasoning from the *Dictionary of Occupational Titles* (DOT), the *Zavalin* court answered an apparent conflict does exist, which an administrative law judge must reconcile under Social Security Ruling 00-4p, 2000 WL 1898707 (Dec. 4, 2000).

The *Zavalin* decision is a “must read” decision for anyone who is unfamiliar with potential conflicts between a claimant limited to simple, repetitive tasks, and a particular job’s reasoning level. Judge Jacqueline H. Nguyen’s decision provides an excellent description of the issue, carefully explaining the reasoning for the court’s determination. Further, Judge Nguyen’s decision informs the reader which circuits found a conflict exists and which have not.

The Legal Framework for Step Five

The Court begins by discussing the legal framework for step five, which hold the Commissioner has the burden of identifying “jobs existing in substantial numbers in the national economy” the claimant could perform despite his or her limitations. *Zavalin*, 778 F.3d at 845 (internal quotation marks omitted) (quoting *Johnson v. Shalala*, 60 F.3d 1428, 1432 (9th Cir. 1995) (citing 20 C.F.R. § 416.920(g)); see also 20 C.F.R. § 404.1520(g). Meeting this burden requires the ALJ to first assess the claimant’s RFC—the most the claimant can do despite his or her limitations. *Id.* (citing 20 C.F.R. § 416.945(a)(1)); see also 20 C.F.R. § 404.1545(a)(1). Next, the ALJ determines whether occupations exist that the claimant could perform. *Id.* (citing 20 C.F.R. § 416.966); see also 20 C.F.R. § 404.1566. To meet this burden, the ALJ may rely on the information found in the DOT. *Id.* at 845–46 (internal quotation omitted) (quoting *Terry v. Sullivan*, 903

F.3d 1273, 1276 (9th Cir. 1990) (citing 20 C.F.R. §§ 416.969, 416.966(d)(1)); see also 20 C.F.R. §§ 404.1569, 404.1566(d)(1). The ALJ may also rely on testimony from a vocational expert (VE) about specific jobs the claimant could perform despite his or her limitations. *Id.* at 846 (citing *Valentine v. Comm’r of Soc. Sec. Admin.*, 574 F.3d 685, 689 (9th Cir. 2009); 20 C.F.R. § 416.966(e)); see also 20 C.F.R. § 404.1566(e). The purpose of step five is determining whether the ALJ can find jobs in the national economy available to the claimant despite his or her RFC, age, education, and work experience. *Id.* (citation omitted).

Conflict Between the VE’s Testimony and the Information From the DOT

An ALJ must reconcile any apparent conflict between the VE’s testimony and the information found in the DOT by asking the VE to offer a reasonable explanation for the conflict. *Zavalin*, 778 F.3d at 846 (citing *Massachi v. Astrue*, 486 F.3d 1149, 1153–54 (9th Cir. 2007); Social Security Ruling 00-4p, 2000 WL 1898704, at *2 (Dec. 2, 2000)). If the ALJ relies on the VE’s testimony without resolving an apparent conflict, the reviewing court is precluded from determining if substantial evidence supports the ALJ’s decision. *Id.* (citing *Massachi*, 486 F.3d at 1154).

DOT and a Job’s Reasoning Level

Each job description in the DOT includes the job’s General Educational Development (GED) level requirement; i.e., “aspects of education (formal and informal) ... required of the worker for satisfactory job performance.” *Zavalin*, 778 F.3d at 846 (internal quotation marks omitted) (quoting DOT, App. C, 1991 WL 688702 (4th ed. 1991)). Within in GED level is the reasoning ability required for performing the jobs, ranging from Level 1 (lowest or least demanding) to Level 6 (highest or most demanding). *Id.*

The court in *Zavalin* focused on only Levels 2 and 3 Reasoning, noted as:

Level 2:

Apply commonsense understanding to carry out detailed but uninvolved written or oral instructions. Deal with problems involving a few concrete

Casey L. Saunders

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FEDERAL CONTINUED ON PAGE 12

Developing the Record in Disability Cases: A Conundrum for Lawyers and Judges

Hon. Robert W. Pratt

*Hon. Robert W.
Pratt*

*The Honorable Robert
W. Pratt currently
serves as a Senior
District Court Judge
in the United States
District Court for the
Southern District of
Iowa having previously
served as Chief Judge
from 2006-2012.*

In the Winter issue of this newsletter, a copy of a speech I gave in 2009 was reprinted in which I contrasted the typical adversarial party-presentation system seen in most courtrooms with the inquisitorial method employed in Social Security administrative hearings. As readers of this newsletter know, the inquisitorial nature of the hearings presents a unique set of challenges for both the administrative law judges (ALJs) presiding over the hearings and the claimants and their representatives. In an effort to ensure the Social Security Administration (SSA) can make more accurate disability determinations, the agency recently enacted a change in the rules regarding what information claimants must provide to the ALJ before the hearing. The new rule will become effective on April 15, 2015; below I briefly explore the changes that were made, and discuss the ethical responsibilities lawyers have to both their clients and the agency.

It is well established that while claimants have the burden to prove they are entitled to benefits, the ALJ has the duty to “fully and fairly develop the facts.” *Sellars v. Sec’y, Dep’t of Health, Educ. & Welfare*, 458 F.2d 984, 986 (8th Cir. 1972). The ALJ must investigate the facts and develop the record both for and against granting benefits. *Richardson v. Perales*, 402 U.S. 389, 400–01 (1971). The duty of an ALJ is especially important in cases where the claimant is not represented or has an impairment that limits the claimant’s ability to present evidence. See *Higbee v. Sullivan*, 975 F.2d 558 (9th Cir. 1992). But the ALJ’s duty is not absolute—the ALJ is not required to act as an advocate for the claimant. It is incumbent upon the claimants and their representatives to provide enough information to the ALJ so that the record may be fully and fairly developed. This was illustrated in *Maes v. Astrue*, 522 F.3d 1093, 1097 (10th Cir. 2008), where the Tenth Circuit stated that the ALJ’s duty to develop the record “does not permit a claimant, through counsel, to rest on the record—indeed to exhort the ALJ that the case is ready for decision—and later fault the ALJ for not performing a more exhaustive investigation.”

The extent of claimants’ duty to provide evidence both favorable and unfavorable to their claims has been the topic of much debate among lawyers. Under most state ethics requirements, a lawyer is required to zealously advocate for the client, which would typically prevent a lawyer from readily turning over evidence viewed as adverse to the client’s interests. Some lawyers have asserted that these ethical obligations conflict with the SSA’s current requirement that claimants provide all evidence to the ALJ that is “material” to a disability determination. See 10 CFR § 404.936; see also 42 U.S.C. § 1320a-8 (imposing a civil monetary penalty for making a false statement of material fact or knowingly omitting a material fact in connection with a social security proceeding). The recent SSA rule change abandons the term “material” and instead requires claimants to produce all evidence that “relates” to their claim—even if it may be unfavorable. The SSA received several comments regarding the new rule from lawyers concerned that “the requirement for attorney representatives to assist claimants in submitting related but unfavorable evidence would violate their state bar ethics rules requiring the preservation of client confidentiality and zealous representation.” Submission of Evidence in Disability Claims, 80 Fed. Reg. 14828-01 at *14832 (Mar. 20, 2015) (to be codified at 20 CFR pts. 404, 405, 416). Attorneys also expressed concern that the new rule would require them to submit attorney work product in violation of state rules, or might place them in a situation where claimants direct them not to disclose unfavorable evidence but the lawyer is required to do so under the new rule. *Id.* The SSA found these concerns unpersuasive for four reasons. First, the new rule excludes from the definition of “evidence” any oral or written communication that would be subject to attorney-client privilege or the attorney work product doctrine. *Id.* Second, the American Bar Association’s Model Rules of Professional Conduct allow lawyers to disclose information that might otherwise vio-

DISABILITY CONTINUED ON PAGE 16



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Long Term Disability Claims: A Primer for Social Security Attorneys

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How often, in the course of your Social Security practice, has a client approached you with a question regarding long-term disability (LTD) benefits? With 32.1 million Americans, or approximately 22 percent of the U.S. workforce, receiving employer-sponsored disability insurance, and many more purchasing individual disability policies, the subject is bound to come up.¹

Unfortunately, for many attorneys, the mere mention of the word “ERISA” is enough to make them wince with pain. The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*, which governs nearly all employer-sponsored benefits, including disability benefits, is so famously complicated that one court has described it as “Everything Ridiculous Imagined Since Adam.”²

This article seeks to dispel some of the misapprehensions about the ERISA statute. It will endeavor to show that, at least as far as disability benefits are concerned, there are more similarities between the Social Security Act and the ERISA statute than initially meet the eye – as well as some important differences. It is our hope that after reading this article, you will be able to answer questions about long-term disability benefits with aplomb.

ERISA: A Brief Overview

ERISA was originally enacted in 1974 to protect pension plan participants and beneficiaries following the catastrophic collapse of the Studebaker pension plan in 1963.³ The statute requires employers to hold pension benefits in trust and imposes upon them fiduciary duties to invest prudently and to administer plans solely in the interest of plan participants and beneficiaries.

During the drafting process, Congress expanded ERISA to apply not only to pension benefits but also to welfare benefits, even though the latter need not be held in trust and are exempt from the statute’s vesting provisions.

ERISA applies to all employer-sponsored benefit plans except government and church plans, although church plans can opt into ERISA’s protections. Many short-term disability plans, also known as “salary continuation programs” or “pay-roll practices” also fall outside ERISA’s purview.

ERISA preempts all state laws that “relate to any employee benefit plan,” except for criminal laws and laws which regulate insurance, banking, and securities. 29 U.S.C. § 1144. Employers can avoid being subject to state insurance law by “self-funding” their plans through a trust or through their general assets.

ERISA’s Requirement of a “Full and Fair Review”

The ERISA statute provides, at 29 U.S.C. § 1133, that claimants are entitled to written notice that a claim for benefits has been denied and an opportunity for a “full and fair review” by the fiduciary denying the claim. Courts have interpreted that provision to give rise to a “duty to exhaust administrative remedies” prior to filing suit, even though nowhere in the text of the ERISA statute does it say appeals are mandatory.⁴

The U.S. Department of Labor has promulgated regulations interpreting what constitutes a “full and fair review.”⁵ Among other things, claimants have the right to request, free of charge, reasonable access to copies of all documents, records, and other information “relevant” to their claim for benefits. The ERISA statute also requires plan administrators to comply with a request for plan documents within 30 days or face a statutory penalty of up to \$110 per day for non-compliance.⁶

Plan administrators must provide claimants with “at least” 180 days to submit an appeal.⁷ Claimants who submit a late appeal run the risk of having their appeal denied and having their lawsuit dismissed for failure to exhaust, although plan administrators may, in their discretion, accept a late appeal if the claimant provides an explanation.⁸ Upon receipt of an appeal, the plan administrator must issue a decision within 45 days, but it can request a one-time extension of up to 45 days, for a total of 90 days. A plan administrator’s failure to comply with these timelines generally enables a claimant to proceed directly to court.

ERISA and the Social Security Act

The relationship between benefit eligibility under an ERISA LTD disability insurance plan and disability under the Social Security Act has charted a wavering course through the courts.

Although the standards of disability are often virtually identical, for many years the deference owed to an award of SSDI or SSI varied from circuit to circuit.⁹ Then, in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), the Supreme Court brought a halt to a growing trend in long term disability cases for granting automatic deference to the opinion of the treating doctor so long as her opinion is supported by and not inconsistent with the other evidence. Due to *Nord*, because an insurer is not required to give deference to the opinion of a treating physician over its own file-review opinion, a finding of disability by the SSA may not be given great weight by the court if the insurer produces a well-documented and reasoned file-review opinion.

However, upon a review of the relationship between SSA benefits and LTD eligibility by the Supreme Court five years later in *Metropolitan Life Insurance Co. v. Glenn*, 554 U.S. 105, 115 (2008), it became clear that disability determinations made by the SSA are relevant to disability determinations made under ERISA plans, and that a claim administrator's failure to substantively consider the determination in making its own benefit decisions "suggests arbitrary decision-making."¹⁰ The Court went even further to state that it is "procedurally unreasonable" to ignore an SSA finding without adequate reasons when the insurer (as it often does) provides SSA representation and reaps the financial reward of the benefit award.

Following *Glenn*, nearly all of the circuit courts have incorporated and expanded upon this requirement. The court in *Raybourne v. CIGNA*, 700 F.3d 1076 (7th Cir. 2012) echoed the Glenn finding and made it clear that insurers need to directly address the Social Security determination and has the burden of explaining why it reached a different decision. *Melech v. Life Ins. Co. of N. Am.*, 739 F.3d 663 (11th Cir. 2014) recently held that a disability insurer must obtain and consider Social Security evidence even if

the claimant did not provide it.

Failing to adequately consider an award of Social Security disability benefits under the Glenn model has specifically landed two insurers in trouble. Following investigations by state insurance commissioners, both Unum and CIGNA have entered into Regulatory Settlement Agreements, binding themselves to more robust consideration of the findings of the Social Security Administration.¹¹ The RSA concessions were reached after the state insurance commissioners determined that the insurers routinely ignored favorable rulings under the SSA guidelines, even after providing representation to apply for benefits.

Nonetheless, there are three main differences between making disability determinations under the SSA guidelines and ERISA plan guidelines that have permitted insurers to deny or terminate benefits in the face of an SSA award. The first difference still remains from the *Nord* decision discussed above – because there is no Treating Physician Rule, a disability insurer can often successfully refute an SSA finding by supplying a sufficiently supported file-review opinion. The second difference involves determinations made within the Medical-Vocational ("Grid") framework – a concept which generally does not exist in LTD benefit plans. And the third difference regards an LTD policy's limitations on the length of payable benefits for certain specific illnesses.

Once a claimant reaches age 50, the SSA will routinely use the Grid guidelines to find that individual disabled, even if it is clear that the individual would be disabled without the aid of the framework. Although many LTD benefit plans have income thresholds within their Any Occupation standard of disability, the plans do not utilize a rigid grid-type system related to the age and experience of a participant. Thus, (with some notable exceptions) courts have given insurers much more leeway in disregarding an SSA award when that award utilized the Grid framework, due to the fact

FREQUENTLY ASKED QUESTIONS

My client stopped working 5 years ago. Can he still apply for disability benefits?

Yes. Most disability plans have a "proof of loss" provision which requires that that written proof of claim be submitted within 30 to 90 days, but no later than one year. However, in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), the Supreme Court ruled that the notice-prejudice rule, which requires insurers to demonstrate they have been unfairly prejudiced by late notice of claim, is saved from ERISA preemption. Thus, participants in insured plans who reside in states that have adopted the notice-prejudice rule may prevail in a claim for long-term disability benefits, notwithstanding late notice of claim. Even claimants that don't satisfy the forgoing criteria should still submit a claim, since a plan administrator may always entertain late claims in its discretion, particularly if the claimant provides a good reason for the delay.

If an individual misses the 180-day appeal deadline, should she still appeal?

Yes. A plan administrator may, in its discretion, entertain a late appeal, particularly if the claimant provides a good reason for the delay. See *Edwards v. Briggs & Stratton Ret. Plan*, 639 F.3d 355, 363 (7th Cir. 2011) (dismissing suit where claimant submitted appeal 11 days late and failed to provide an explanation). A better strategy, however, if the claimant knows his or her appeal will be late, is to write to the plan administrator before the 180 days expires to request an extension.

If my client is terminated by her employer, will that affect her disability benefits?

Generally, no. So long as the claimant is

that the determination was made under a “different standard.”¹²

Lastly, many LTD plans specifically limit the length that benefits are payable for certain defined illnesses. Mental illness limitations, typically to 24 months of benefits, are the most common; however, some plans also have limitations for other “subjective symptom” illnesses such as chronic fatigue syndrome, fibromyalgia, and Sick Building Syndrome. Although the insurer bears the burden of proving the applicability of any benefit limitations, once that limitation is established, an award of SSA disability benefits based primarily upon a limited condition would obviously not carry much weight if the individual seeks to establish ongoing LTD eligibility due to a co-morbid physical condition.

Coordination with Other Benefits

After a claimant establishes eligibility for LTD insurance benefits, the benefit amount is usually calculated as a percentage of previously earned income, payable monthly, as defined by the policy’s terms. But most disability insurance benefit plans are written to coordinate with the insured’s other sources of income, allowing the benefit plan to reduce its monthly obligation (up to a defined minimum benefit) by subtracting the benefit amounts received from other sources. That process is commonly referred to as offset, and may involve a number of income sources.

The most common LTD policy offset is for Social Security benefits. That offset would include not only the insured’s own primary benefit, but any dependent benefit she also may become entitled to. If the policy were to extend benefit payments beyond the insured’s Normal Retirement Age, retirement benefits (including any early retirement benefits) would also become an offset. The significant financial benefit of an award of SSA benefits clearly explains why, as touched on above, an insurer will almost always pay for and require the insured to apply for SSDI benefits once LTD benefits become payable.

Along the same lines, distributions under a defined benefit or defined

contribution plan may also be considered offsetting income under an LTD policy. 401K payments are especially vulnerable here – although a distribution at retirement would not be offset, an individual may unwittingly offset his monthly LTD payment by taking an early 401K distribution. Early or accelerated payments under a defined benefit pension plan may also offset the monthly LTD benefit amount, and are often explicitly defined as an offset for plans issued to employers that maintain a pension scheme.

Finally, any other payments related to an injury that caused disability may likely be defined as an offset under the LTD policy. Both worker’s compensation benefits and third-party tort recoveries for lost wages are generally included as offsetting income, whether or not the award is disbursed monthly or in a lump sum. However, when a tort recovery extinguishes the worker’s compensation claim, at least one court has held that the offset would still stand even if the tort award is used to pay back the workers’ compensation carrier – a practice which the SSA explicitly rejected in POMS §DI 52001.090.¹³

ERISA Litigation

The ERISA statute affords very limited remedies. Participants and beneficiaries may bring suit to recover benefits due under the plan; for a declaratory judgment or an injunction; for plan-wide relief; and for “other appropriate equitable relief.”¹⁴ In addition, successful claimants may recover attorney’s fees, prejudgment interest, and costs.¹⁵

Importantly, ERISA does not provide for compensatory or punitive damages. However, courts will fashion an equitable remedy where the plan does not otherwise provide relief.¹⁶ State courts enjoy concurrent jurisdiction over suits for benefits; all other suits must be brought in federal court.

The ERISA statute is silent as to what standard of review applies to benefit claims; however, in *Firestone Tire & Rub-*

“actively employed” on the date the disability arises, the claimant is covered under the disability plan, regardless if his or her employment is subsequently terminated. However, some plans exclude coverage for employees that are terminated “for cause,” so claimants should always consult the plan documents.

My client’s short-term disability benefits were denied. Can he still apply for long-term disability benefits?

Generally, yes. Unless the disability plan specifically states that receipt of short-term disability benefits is a pre-requisite to applying for long-term disability benefits (most do not), the plan administrator should conduct an independent examination as to whether the claimant qualifies for long-term disability benefits. Although it may seem counterintuitive, claimants should apply for long-term disability benefits even if their short-term disability claim has been denied, since failure to do so could dramatically reduce the amount of benefits recovered in subsequent litigation.

My client’s claim was denied based on a pre-existing condition, even though she worked for her former employer for many years. How can that be?

When an employer switches long-term disability carriers, or when one company is acquired by another company, participants and beneficiaries in the new plan may find that their claims are subject to a pre-existing condition limitation, unless the new plan is carefully drafted. Employees in these circumstances should demand written assurance from their employer of their grandfathered status in advance of any changes to their policy.

CLAIMS CONTINUED ON PAGE 14

Anecdotal Evidence of the Suicide Epidemic Among Social Security Disability Applicants (Reports from the Field)

N. David Kornfeld

In the Winter 2015 issue, I delved into the question of suicide in Social Security disability cases. I requested anecdotal stories from both FBA members and from my colleagues generally, who may have dealt with similar experiences. As expected, the stories have been tragic and unfortunately quite large in number. In retelling and recounting the unvarnished stories of attempted and committed suicides, it is my hope to both trigger dialogue and research aimed to reduce the frequency of this epidemic. Below is a summary of some of the stories from Social Security Disability attorneys around the country. I will let the summaries speak for themselves. A common theme is that the delays in the process itself and the languishing of claims (which often are minimized and rejected) does play a significant role. As noted previously, feel free to email additional stories if you have yet to share and wish to do so, as this is a topic that I will continue to pursue.

An attorney practicing in California indicated in 2011 having had two SSA disability claimants who committed suicide with 1 attempted suicide. "The attempted suicide was a young man in his thirties, the brother of an attorney practicing in a different field of law. My client had been diagnosed with a non-malignant brain tumor, was losing his sight, had already lost a successful career as a therapist (mental health). We met one afternoon. I had a gut feeling my client was going to try to commit suicide. I called my friend, the client's brother, and told him of my gut feeling and concerns. His brother attempted suicide the next day with pills. His reasoning for attempting suicide was that the length of time it would take to go to hearing (2 years at that time or a possibly favorable decision within 6 months to 1 year) was too long to wait as he would have nothing. Thankfully, surgery and chemo was successful, he has regained limited sight and remains disabled. The next two suicides were clients who had similar situations. Both gentlemen had waited YEARS to file; had exhausted all assets to provide for their families; both told the presiding ALJs that if they were not awarded benefits,

they had no reason to live. One gentleman won his hearing, but left a note that he could no longer live with the label of disabled. The second gentleman lost his hearing (lack of medical records due to passage of time and did not qualify for SSI), received the Unfavorable Decision and shot himself in the chest that afternoon with no note."

An attorney in Minnesota had a client in his thirties commit suicide: "My client was a 36 year old former banker who had two failed back surgeries. On the function report he said he could no longer handle a checking or savings account. What I can gather from the medical records is that the scar tissue around his spine kept getting tighter and tighter until he could no longer take the pain. He lost the use of his right leg and was falling all the time. I was able to ascertain from the records that he had squirreled away two full prescriptions of Percocet. He told his docs that he lost the prescriptions or that they fell on the floor and were swept away. I really liked this young man, and we interacted on a consistent basis. His request for hearing remained pending at the time of his death. He was the age of my own kids and his death hit me hard."

An attorney in Illinois reports that their office has seen 4 deaths from suicide within the last 3 years in pending cases. The attorney further stated, "Suicide is a problem in our community for mostly young people. The young people are now using heroin and not surviving."

An attorney from the Ninth Circuit reported on one case: "At the first ALJ hearing, the ALJ rejects the examining psychologist who says the claimant is very fragile, high risk for suicide, can't tolerate stress of work. The ALJ rejects the opinion and relies on the state agency psychologist who says he can do simple work. After the denial, the claimant took ALJ's advice and tried to work. He made mistakes at simple work within first two months, became very despondent, took a gun and shot himself in the chest. He tried to

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shoot his heart (but barely missed), because he says that's where he hurt. Without knowing about this suicide attempt FDC remands saying ALJ improperly rejected examining psychologist."

From an attorney in Alabama: "I had a client a few years back, who got his initial denial and tried to commit suicide. He came in for his appeal in the dead heat of the summer with a coat on. I asked him why he was wearing a coat when it was 100 degrees outside and he showed me his staples. Stapled from wrist to elbow. He got the initial denial and immediately butchered himself. He, luckily, was saved and I got an on the record (OTR) favorable shortly thereafter."

An attorney in Pennsylvania described a conference breakout session for Social Security representatives: "I asked for a show of hands of how many of us had at least one client suicide, while waiting for benefits. I thought I would get 50 percent. Every single person raised their hand! The only case I had was from a number of years ago. The lady killed herself with a sleeping pill after the administrative denial while we were waiting for the answer to the federal court complaint to be filed. No indication that she was that bad and I was shocked. (Her primary problems, from the record, were physical pain, not mental health.)"

From another attorney in Pennsylvania: "I have a client that I remember particularly well. He was a very sick man. Over 50 and obviously would grid out in my opinion. He struggled financially throughout the pendency of his claim. He was constantly in court regarding child support arrears. I can't tell you how many times I had to write to the court to explain that we were appealing his claim and to hold off on jailing him. Eventually, we got to hearing and we won the same day. He was very excited. He died shortly thereafter, prior to receiving the payment. We got conflicting stories from his ex wife as to how he died. We are not sure whether it was suicide or a heart attack. Truthfully, neither would surprise me. It took so long for him to get paid, every day was a struggle for him."

From an attorney in New York: "In a case involving a client with suicidal ideation, we got fully favorable decision March 2015. The treating psychologist was supportive on MSS form and the consulting psychiatrist said the client meets Listing 12.04. The medical expert gave testimony by phone and said he was unable to confirm that 12.04 was met because in his opinion claimant was exaggerating her symptoms. ALJ found that none of the other examining doctors thought she was exaggerating symptoms and they were in agreement regarding her significant mental restrictions, including suicidal ideation."

Another response from an attorney in South Carolina: A South Carolina attorney with 43 years of experience focused on the issue of deaths during cases generally, which he thinks

is a significant issue regardless of whether the death was related to suicide. The attorney wrote, "How many of the dismissals issued by ODAR are for dead claimants? And how many hearings have taken place for dead claimants? In SSI claims there frequently is no party who qualifies as a substitute payee. How many claims awarded end within 5 years because the claimant dies?"

An attorney in Texas shared a painful story about a young man committing suicide the night after a hearing: "I never really recovered from this one and I have been doing this for well over three decades. I represented a claimant whose twin brother killed himself at age 18. This was his only sibling. The claimant, surviving twin, went to college but loved his brother and never recovered and became addicted to heroin. He moved away from home, but his parents continued to support him. By age 28, he got clean by himself and when he came to me had been clean for 3 years. He was in psychiatric care, and compliant. His depression was described by his attending psychiatrist as 'one of the most overwhelming the physician ever saw.' The young man rarely left his home and preferred to take prescribed medications and sleep all day. When awake he could never overcome his brother's death. He was denied at initial and recon, despite compliance and AP reports that were comprehensive and described the claimant as disabled. His GAFs never were above 40, had no social life. He was also consistently suicidal. His parents came to town for the hearing. Unfortunately, the judge is infamous in this region for his bias against real and imagined drug abusers. Remember this claimant had been clean for years, labs showed this and the treating physician further explained this in repeated documents. The day of the hearing he was the happiest he had ever been. He was very gentle and shy. His parents appeared and testified. After they did so, the judge turned to the claimant and asked him how he felt, after manipulating his parents' money for heroin for many years. The claimant had minutes before describing suicidal ideation and began to cry and said he felt horrible, had let his parents down. The judge showed extreme disdain and even disbelief that the claimant was clean. That night the claimant stayed with his parents in the hotel they had rented. In the middle of the night, he came into parent's room, said he was afraid and sad, and asked to sleep at the foot of the bed. When they awoke, he was dead. He overdosed on prescribed medication. I wrote a post-hearing brief, acknowledged by the ALJ and the ODAR. The ALJ took 4 months to make the decision. He denied the case at step one, stating claimant had been engaging in substantial gainful activity (SGA). The claimant made \$3000 in one year and reported it. We mentioned this in the brief as an unsuccessful work attempt (UWA). The parents still call me on the anniversary of his death. I can say both remain heartbroken. They accepted this as god's will and would not allow an appeal. The claimant's psychiatrist was so shaken up, he actually

SUICIDE CONTINUED ON PAGE 19

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Id. at 847 (citing DOT, App. C, 1991 WL 688702).

Decisions From Other Courts

The Tenth Circuit Court of Appeals held the limitation to simple and routine work tasks was inconsistent with the demands of Level 3 Reasoning and such limitations were more consistent with Level 2 Reasoning. *Zavalin*, 788 F.3d at 846 (internal quotations omitted) (quoting *Hackett v. Barnhart*, 395 F.3d 1168, 1176 (10th Cir. 2005)). However, the Seventh Circuit Court of Appeal and the Eighth Circuit Court of Appeal reach the opposite conclusion. *Id.* (citing *Terry v. Astrue*, 580 F.3d 471, 478 (7th Cir. 2009); *Renfrow v. Astrue*, 496 F.3d 918, 921 (8th Cir. 2007)). The *Zavalin* court noted both the Seventh Circuit and the Eighth Circuit provided little analysis for reaching their conclusions. *Id.* The court also acknowledged the different conclusions from the district courts within their own circuit. *Id.* (citing *Adams v. Astrue*, 2011 WL 1833015, at *4 (N.D. Cal. May 13, 2011) (unpublished) (finding a conflict); *Wentz v. Astrue*, 2009 WL 3734101, at *13–5 (D.Or. Nov. 4, 2009) (unpublished) (finding no conflict)).

The Approach Adopted by the Ninth Circuit Court of Appeals

The *Zavalin* court quoted language from both the *Hackett* decision and the *Adams* decision. *Zavalin*, 788 F.3d at 847 (internal quotations omitted) (quoting *Hackett*, 395 F.3d at 1176; *Adams*, 2011 WL 1833015, at *4). The court further rejected the Commissioner's attempt to tie reasoning levels to the claimant's education level, noting that reasoning levels relate to the claimant's specific abilities and not educational background. *Id.*

A Seventh Circuit decision written by Judge Posner finding numerous errors and criticizing the ALJ's exclusive reliance on objective medical test results for weighing claimant's credibility. *Adaire v. Colvin*, 778 F.3d 685 (7th Cir. 2015).

Preliminary Statement

One sentence from the court's acerbic decision in *Adaire* clearly defines the court's sentiments towards the administrative law judge's determination: "The administrative law judge's opinion is riddled with errors." *Adaire*, 778 F.3d at 687. Judge Richard A. Posner wrote the decision, expressing his frustration over the logic administrative law judges consistently use when weighing a claimant's credibility, as well as medical source opinions. *Id.* at 687–88. According to Judge Posner, administrative law judges base their reasoning on the following syllogism: a claimant's statements should never be believed; disability determinations are based only on results from objective testing; therefore, all statements by the claimant that are unsubstantiated by objective

testing must be dismissed. *Id.* Judge Posner applied his criticism of this logic to both the weighing of the claimant's statements and weighing medical opinion evidence. *Id.*

The *Adaire* decision also confronts both a consultative examiner's statements and the inferences administrative law judges usually draw from those statements. *Id.* at 687–88. For example, the consultative examiner reported the claimant displayed normal functioning when observed leaving the office. *Id.* at 687. From this statement, the administrative deduced that the claimant is acting—only shows the alleged extreme limitations while being observed. *Id.* Judge Posner brushes the consultative examiner's statement aside because it is unrealistic to assume the doctor or staff member actually followed the claimant to the parking lot to make this observation. *Id.* at 687–88. This example illustrates the importance of thinking critically about a source's actual statements.

Brief Summary of the Facts of the Case

The claimant in *Adaire* suffered from both mental and physical impairments. SSA previously found the claimant disabled, but they later reversed their determination because the claimant was employed. Three years later, the claimant's employer fired him for failing to meet the demands of his job. The claimant re-applied for benefits two years after his termination. The administrative law judge (ALJ) determined the claimant was capable of performing light unskilled work.

Symptoms of pain that are uncorroborated by objective evidence

A significant frustration for the court was the ALJ's dismissal of any pain testimony not tied to an objective injury or illness. *Adaire*, 778 F.3d at 687. The court noted this is a "recurrent error," and not specific to this case. *Id.* (citing *Pierce v. Colvin*, 739 F.3d 1046, 1049–50 (7th Cir. 2014); *Myles v. Astrue*, 582 F.3d 672, 676–77 (7th Cir. 2009); *Johnson v. Barnhart*, 449 F.3d 804, 806 (7th Cir. 2006); *Carradine v. Barnhart*, 360 F.3d 751, 753 (7th Cir. 2004)). Moreover, SSA's own rules prohibit ALJs from disregarding a claimant's statements about pain simply for the lack of substantiation by objective medical evidence. *Id.* (citing Social Security Ruling 96–7p, 1996 WL 374186, at *4 (July 2, 1996)). More puzzling to the court was that the ALJ rejected the claimant's statements despite the fact the record contained considerable objective evidence of pain. *Id.*

Inferences Drawn from a Consultative Examiner's Report Must be Reasonable

Next, the court attacked several deductions the ALJ made from a consultative examiner's report. *Id.* at 687–88. First, the consultative examiner reported that the claimant displayed "near normal" functioning when leaving the doctor's office. *Id.* at 687. From this, the ALJ concluded the claimant did not display any extreme limitations when he was unaware of being observed. *Id.* The court took exception to this statement, noting it requires one to assume the doctor or member of his staff had

followed the claimant for a supplemental examination—something the court found highly improbable. *Id.* at 687–88. Further, the consultative examiner’s report did not state the claimant was unaware the medical staff was observing him. *Id.* at 687. Similarly, the ALJ’s reliance on the consultative examiner’s observation that the claimant moved around “with ease” and a “normal gait” showed the court only that he did not limp. *Id.* at 688. The ALJ did not explain why the truthfulness of the claimant would suggest that he limped. *Id.* The consultative examiner’s statement that the claimant might be “having an exaggerated pain response” indicated to the ALJ that the consultative examiner accused the claimant of malingering. *Id.* The court understood the consultative examiner’s statement differently, labeling the phrase as “medical jargon” that meant a patient experienced more pain than would be expected. *Id.* Given the nature of the claimant’s impairments, the consultative examiner’s statement about exaggerated pain response failed to demonstrate anything out of the ordinary. *Id.*

Principles for Weighing Credibility Also Apply When Weighing Medical Opinions

The court returned to its criticism of ALJ’s exclusive reliance on objective medical test results for weighing credibility. Here, the ALJ dismissed the testimony from a psychologist and a therapist, both of whom stated that the claimant experienced panic attacks, though neither had witnessed any of these attacks. *Id.* The court determined the ALJ had no reason to disbelieve the psychologist and therapist’s testimony. *Id.* The only reason the ALJ rejected this testimony comes from her philosophy that nothing a claimant says should be believed because disability determinations are exclusively believed on objective medical test results. *Id.* Again, the court held that the ALJ’s philosophy conflicts with SSA’s rules. *Id.*; see Social Security Ruling 96-7p, 1996 WL 374186, at *4 (July 2, 1996).

The ALJ rejected another examining physician’s opinions because she claimed they were based entirely on the claimant’s subjective statements and the physician was “apparently sympathetic” to the claimant. *Id.* The court held the ALJ’s first statement repeats the “fundamental error” that a claimant’s statement warrant “zero weight.” *Id.* For the second statement, the ALJ failed to explain why she considered the physician was “apparently sympathetic,” and, if so, why she thought the physician provided false evidence. *Id.*

Inaccurate Statements on Claimant’s Credibility

For the final point, the court directed its criticism towards two statements the ALJ made about the claimant’s credibility. *Id.* First, the ALJ claimed that if the claimant’s statements were true, he “would be seeking treatment for his extreme symptoms.” *Id.* The ALJ’s claim lacked support from the record, which showed the claimant sought and received almost continuous treatment. *Id.* For the second, the ALJ claimed if the claimant’s statements were true, he would be unable to “take care of his children.” *Id.* The court pointed to the claimant’s testimony, which was without contradiction, that he could only provide “limited, occasion-

al care of his children.” It is the claimant’s father, with whom he lives, who provided most of the child care when the claimant’s girlfriend goes to work. *Id.* REVERSED AND REMANDED

Another Seventh Circuit decision written by Judge Posner finding that the ALJ’s decision was unsupported by substantial evidence in connection with the assessment of the claimant’s pain – relationship between VA disability and SSA disability discussed. *Hall v. Colvin*, 778 F.3d 688 (7th Cir. 2015).

Preliminary Comments

The decision in *Hall* was written by Judge Richard A. Posner on February 20, 2015, two days after his decision in *Adaire v. Colvin*, 778 F.3d 685 (7th Cir. 2015). Common to both decisions is Judge Posner’s instruction to the administrative law judges that they cannot dismiss a claimant’s complaints of pain exclusively because they are unsubstantiated by objective medical test results. *Hall*, 778 F.3d at 691 (citing Social Security Ruling 96-7p, 1996 WL 374186, at *4 (July 2, 1996)); *Adaire*, 778 F.3d at 687 (same). However, the tone of Judge Posner’s writing is noticeably different between these two decisions. *Id.* In *Adaire*, Judge Posner expressed frustration over administrative law judges repeating the same error despite the court’s instructions to do otherwise. *Adaire*, 778 F.3d at 687 (citations omitted). Contrarily, Judge Posner presented a milder critique of this same error. *Hall*, 778 F.3d at 691.

The real importance of *Hall* is the court’s comparison between a Veterans Administration disability determination and a Social Security disability determination. *Hall*, 778 F.3d at 691 (citations omitted). While there are differences between the two agencies methods, the court considers them small. *Id.* The court looks to the language each agency uses when finding a claimant disabled, and illustrates how the language from one corresponds with the language from the other. *Id.* Both administrative law judges and claimant’s representatives could benefit from this decision when handling claimant, previously rated by the Veterans Administration.

Brief Summary of the Facts of the Case

The claimant in *Hall* suffered an ankle injury while serving in the military, and was discharged because of the resulting pain. *Hall*, 778 F.3d at 689. The Veterans Administration (VA) rating the claimant as 70 percent disabled, “unemployable” in “a substantially gainful occupations,” and totally disabled. *Id.* (citing 38 C.F.R. § 4.16). Over the following nine years, the pain from the claimant’s ankle injury, combined with other impairments, worsened, which left him disabled by SSA’s standards. *Id.* at 689–90.

The claimant filed his application and later testified during an administrative hearing. *Id.* According to his testimony, the claimant reported that he was incapacitated for six days every month. *Id.* Further, the pain medications and muscle relaxers made him feel “drowsy” and “foggy.” *Id.*

The vocational expert testified if one of the claimant’s doctors limited him to sitting for no more than 15 minutes continuously and standing for no more than 10 and the claimant’s tes-

timony was credible, then Hall was disabled; if not, the claimant could perform other work. *Id.*

In her decision, the administrative law judge (ALJ) emphasized the “significant” amount of time the claimant cared for his children, which was only 12 days and needing his father’s help for six of them. *Id.* The ALJ doubted the claimant’s medications caused drowsiness, and blamed him for not seeking physical therapy sooner, insinuating he was responsible for his problems. *Id.* A VA doctor offered opinions supporting the claimant’s testimony; however, the ALJ determined they were of little value. *Id.* The doctor had only seen the claimant three times, which raised suspicions with the ALJ. *Id.* She was unimpressed by the claimant’s explanation about how difficult it is to get an appointment with a VA doctor. *Id.* (citing Richard A. Oppel Jr. and Abby Goodnough, *Doctor Shortage Is Cited in Delays at V.A. Hospitals*, N.Y. Times, May 29, 2014, available at www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html).

The ALJ’s primary reason for finding the claimant not disabled is the lack of support for the claimant’s pain from x-ray studies. *Id.* The court did not accept the ALJ’s complete reliance on the x-ray studies because an MRI is better than an x-ray for analyzing soft-tissue injuries. *Id.* (citing National Library of Medicine, Medline Plus, *Lumbosacral Spine X-Ray*, www.nlm.nih.gov/medlineplus/ency/article/003807.html). While the claimant underwent two previously MRI studies, both studies were performed well before his onset date. *Id.* There was a third MRI performed, which showed degeneration in the thoracic spine and some spinal stenosis. *Id.* at 690–91. However, this MRI was too late for consideration by the ALJ. *Id.* at 691.

Comparing the Veterans Administration’s disability standards with the Social Security Administration’s disability standards

Because the standards for determining disability differ between the VA and SSA, the VA’s determination that the claimant was disabled had only a marginal influence for the ALJ. *Id.* The court agreed that there were differences between the two agencies, but they considered the differences as small. *Id.* (citing *McCartey v. Massanari*, 298 F.3d 1072, 1076 (9th Cir. 2002)). The VA

considers pain alone can support a finding of disability, but for the SSA, pain is only a symptom of disability. *Id.* (citing 20 C.F.R. § 404.1529; 38 C.F.R. §§ 4.40, 4.45, 4.59). Additionally, the SSA finds a claimant is or is not disabled, without any varying degrees between the two. *Id.* In comparison, the VA bases compensation by the degree to which the claimant is disabled, which in the present case was 70 percent disabled, but the VA also declared the claimant unemployable because of his disability. *Id.* (citing 38 C.F.R. § 4.16). The court held the VA’s conclusion—claimant unemployable due to his disabilities—corresponds with SSA’s definition of disability—claimant is disabled if his medical conditions preclude substantial gainful employment. *Id.* (citing 42 U.S.C. § 423(c)(1)(A)).

Symptoms of pain that are uncorroborated by objective evidence

The court viewed the ALJ’s “most serious error” was her opinion that complaints of pain can only be credible when confirmed by objective tests. *Id.* Even assuming the ALJ’s opinion was correct; she should have ordered an MRI before issuing her decision because of the limitations x-rays have with establishing the existence of pain. *Id.* The court understood that without objective confirmation, ALJs must perform the obscure task of determining whether the claimant is telling the truth, when the claimant has a reason to exaggerate. *Id.* Regardless, SSA set a clear policy that forbids ALJs from denying benefits simply because no objective evidence verifies the claimant or another witness’s report of pain. *Id.* (quoting Social Security Ruling 96-7p, 1996 WL 374186, at *4 (July 2, 1996)) (citing *Pierce v. Colvin*, 739 F.3d 1046, 1049–50 (7th Cir. 2014; *Carradine v. Barnhart*, 360 F.3d 751, 753 (7th Cir. 2004)). In this case, several of the claimant’s doctors remarked that the claimant experienced pain while examined, which the court held as corroboration of the claimant’s testimony. *Id.* If the ALJ had doubts, she could have ordered an MRI; however, her failure to do so left her determination unsupported by substantial evidence. *Id.* REVERSED AND REMANDED

CLAIMS CONTINUED FROM PAGE 8

ber Co. v. Bruch, 489 U.S. 101, 115 (1989), the Supreme Court ruled that a denial of benefits is reviewed under the *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,” in which case the denial of benefits is reviewed only for abuse of discretion. Immediately following *Firestone*, nearly every plan administrator amended its plan to include language conferring discretion upon plan administrators to interpret the terms of the plan and to make benefit determinations. Plaintiff’s attorneys have challenged the validity of these “discretionary clauses” with varying success. Additionally, under the leadership of the National Association of Insurance Commissioners, at least 20

states have adopted some form of ban on discretionary language in disability insurance policies, although those laws are ineffective against self-funded plans.

A consequence of deferential review is that discovery in ERISA benefit denial cases tends to be extremely limited. Generally speaking, ERISA litigation conducted under the abuse of discretion standard of review is conducted based on the “administrative record” developed prior to litigation, much like in Social Security proceedings.¹⁷ That has changed somewhat since *Metro. Life Ins. Co. v. Glenn*, *supra.*, in which the Supreme Court arguably opened the door to discovery pertaining to the plan administrator’s conflict of interest as both the evaluator and payor of claims, although this remains

a hotly debated subject within the courts.¹⁸

Fortunately, in *Hardt v. Reliance Std. Life Ins. Co.*, 560 U.S. 242, 245 (2010), the Supreme Court clarified that a court may, “in its discretion,” award fees and costs “to either party” as long as the fee claimant has achieved “some degree of success on the merits,” which in *Hardt* included a remand to the plan administrator for further consideration of the plaintiff’s entitlement to benefits.

Finally, the ERISA statute does not set forth a statute of limitations for benefit claims brought under 29 U.S.C. § 1132(a) (1)(B). Instead, courts imply the statute of limitations from the most analogous state statute (usually breach of contract), unless the plan contains a contractual limitations period. But in the recently decided *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013), the Supreme Court resolved a circuit split regarding whether the statute of limitations for benefit claims is tolled during the appeals process, ruling that an ERISA plan’s contractual limitations period can be enforced, so long as the claimant has a “reasonable” time after exhausting his or her administrative remedies to file suit. This decision has generated a great deal of uncertainty as to how to calculate the statute of limitations, particularly in cases where benefits are terminated after being paid for a number of years.

Conclusion

Appeals and litigation under the ERISA statute bear many similarities to Social Security practice, although the administrative law paradigm has questionable applicability to ERISA proceedings. Nevertheless, many of the concepts discussed in this article should already be familiar to Social Security practitioners. We hope this article will prove useful to you in your Social Security practice, and maybe even inspire you to handle an ERISA case yourself.

Endnotes

¹www.pressherald.com/2014/07/17/employers-dropping-long-term-disability-coverage/.

²*Florence Nightingale Nursing Service Inc. v. Blue Cross and Blue Shield*, 832 F. Supp. 1456, 1457 (N.D. Al. 1993), *aff’d*, 41 F.3d 1476 (11th Cir. 1995).

³In an attempt to compete for talent with the Big Three automakers in the midst of its financial collapse, Studebaker repeatedly promised increased future pension benefits to its employees without any hope of ever funding the future obligations. Upon its closure in December 1963, the company terminated the pension plan, costing its employees approximately \$15 million dollars in promised benefits. The Studebaker failure moved Congress to enact the Employee Retirement Income Security Act in 1974. *See* James A. Wooten, “The Most Glorious Story of Failure in the Business”: The Studebaker-Packard Corporation and the Origins of ERISA, 49 Buff. L. Rev. 683 (2001).

⁴*E.g., Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 650 (7th Cir. 1996) (affirming that the district court, in its discretion,

may require exhaustion as a prerequisite to filing a federal lawsuit).

⁵29 C.F.R. § 2560.503-1.

⁶29 U.S.C. §§ 1024(b), 1132(c).

⁷29 C.F.R. § 2560.503-1(h) (3).

⁸*E.g., Edwards v. Briggs & Stratton Ret. Plan*, 639 F.3d 355, 363 (7th Cir. 2011) (dismissing suit where claimant submitted appeal 11 days late and failed to provide an explanation).

⁹*Compare Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1286 (9th Cir.1990), *cert. denied*, 498 U.S. 1087, 111 S.Ct. 964, 112 L.Ed.2d 1051 (1991); *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793 (8th Cir.2002) *with Ladd v. ITT Corp.*, 148 F.3d 753 (7th Cir. 1998); *Calvert v. Firststar Finance Inc.*, 409 F.3d 286 (6th Cir. 2005).

¹⁰*Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.3d 758, 776-777 (7th Cir. 2010).

¹¹www1.maine.gov/pfr/insurance/Admin_Enforcement_Actions/RSA_2013/CIGNA_RSA.pdf; maine.gov/pfr/insurance/unum/unum_exam_settlement.htm.

¹²When courts have utilized the Grid findings as evidence of disability under an LTD plan, it typically does so under a more traditional transferrable skills analysis – the insured was not highly educated and had no transferrable skills, and thus the Grid was used to illustrate the futility of finding alternative suitable employment. *See Demirovic v. Building Service 32B-J Pension Fund*, 467 F.3d 208, 216 (2d Cir. 2006) (holding that the Medical-Vocational Rules form an instructive framework for analyzing disability claims); *Poulos v. Motorola Long Term Disability Plan*, 93 F.Supp.2d 926, 932 (N.D. Ill. 2000) (same).

¹³*Connecticut General Life Insur. Co.*, 272 F.3d 127 (2d Cir. 2001). Although the SSA also has an offset for workers’ compensation benefits, POMS § DI 52001.090 requires that no offset be taken when the tort award pays back the workers’ compensation carrier, since it is if the workers’ compensation payments had never been made.

¹⁴29 U.S.C. § 1132. However, an award of benefits is not assumed. In yet another similarity between ERISA and Social Security litigation, federal courts often remand the decision back to the plan administrator for further evaluation even though ERISA, unlike the Social Security Act, does not expressly authorize remands. *See generally Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 978 (7th Cir. 1999).

¹⁵29 U.S.C. § 1132(g).

¹⁶*Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (awarding equitable relief pursuant to 29 U.S.C. § 1132(a) (3) where the ERISA statute would otherwise provide no relief).

¹⁷*See, e.g., Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981-982 (7th Cir. 1999) (“Deferential review of an administrative decision [*982] means review on the administrative record.”).

¹⁸*See, e.g., Dennison v. MONY Life Ret. Income Sec. Plan for Empl.*, 710 F.3d 741 (7th Cir. 2013) (acknowledging a “softening” in the availability of conflict discovery following *Glenn*).

late ethics rules if “other law” or a “court order” requires the disclosure. *Id.* at *14833. According to the SSA, the new rule constitutes “other law.” *Id.* Third, even if a particular state has not adopted something similar to the ABA Model Rule, “the notion that an attorney could be punished by his or her state bar for complying with federal law in a federal forum is antithetical to the Supremacy Clause.” *Id.* (quoting Robert Rains, *Professional Responsibility and Social Security Representation: The Myth of the State-Bar Bar to Compliance with Federal Rules of Production of Adverse Evidence*, 92 Cornell L. Rev. 363, 392 (2007)). Fourth and finally, the SSA states that it is “unaware of any other forum that permits attorneys to withhold unfavorable evidence, if it relates to an issue in the case.” *Id.* “Accordingly, in the situation described by several commenters where the claimant directs the representative to withhold unfavorable evidence, that communication is privileged, but the evidence would still have to be produced.” *Id.*

The new rule highlights that the administrative hearing is meant to be inquisitorial and collaborative rather than adversarial. The goal of the proceeding is not to “win” benefits for the client; rather, the representative’s job is to ensure the record contains enough information for the ALJ to meet his or her duty to make a full and fair record of the facts, and in turn a fair determination of whether the claimant is entitled to benefits. Representatives will still zealously advocate for their clients by reaching out to medical professionals to gather relevant information, and persuading the ALJ as to why favorable pieces of evidence may be more reliable or relevant than unfavorable pieces of evidence. In other words, this new rule should not affect already ethical lawyers who generally only file cases on behalf of claimants whom the lawyer believes have meritorious claims for benefits.

It has been my experience, both when I was a lawyer practicing social security law, and now while serving as a federal judge, that the overwhelmingly vast majority of attorneys are ethical and practice law according to the highest standards. It is my opinion that the aforementioned rule is aimed at a small number of “bad apples” who are, sooner or later, going to be discovered and driven from the practice of law.

What concerns me more than lawyers hiding unfavorable evidence of non-disability is lawyers not doing enough to assist the ALJs so that a favorable decision can be reached at the earliest possible time. In any social security disability case, the most important question is that of residual functional capacity (“RFC”). See *McCoy v. Schweiker*, 683 F.2d 1138, 1147 (8th Cir. 1982) (en banc), *abrogated on other grounds by Higgins v. Apfel*, 222 F.3d 504, 505 (8th Cir. 2002). RFC is what the individual who has a severe impairment can still do. “[I]t is the ability to perform the requisite physical acts day in and day out, in the sometimes competitive and stressful conditions in which real people work in the real world.” *Id.* An ALJ determines RFC based on all relevant evidence,

but it is a medical question and must be supported by some medical evidence. See, e.g., *Masterson v. Barnhart*, 363 F.3d 731, 738 (8th Cir. 2004).

The same can be said of mental impairments. Expert testimony is required to establish RFC. As Judge Richard Posner wrote in *Wilder v. Chater*, 64 F.3d 355, 337 (7th Cir. 1995): “Severe depression is not the blues. It is a mental illness; and health professionals, in particular psychiatrists, not lawyers or judges, are the experts on it.” It is my experience that most cases involve combinations of physical and mental impairments. The claimant’s lawyer can provide invaluable service by skillfully questioning the physician(s) to obtain the relevant information so that the ALJ can make the best decision possible, and so that the record is fully developed if it needs to be reviewed by the district or appellate court.

Often, the records of disability cases consist of hundreds of pages of treatment notes, but because the physicians are not treating the patient in the context of a worker’s compensation claim or a personal injury case, no mention is made of the patient’s ability or inability to function in a work setting. The lawyer should write to the treating physicians and obtain medical opinion regarding the client’s ability to function in competitive work environments. The ALJ needs to know how physical impairments limit the claimant’s ability to perform exertional activities such as lifting, carrying, standing, walking, etc. The ALJ also needs to know how the non-exertional aspects of the impairment limit the claimant. The best source of this information is the treating physician, and the lawyer should assist the ALJ by soliciting it from the physician. The physician need not opine whether or not the claimant is disabled—that is a decision for the Commissioner to make—but the physician is the best authority on how physical and/or mental impairments limit the patient’s ability to function day in and day out. In *Newland v. Apfel*, 204 F.3d 853, 858 (8th Cir. 2000), the court quoted Circuit Judge Richard S. Arnold who, while sitting as a district court judge in *Ford v. Secretary of Health and Human Services*, 662 F. Supp. 954, 955 (W.D. Ark. 1987), said: “‘The key issue in this case is Ford’s RFC. This is a medical question.’ ‘The issue, of course, is not whether Ford has had heart attacks, documented or not, but how his heart attacks are now affecting his ability to function physically.’”

The goals of the lawyers and the ALJs are the same—“that deserving claimants who apply for benefits receive justice.” *Battles v. Shalala*, 36 F.3d 43, 44 (8th Cir. 1994) (quoting *Sears v. Bowen*, 840 F.2d 394, 402 (7th Cir. 1988)). In my opinion, the system works best when ALJs and lawyers work together to fully and fairly develop the record. In that way, when the case comes to the court for judicial review, the record is such that the court can affirm, remand, or reverse and award benefits based on a well-developed record.

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By signing this application, I hereby apply for membership in the Federal Bar Association and agree to conform to its Constitution and Bylaws and to the rules and regulations prescribed by its Board of Directors. I declare that the information contained herein is true and complete. I understand that any false statements made on this application will lead to rejection of my application or the immediate termination of my membership. I also understand that by providing my fax number and e-mail address, I hereby consent to receive faxes and e-mail messages sent by or on behalf of the Federal Bar Association, the Foundation of the Federal Bar Association, and the Federal Bar Building Corporation.

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(Signature must be included for membership to be activated)

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Application continued on the back



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plicants. The article that I have written for this issue is a follow-up of sorts, re-telling and re-visiting anecdotal stories from around the country documenting the epidemic from several attorneys who wrote to me in response to the article. I still hope to collect more stories, so if you have one which you have yet to share, please feel free to describe what happened and send it to my email address at ndksocialsecuritylaw@gmail.com.

Also, if you simply have an idea for a relevant article which you would want to publish, I would be happy to hear

what you have in mind and assist you in any way to make your article a reality.

I hope you find this issue once again to be both interesting and valuable in your day to day endeavors in the field of Social Security law. I look forward to working on the next issue, which will be our Winter 2016 release. Thank you again to Judge Wascher for his efforts on behalf of the Section. Have a great summer and fall.

Best to all,
N. David Kornfeld

SUICIDE CONTINUED FROM PAGE 10

took a leave of absence for a month. He has never gotten over this either. Three of my clients have committed suicide after appearing before this judge. In 10 years, he has denied every case I have presented. This is not about the judge as much as it is the young man, and how horrible I feel as a representative for failing this claimant and his family, and how ashamed I am that SSA allows such a thing to occur."

An attorney practicing in New Jersey who has represented claimants for over 20 years reported a number of client suicides and revealed "one still haunts me." The attorney described her client as a woman suffering from a multitude of physical and mental impairments. When the attorney first met the client, the attorney advised her that denials of initial claims and Reconsiderations were the norm, sharing with her the percentage of cases that were denied at these levels and assuring her that a denial of a claim at these levels was not a reflection of the merits of the claim. Upon receiving the denial, the attorney immediately filed the Request for Hearing. The next day, the attorney sent the claimant a letter acknowledging the denial, advising her that an appeal had been filed, and reminding her not to be too discouraged. Unfortunately, the claimant committed suicide the same day she received the denial letter. The attorney stated, "The claimant said good night to her husband, went to bed and took an overdose of medications. She left a suicide note. Although I have not read the note, her husband told me that she had

stated that one of the reasons she decided to take her life was that she was upset by the denial of the SS benefits. She stated that she had hoped that she would be approved for benefits because the couple was struggling financially, at risk of losing their home, and the benefits would have eased the financial stress. Her husband stated that she had felt very guilty about not being able to contribute to the family finances and she was upset that her husband had to work such long hours to try and support them. Her husband told me that she stated that she took her life because she did not want to continue to be a financial burden to her husband any longer. A little over 8 months after her death, a hearing was held and she was found to be disabled." The attorney further stated, "To this day, I regret not having picked up the phone and called the claimant to reassure her about the viability of her claim, despite the denial. Perhaps if I had made a phone call instead of sending the letter, there would have been a different outcome. I just did not know that she would react to the denial with despair, rather than disappointment. It is a shame that the SSA is not required to include their own statistics concerning their denial rates in the denial letters. Perhaps if she had been reminded in the denial letter that, on average, each fiscal year the SSA denies approximately 89 percent of all Request for Reconsiderations, she would not have given in to the despair."

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