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Navigating ERISA's Claims Review Process

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Introduction

Consistent with the Employee Retirement Income Security Act[1] and with regulations[2] promulgated by the Department of Labor, employee benefit plans governed by ERISA must include a comprehensive claims procedure meeting statutory, regulatory, and judicial requirements. Such procedures are intended to avoid frivolous lawsuits under ERISA, ensure that benefit claims receive consistent treatment, offer a nonadversarial method of claims settlement and minimize costs for all involved.[3]

In general, plan procedures must give participants adequate notice of the plan administrator's decision regarding their benefit claim, as well as information on how that decision was reached.[4] Participants must also be given adequate means to contest such determinations. Ultimately, participants must be apprised of their right to judicial recourse if they have followed plan procedures but remain dissatisfied with the result.[5]

Under the "exhaustion doctrine," federal courts permit plan participants to challenge benefit determinations in court only after the participants have first exhausted their plan's internal administrative remedies, unless the court determines that resort to such procedures is futile, nonexistent or would result in irreparable harm to the claimant.[6]

However, if a plan's claims procedure fails to meet the requirements specified in the statute and regulations, the claim is deemed exhausted and the claimant is entitled to bring the claim directly to federal court.[7]

Once in court, determination of the applicable standard of judicial review is critical in deciding whether a plan administrator's ruling will be upheld. As will be discussed later in this report,[8] under the abuse of discretion standard, the court will give much deference to the plan administrator's ruling, and thus present a claimant with a difficult hurdle in challenging such a determination. Under the de novo standard, however, no deference will be shown, thus increasing the chance of a successful challenge. A showing that the plan administrator acted under a conflict of interest is a factor to be

[1] 29 U.S.C. § 1133 provides:
In accordance with regulations of the Secretary, every employee benefit plan shall—
(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

[2] 29 C.F.R. § 2560.503-1(b).

[3] *Amato v. Bernard*, 618 F.2d 559, 2 EBC 2536, 2543 (9th Cir. 1980)(establishing an administrative exhaustion requirement under ERISA and setting forth the rationale for doing so).

[4] 29 C.F.R. § 2560.503-1(g).

[5] 29 C.F.R. § 2560.503-1(j).

[6] *Amato, supra.*; *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 959 F.2d 655, 658-59 (7th Cir. 1992).

[7] 29 C.F.R. § 2560.503-1(l).

[8] See "Standard of Court Review" below.

considered; however, it wouldn't alter the standard of judicial review.[9]

Impact of the ACA: The Affordable Care Act (Pub. L. No. 111-148) requires group health plans to include several provisions relating to both the scope of coverage provided, as well as the elimination of coverage exclusions such as pre-existing conditions, as well as the removal of limitations on the amount of benefits payable. Plans that were in existence as of March 23, 2010, the date ACA was enacted, and that provided coverage for at least one individual—that is, grandfathered plans—are temporarily exempt from some of these those requirements until plan renewals, when the plans then become subject to the ACA.

Another key requirement of the ACA is that all new plans, as well as plans that can no longer be grandfathered, are subject to independent external review requirements under the standards established by the National Association of Insurance Commissioners. Those standards require the random selection of a reviewer independent of the insurance company or benefit plan in determining issues such as disputes concerning the medical necessity of treatment.

It is too soon yet to ascertain the full dimension of how the ACA will impact ERISA claim review procedures.

Claims Review Procedures

To develop a plan procedure that will be insulated from attack, plan designers must comply with the regulations attendant to ERISA Section 503. [10] Those regulations, which were last updated in 2000[11] apply to claims filed on or after Jan. 1, 2002.

Under the regulations, every employee benefit plan must "establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. . . ."[12] In general, these claims procedures must meet several broad standards intended to insure a "full and fair review." Those standards clarify that claimants are entitled to receive, free of charge, all relevant documentation applicable to the claim, that the plan provisions are applied consistently as to similarly situated claimants, guarantee the right to appoint an authorized representative such as an attorney or a physician in a medical benefits claim and to insure that in cases involving medical judgments that physicians possessing appropriate expertise be consulted.[13] The regulations also establish time frames both as to the submission of claims and appeals as well as times for deciding appeals, which are highly compressed in urgent medical situations.[14]

Initial Benefit Determination

The regulations controlling the initial benefit determination focus on a plan's obligation to notify claimants of a benefit determination.[15] The regulations set rigid time limits for each step and explain precisely what information must be included in the notification.

Notification Requirements

It is important that notice of an initial benefit determination be understandable, comprehensive and furnish a basis for perfecting an appeal. Failure to provide adequate notification of an adverse benefit determination will affect the claimant's ability to properly appeal such determination and may ultimately result in a court overturning a benefit denial.[16]

Generally, the initial benefit determination notice must set forth—in a manner calculated to be understood by the claimant—the following information:[17]

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- a description of the plan's review procedures and applicable time limits, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following exhaustion of the plan's administrative remedies.[18]

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[9] *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 43 EBC 2921 (2008).

[10] 29 U.S.C. § 1133.

[11] 65 FR 70246 (November 21, 2000).

[12] 29 C.F.R. § 2560.503-1(b). The phrase "adverse benefit determination" is defined in the regulations as "any of the following: a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate." 29 C.F.R. § 2560.503-1(m)(4).

[13] 29 C.F.R. § 2560.503-1(b)(5).

[14] 29 C.F.R. § 2560.503-1(i).

[15] 29 C.F.R. § 2560.503-1(f).

[16] *See, e.g.*, *Holmstrom v. Metro. Life Ins. Co.*, 615 F.3d 758, 49 EBC 1954 (7th Cir. 2010)(court characterized plan administrator's evasive communications as a "moving target," pointing out the need for the plan administrator to specify what evidence the claimant is being asked to provide in order to perfect an appeal).

[17] 29 C.F.R. § 2560.503-1(g).

[18] 29 C.F.R. § 2560.503-1(g). Several rulings have specified the necessity of the claims process being a dialogue. *See*, *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 20 EBC 2767 (9th Cir. 1997)(citing the movie Cool Hand Luke -"What we got here is a failure to communicate"). Similarly, in *Friedrich v. Intel Corp.*, 181 F.3d 1105, 28 EBC 1339 (9th Cir. 1999), the court admonished the plan for acting as the claimant's "adversary." And in *Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807-808 (10th Cir. 2004), the court explained that in the claim appeals process, the administrator's role differs from that of a judge "where the parties bear almost all of the responsibility for compiling the record, and the judge bears little or no responsibility to seek clarification when

Timing Provisions

DOL regulations generally require plan administrators to furnish participants and beneficiaries with written or electronic notice of denial of their claim within a reasonable period of time, but not later than 90 days after the plan receives the claim. Although, as discussed below, time frames may vary depending on the nature of the claim. However, there may be adverse consequences if a plan administrator misses a deadline.[19]

A plan administrator is allowed to invoke "special circumstances" as justification to obtain an extension of time for processing the claim. In such an instance, written notice of the extension must be furnished to the claimant within the initial 90-day period. The extension cannot exceed a period of 90 days from the end of the initial period. The extension notice must indicate the special circumstances that require a time extension and date by which the plan expects to render the benefit determination.[20]

Different types of benefits might be subject to more stringent timing provisions. The preamble to the final rule clarifies that a determination of which time schedule is applicable to a claim depends on the nature of the claim, regardless of whether the benefits are provided under a multiemployer benefit plan or separate plans. Thus, claims for different benefits under the same plan may be subject to different time limits.[21]

Group Health Care Plans

In general, group health care plans are subject to shorter time limits and stricter provisions than other benefit plans. Health care claims generally are classified as urgent care claims, pre-service claims or post-service claims.[22]

Urgent care claims are defined as either a claim:[23]

- for medical treatment that, if considered non-urgent, "could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function"; or
- involves a medical condition that, in the opinion of an informed physician, would subject the claimant to severe pain that cannot be managed adequately without care or treatment.

A treating physician's determination regarding whether a claim is "urgent" will be considered conclusive. In all other cases, the determination is governed by the standard of a "prudent layperson."[24]

Initial benefit determinations for urgent care claims must be decided as soon as possible taking into account the medical situation, but not later than 72 hours after the plan receives the claim.[25] Final determinations on disputed claims for urgent care also must be made within 72 hours of notice to the plan that the participant is challenging the initial claim denial.

Non-urgent care claims are further classified as either pre- or post-service claims. Pre-service claims—where receipt of the benefit is conditioned upon approval of the claim in advance of receiving the care[26]—initially must be decided within a maximum of 15 days, or a maximum of 30 days upon review of an adverse benefit determination.[27] Post-service claims initially must be decided within a maximum of 30 days, or a maximum of 60 days upon review.[28]

The regulations allow the decisionmaking process on both types of claims to be extended for one additional period of 15 days after expiration of the relevant initial period. The additional 15-day extension is available if the plan administrator determines that the extension is necessary for reasons beyond the control of the plan.

Disability Benefits

The initial claims determination for disability benefits is subject to a 45-day time limit. The plan administrator can extend this period for up to two additional 30-day periods, if adequate notice is given to the claimant before expiration of the current review period.[29]

As with health care claims, extensions are available only if the administrator determines that they are necessary for reasons beyond the plan's control, such as failure of the claimant to provide necessary information.

Pension and Welfare Plan Disclosure Requirements

The DOL regulations require that "a plan's claims procedures include administrative safeguards and processes designed to ensure and to verify that benefit claims determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." However, the rule

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the evidence suggests the possibility of a legitimate claim." Instead, plan administrators are expected to notify claimants of any additional evidence that might be necessary to prove a legitimate claim.

[19] According to 29 C.F.R. § 2560.503-1(l), a failure to comply with the regulations could result in a "deemed exhaustion" permitting a claimant to go directly to court to seek relief. Moreover, a failure to render a timely claim decision could lead to a loss of discretionary authority and thus a forfeiture of a right to a deferential standard of court review. *See*, *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Protection Plan*, 349 F.3d 1098, 31 EBC 2622 (9th Cir. 2003). However, there are no penalties imposed for delays according to *Walter v. IAM Pension Fund,* 949 F.2d 310, 14 EBC 1841, 1847 (10th Cir. 1991) (even accepting the plan's failure to comply with DOL's 90-day response requirement, "ERISA does not provide a private cause of action for damages to compensate a pensioner for delay").

However, a claimant's delay in submitting a claim or appeal may bar the claim altogether. *See*, *Edwards v. Briggs & Stratton*, 639 F.3d 355, 51 EBC 1626 (7th Cir. 2011)(failure to submit a timely claim appeal constituted a failure to exhaust remedies resulting in dismissal of case).

[20] 29 C.F.R. § 2560.503-1(f)(1).

[21] ERISA Claims Procedures, 65 Fed. Reg. at 70,247, n.4.

[22] 29 C.F.R. § 2560.503-1(f).

[23] 29 C.F.R. § 2560.503-1(m)(1)(i).

[24] *Id.*

[25] 29 C.F.R. § 2560.503-1(f)(2)(i).

[26] 29 C.F.R. § 2560.503-1(m)(2).

[27] 29 C.F.R. § 2560.503-1(f)(2)(iii)(A).

[28] 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).

[29] 29 C.F.R. § 2560.503-1(f)(3).

does not stipulate how such processes should be designed.

The regulation's disclosure requirements stipulate that plans must, upon request, give claimants whose claims are denied any information that the plan generated or obtained in making the determination that "was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination."[30] The plan also must specifically identify to those claimants any internal rules, guidelines or protocols that served as the basis for the adverse determination.[31]

Appeals Requirements

Every employee benefit plan must set forth a procedure by which a claimant has reasonable opportunity to appeal an adverse benefit determination to an appropriately named plan fiduciary. The appeals procedures must provide a full and fair review of the claim and initial benefit determination.[32]

A plan may require two levels of mandatory appeals before a claimant would be entitled to file suit.[33] Additional voluntary levels of appeal are permitted, with certain restrictions. However, a claimant's failure to participate in a voluntary appeal may not be used as a basis for claiming a failure to exhaust administrative remedies.[34]

Opportunity for Full and Fair Review

An appeal determination will be afforded discretion in court only if the claimant is provided an opportunity for full and fair claim review. "Full and fair review" is a catchall phrase that includes the claimant's right to present an appeal within a certain amount of time and have access to certain documents or information, as well as the types of evidence the appeals board must consider in making its final determination.

General Requirements

In general, to satisfy the full and fair review requirement, the appeals processes must:[35]

- depending on the type of claim at issue, allow claimants at least 60 days following receipt of notification of an adverse benefit determination within which to appeal the determination;
- provide claimants the opportunity to submit written comments, documents, records and other information relating to the claim;
- provide claimants reasonable access, upon request and free of charge, to all documents, records and other information relative to the claim; and
- provide a review that takes into account all comments, documents, records, and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination.

Group Health Plans and Disability Benefits

With respect to post-service health claims and claims involving disability benefits, plans must allow claimants at least 180 days following receipt of notification of an adverse benefit determination to appeal the determination.[36] Shorter time frames apply to urgent care claims and pre-service medical claims.[37]

The plans must provide for a review that doesn't afford deference to the initial adverse benefit determination. The review must be conducted by an appropriate named plan fiduciary who is neither the individual who made the initial adverse benefit determination nor his or her subordinate.[38]

When there is an adverse decision in cases involving health care or disability benefit claims that involve a medical judgment, the designated named appeals fiduciary must consult with a health care professional who has experience in the relevant field of medicine and is independent of anyone who participated in the initial adverse decision.[39]

The plan must provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.[40]

Under 29 C.F.R. § 2560.503-1(f) and (g), an "adverse benefit determination" includes any denial, reduction or termination of a benefit. Thus a plan is required to give a claimant notice of an adverse benefit determination when the plan, while seeking periodically to confirm the claimant's disability, determines that the claimant is no longer disabled and terminates disability benefits. However, the termination of benefits at the end of a specified predetermined benefit period wouldn't be an adverse benefit determination, and would therefore not require such notice. [41]

Statement of Scientific Judgment

If a health care claim is denied—either initially or upon review—because the care is deemed not to be medically necessary or experimental in nature, the claim denial notice must "explain the scientific or clinical judgment of the plan in applying the terms of the plan to the

[30] 29 C.F.R. § 2560.503-1(m)(8).
[31] 29 C.F.R. § 2560.503-1(g)(1)(v)(A).
[32] 29 C.F.R. § 2560.503-1(h)(1).
[33] 29 C.F.R. § 2560.503-1(c)(2).
[34] 29 C.F.R. § 2560.503-1(c)(3).
[35] 29 C.F.R. § 2560.503-1(h)(2).
[36] 29 C.F.R. § 2560.503-1(h)(3)(i).
[37] 29 C.F.R. § 2560.503-1(i).
[38] 29 C.F.R. § 2560.503-1(h)(3)(ii).
[39] 29 C.F.R. § 2560.503-1(h)(3)(iii), (v). An independent health care professional is one who is different from, and not subordinate to, any individual who was consulted in the initial decision.
[40] 29 C.F.R. § 2560.503-1(h)(3)(iv).
[41] Question C-18; PWBA question and answer guidance issued May 29, 2002. Available at http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html(104 Pens. & Ben. Daily (BNA) May 30, 2002).

claimant's medical circumstances, or include a statement that such an explanation will be provided free of charge" upon request.[42]

Content of Appeal Determination Notification

General Requirements

In the case of an adverse benefit determination on review, the plan administrator must provide the claimant with written or electronic notification of the determination. The notification shall set forth, in a manner calculated to be understood by the claimant:

- the specific reason or reasons for the adverse determination;[43]
- a reference to the specific plan provisions on which the benefit determination is based;[44]
- a statement that the claimant is entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim; and[45]
- a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain information about such procedures.[46]

Group Health Care Plans

In a case involving a group health plan or plan that provides disability benefits, the notification is subject to the following additional requirements:

- If an internal rule, guideline or protocol was relied upon in making the adverse determination, such criterion or a statement describing such rule must be provided to the claimant upon request at no charge.[47]
- If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion, the plan must provide an explanation of the scientific or clinical judgment for the determination and how it applies specifically to the claimant's circumstances, or a statement that such information will be provided free of charge upon request.[48]
- The following statement must be included: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."[49] The Affordable Care Act has provisions for external independent review administered through state insurance regulatory agencies.[50]

Timing of Appeal Determination Notification

General Requirements

In general, a claimant is entitled to notification of the appealed benefit determination within a reasonable period of time, not to exceed 60 days after the plan receives the claimant's request for review.

A plan administrator can determine that special circumstances—such as the need in the case of a plan managed by a board of trustees to hold a hearing—require an extension of time. If such an extension is required, written notice of the extension must be furnished to the claimant prior to termination of the initial 60-day period. In no event can the extension exceed a period of 60 days from the end of the initial period. The extension notice should indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination upon review.[51]

Timing requirements might vary for plans with a committee or board of trustees that is designated as the appropriate name fiduciary and holds regularly scheduled meetings on at least a quarterly basis.[52]

Group Health Care Plans

In the case of a claim involving urgent care, the plan administrator must notify the claimant of the plan's appealed benefit determination as soon as possible, taking into account medical exigencies, but not later than 72 hours after the plan receives the claimant's request for review of the initial benefit determination.[53] The 72-hour rule encompasses weekends and holidays.

In the case of a pre-service claim, the plan administrator must notify the claimant of the plan's appealed benefit determination within a period of time that is reasonable and appropriate to the medical circumstances.

If the plan allows for one level of appeal, the notification must be provided within 30 days of the plan's receipt of the claimant's request for appeal. If the plan allows for two levels of appeal, such notification shall be provided—with respect to either of the levels of appeal—within 15 days after the plan receives the claimant's request for review.[54]

In the case of a post-service claim, the plan administrator must notify the claimant of the appeals determination within a reasonable time. If the plan allows for one level of appeal, such notification shall be provided not later than 60 days after the plan receives the claimant's request for review. If the plan allows for two levels of appeal, such notification must be provided—with respect to either level of appeal—within 30 days after the claimant's request for review is received.[55]

However, time limits for determination of post-service claims might be different in the case of a multiemployer plan with a committee or board of trustees that holds

[42] 29 C.F.R. § 2560.503-1(g)(1)(v)(B).
[43] 29 C.F.R. § 2560.503-1(j)(1).
[44] 29 C.F.R. § 2560.503-1(j)(2).
[45] 29 C.F.R. § 2560.503-1(j)(3).
[46] 29 C.F.R. § 2560.503-1(j)(4).
[47] 29 C.F.R. § 2560.503-1(j)(5)(i).
[48] 29 C.F.R. § 2560.503-1(j)(5)(ii).
[49] 29 C.F.R. § 2560.503-1(j)(5)(iii).
[50] See, generally, http://www.dol.gov/ebsa/healthreform.
[51] 29 C.F.R. § 2560.503-1(i)(1)(i).
[52] 29 C.F.R. § 2560.503-1(i)(1)(ii); also see *Barboza v. California Assn. of Professional Firefighters*, 651 F.3d 1073, 51 EBC 2183 (9th Cir. 2011)(explaining that rule applies only to multiemployer plans).
[53] 29 C.F.R. § 2560.503-1(i)(2)(i).
[54] 29 C.F.R. § 2560.503-1(i)(2)(ii).
[55] 29 C.F.R. § 2560.503-1(i)(2)(iii)(A).

regularly scheduled meetings on at least a quarterly basis.[56]

Disability Claims

Claimants who appeal disability benefit determinations are entitled to notification of the determination on appeal within a reasonable period of time, not to exceed 45 days after the plan receives the claimant's request for review. A plan administrator can extend the time period if he or she determines that special circumstances—such as the need to hold a hearing—require an extension.

If an extension is required, written notice of the extension must be furnished to the claimant prior to the termination of the initial 45-day period. In no event can the extension exceed a period of 45 days from the end of the initial period. The extension notice should indicate the special circumstances requiring a time extension and the date by which the plan expects to render the determination on review.[57]

Timing requirements might vary for plans with a committee or board of trustees that is designated as the appropriate named fiduciary and holds regularly scheduled meetings on at least a quarterly basis.[58]

Voluntary Levels of Appeal

To the extent that a plan offers voluntary levels of appeal—except to the extent that they are required by state law—including alternative dispute resolution, the claims procedures must provide that the plan:[59]

- waives its right to assert the claimant's failure to exhaust administrative remedies because the claimant did not elect to submit a voluntary appeal dispute provided by the plan;
- agrees that any statute of limitations or other timeliness defense is tolled during the time that such voluntary appeal is pending;
- provides that a claimant can elect to submit a benefit dispute to the voluntary level of appeal only after exhaustion of the mandatory levels of appeal;
- provides to a claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal; and
- doesn't impose any fees or costs for the voluntary level of appeal on the claimant.

Voluntary appeals may not be subject to the same rules as mandatory appeals and can shorten the time frames applicable to rules governed by the regulations.[60]

[56] 29 C.F.R. § 2560.503-1(i)(2)(iii)(B).
[57] 29 C.F.R. § 2560.503-1(i)(3)(i).
[58] 29 C.F.R. § 2560.503-1(i)(3)(ii).
[59] 29 C.F.R. § 2560.503-1(c)(3).
[60] See, *Price v. Xerox Corp.*, 445 F.3d 1054, 37 EBC 1617 (8th Cir. 2006); *DaCosta v. Prudential Ins. Co. of America*, No. 10-CV-720 (JS) (ARL), 50 EBC 1338 (E.D.N.Y. Nov. 12, 2010).

Procedural Violation Remedies

The courts have been unwilling to provide substantive remedies for noncompliance with a plan's internal procedures. Instead, some courts remand the action to the plan administrator.[61] However, in *Schleibaum v. Kmart Corp.*,[62] the Seventh Circuit, while conceding that "normally, in an action for an inadequate denial letter, the remedy is to remand the case to the administrator for a full and fair hearing of the claim," instructed the lower federal district court on remand to "exercise its equitable powers in fashioning an appropriate level of damages." According to the appeals court, a remand to the plan administrator would be futile due to the "untimely" death of the plan participant.[63] In other cases, though, a penalty for a plan administrator's failure to comply with the rules for terminating benefits is the restoration of the status quo ante.[64] In other circumstances, non-compliance may lead to a forfeiture of deferential review.[65]

Mandatory Arbitration Requirements

Plans can require some limited forms of mandatory, but not binding arbitration. Arbitration can be one of the two permissible levels of mandatory appeal, so long as the claimant is not precluded from challenging the decision in court pursuant to ERISA Section 502(a).[66]

Exhaustion of Administrative Remedies

Exhaustion Doctrine Applied to Benefit Claims

ERISA doesn't specifically require that a plan participant or beneficiary exhaust the plan's claims procedure before filing a lawsuit. However, many courts have developed an "exhaustion doctrine" that requires plaintiffs to exhaust the plan's administrative remedies before they can file a lawsuit.

[61] *Crocco v. Xerox*, 137 F.3d 105, 109, 28 EBC 1137 (2d Cir. 1998); *Jones v. American Airlines*, 57 F. Supp. 2d 1224, 1237-38 (D. Wyo. 1999).
[62] 153 F.3d 496, 22 EBC 1649 (7th Cir. 1998).
[63] *Schleibaum*, 22 EBC at 1655-57 ; for other cases granting a substantive remedy *see Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 20 EBC 2767 (9th Cir. 1997), and *Adams v. Cyprus Amax Mineral Co.*, 44 F. Supp. 2d 1126, 23 EBC 1839 (D. Colo. 1999).
[64] *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621, 36 EBC 1362 (7th Cir. 2005)(holding that an insurer's failure to comply with the claim regulations in terminating benefits justified reinstatement in order to restore the claimant to the status quo ante). *Accord*, *Miller v. American Airlines*, 632 F.3d 837, 50 EBC 1900 (3rd Cir. 2011); *Wenner v. Sun Life Assur. Co. of Canada*, 482 F.3d 878, 40 EBC 2631 (6th Cir. 2007).
[65] *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Protection Plan*, 349 F.3d 1098, 31 EBC 2622 (9th Cir. 2003); *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 30 EBC 1449 (10th Cir. 2003), and *Seman v. FMC Corp. Retirement Plan for Hourly Employees*, 334 F.3d 728, 30 EBC 2139 (8th Cir. 2003)(both cases ruled that the failure to conduct a timely appeal resulted in a loss of discretion that the plan would otherwise receive in a court review). The same result was reached in *Nichols v. Prudential Insur. Co. of America*, 406 F.3d 98, 34 EBC 2185 (2d Cir. 2005), which rejected an argument that "substantial compliance" was sufficient.
[66] 29 C.F.R. § 2560.503-1(c)(4).

In its 1980 *Amato v. Bernard* decision,[67] the Ninth Circuit held that the exhaustion doctrine—then applied to federal labor law disputes—was similarly applicable to ERISA disputes.[68] The court wrote that

> the federal courts have long fashioned federal common law under Section 301 of the [Labor Management Relations Act of 1947], . . . and part of that law has been that where administrative remedies are available they must usually be exhausted by an aggrieved party before his Section 301 complaint will be heard. . . . The legislative history of ERISA thus clearly suggests that Congress intended to grant authority to the courts to apply the exhaustion requirement in suits under the Act. [69]

In 1985, the Fifth Circuit summarized the reasoning behind an exhaustion requirement in *Denton v. First National Bank of Waco*:

> The primary purposes of the exhaustion requirement are to: (1) uphold Congress' desire that ERISA trustees be responsible for their actions, not the federal courts; (2) provide a sufficiently clear record of administrative action if litigation should ensue; and (3) assure that any judicial review of fiduciary action (or inaction) is made under the arbitrary and capricious standard, not de novo. Accordingly, decisions of the trustees are disturbed only if they are arbitrary and capricious, not on the basis of what the district court would have done in the first instance. This is necessary to keep from turning every ERISA action, literally, into a federal case.[70]

Other rationales for an exhaustion requirement include the prevention of "premature judicial intervention"; exhaustion also assures the courts that a claim has been fully considered by the plan administrator.[71] Exhaustion is also intended to "decrease the cost and time of claims settlement."[72] Nonetheless, the exhaustion requirement is not jurisdictional and is an affirmative defense subject to waiver.[73]

Despite the courts' imposition of an exhaustion requirement, the courts have uniformly held that attorneys' fees pursuant to ERISA Section 502(g) aren't recoverable for expenses incurred while exhausting administrative remedies.[74] Among the rationales advanced for denying fees is that the presence of attorneys may result in a heightened degree of formality and lead to more protracted litigation. According to the U.S. Court of Appeals for the Fourth Circuit, "the majority of claims should be resolved under informal administrative processes, for which no award of attorney's fees is authorized."[75] However, fees are available for work involved in claim appeals following a court-ordered remand of a benefit claim.[76]

Contract Interpretation Claims

The applicability of the exhaustion requirement depends, in part, on the basis of the claim. While courts are split on whether to require exhaustion for claims based on violations of ERISA itself,[77] exhaustion is required in virtually all benefit claims. Thus, if a plaintiff's claim is based solely on the interpretation or application of the terms of the plan, courts have held that the plaintiff is required to exhaust his or her administrative remedies by following the plan's claims procedure.

In its 1990 *Springer v. Wal-Mart Assocs.' Group Health Plan* decision,[78] the Eleventh Circuit emphasized that there was no division among federal courts regarding the applicability of the exhaustion doctrine to claims that addressed a benefit determination, writing, "Assuming the district court's reference to 'disagreement among federal courts' to refer to the Circuit split . . . , that split is irrelevant to the instant case because Springer's claim is based simply on breach of contract rather than any statutory violation. In short it is no longer open to serious dispute that plaintiffs in ordinary breach-of-contract ERISA actions must normally exhaust available administrative remedies."[79]

Statutory Claims

Where the claim is based on an alleged statutory violation of ERISA—such as a breach of fiduciary duty, discrimination or a disclosure violation—the circuits are split on whether there is a requirement to exhaust the plan's claims procedure. The Eleventh and Seventh Circuits both have held that, even if the basis of the claim is a violation of ERISA itself, a plaintiff is not excused from exhausting the administrative remedies made available by the plan.[80]

Often, the question whether to require exhaustion depends on the specific statutory claim involved.[81]

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[67] *Amato v. Bernard*, 618 F.2d 559, 2 EBC 2536 (9th Cir. 1980).

[68] *Amato*, 618 F.2d at 567.

[69] *Id.*

[70] *Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1300, 6 EBC 1980 (5th Cir. 1985).

[71] *Powell v. AT&T Communications, Inc.*, 938 F.2d 823, 826 (7th Cir. 1991).

[72] *Wilczynski v. Lumbermens Mutual Casualty Co.*, 93 F.3d 397, 402 (7th Cir. 1996).

[73] *Paese v. Hartford Life and Accident Insur. Co.*, 449 F.3d 435, 37 EBC 2797 (2d Cir. 2006).

[74] *Cann v. Carpenters' Pension Trust for Northern California*, 989 F.2d 313, 16 EBC 1873 (9th Cir. 1993), *Anderson v. Proctor & Gamble*, 220 F.3d 449 (6th Cir. 2000), *Peterson v. Continental Casualty Co.*, 282 F.3d 112, 27 EBC 1896 (2d Cir. 2002), *Rego v. Westvaco Corp.*, 319 F.3d 140, 29 EBC 2680 (4th Cir. 2003) and *Kahane v. Unum Life Ins.Co. of America*, 563 F.3d 1210, 46 EBC 1865 (11th Cir. 2009).

[75] *Rego v. Westvaco Corp.*, 319 F.3d 140, 29 EBC 2680, 2687 (4th Cir. 2003).

[76] *See Peterson, supra.*

[77] See the discussion at "Statutory Claims" below.

[78] 908 F.2d 897, 12 EBC 2271 (11th Cir. 1990).

[79] *Springer*, 908 F.2d at 900.

[80] *Mason v. Continental Group Inc.*, 763 F.2d 1219, 1225-27, 6 EBC 1933 (11th Cir. 1985); *Kross v. Western Elec. Co.*, 701 F.2d 1238, 1243-45, 4 EBC 1265 (7th Cir. 1983); *Williams v. Rohm and Haas Pension Plan, unpub.,* 31 EBC 1686, 1688-89 (S.D. Ind. 2003).

[81] District courts in the Seventh Circuit have excused the exhaustion requirement in actions involving breach of fiduciary duties (*see Joncek v. Teamsters Welfare Fund Local 714*, No. 98 C 4302, 24 EBC 1043, 1046 (N.D. Ill. Aug. 30, 1999); *see also Smith v. Sydnor*, 184 F.3d 356 (4th Cir. 1999), where the Fourth Circuit held that exhaustion wasn't required before a plaintiff may bring an action alleging an ERISA fiduciary duty breach; *Held v. Manufacturers Hanover Leasing Corp.*, 912 F.2d 1197, 28 EBC

The Third and Ninth Circuits, on the other hand, have ruled that a plaintiff need not exhaust the plan's claims procedure before bringing a lawsuit based on a statutory ERISA violation. In general, those rulings have been based on the principle that plan officials shouldn't be permitted to interpret and apply the governing law, but instead should be allowed only to interpret and apply the terms of their plans.[82]

In *Fujikawa v. Gushiken*,[83] a union trustee of multiemployer trust funds brought an action against the employer co-trustees, alleging that they had breached their fiduciary duties under ERISA. The Ninth Circuit held that "[e]xhaustion of internal dispute procedures is not required where the issue is whether a violation of the terms or provisions of the statute has occurred."[84] Although the Third Circuit has ruled that exhaustion is not required in all ERISA cases, one panel of that court held that exhaustion is required where an alleged statutory violation, such as a breach of fiduciary duty claim under ERISA Section 404, is actually a claim based on a denial of benefits under the plan's terms.[85] Citing a prior decision, *Amaro v. Continental Can Co.*,[86] the court noted that, "The fundamental premise of *Amaro* is that plaintiffs suing for violation of an ERISA statutory provision, like plaintiffs in Title VII and FLSA actions, have a direct right to sue in federal court, without regard to any contractual agreement to arbitrate the dispute."[87]

Exceptions to Exhaustion Requirements

Even in situations where courts generally require exhaustion of the plan's claims procedure, courts have allowed certain "common sense" exceptions to this requirement. For example, exhaustion has not been required where the plaintiff can demonstrate that it would be futile, [88] where delay would irreparably harm the participant or beneficiary,[89] or where there has been a denial of meaningful access to any administrative review procedure.[90]

In *Burke v. Kodak Retirement Income Plan*,[91] the Second Circuit held to be inadequate language in an employee handbook informing participants who wished to appeal a plan administrator's decision that they "should" within 90 days ask for a review. Concluding that the claimant in the case was denied an opportunity for a full and fair review, the appeals court declined to equate the word "should" with the word "must," since the plan easily could have explicitly used mandatory language.[92] Furthermore, the appeals court said that the handbook failed to indicate that there were any adverse consequences of failing timely to make an appeal.

1354 (10th Cir. 1990), where, in a case involving a claim under ERISA § 510's prohibition against interfering with benefits, the Tenth Circuit refused to require exhaustion of the plan's internal procedures; and *Chailland v. Brown & Root, Inc.*, 45 F.3d 947, 19 EBC 1369 950-51 (5th Cir. 1995), where exhaustion was not required in an ERISA § 510 claim) (*contrast Simmons v. Wilcox*, 911 F.2d 1077, 1081 (5th Cir. 1990)(exhaustion required in action alleging breach of fiduciary duty).

[82] *Fujikawa v. Gushiken*, 823 F.2d 1341, 8 EBC 2249 (9th Cir. 1987); *see also Zipf v. AT&T*, 799 F.2d 889, 7 EBC 2289 (3d Cir. 1986) , and *Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244, 27 EBC 1481, 1487-88 (3d Cir. 2002); *Held v. Manufacturers Hanover Leasing Corp.* , 912 F.2d 1197, 1359-60, 28 EBC 1354 (10th Cir. 1990) (agreeing with the Ninth and Third Circuits that a "plaintiff need not exhaust administrative remedies, prior to bringing an action under § 510 of ERISA"); (however, in *Brewer v. Dana Corp. Spicer Heavy Axle Div.*, 205 F. Supp. 2d 511, 28 EBC 2237, 2241-42 (W.D.N.C. 2002) the district court required exhaustion of administrative remedies in an action involving an ERISA § 510 claim); *Campanella v. Mason Tenders' District Council Pension Plan,* 299 F. Supp. 2d 274, 32 EBC 1457, 1462 (S.D.N.Y. 2004) (saying that although the U.S. Court of Appeals for the Second Circuit has "yet to address whether it requires exhaustion of claims generally alleging statutory ERISA violations," the district court found persuasive the rulings of the "Third, Fourth, Fifth, Sixth, Ninth and Tenth Circuits" that "exhaustion is not a prerequisite to actions asserting statute-based ERISA claims." The district court agreed with the reasoning of those courts that "although plan fiduciaries may have expertise in interpreting the terms of a particular plan, it is primarily the role of the judiciary to engage in statutory interpretation.").

[83] *Fujikawa v. Gushiken*, 823 F.2d 1341, 8 EBC 2249 (9th Cir. 1987).

[84] *Fujikawa*, 823 F.2d at 1345.

[85] *D'Amico v. CBS Corp.*, 297 F.3d 287, 28 EBC 1656, 1657-59 (3d Cir. 2002).

[86] *Amaro v. Continental Can Co.*, 724 F.2d 747, 751, 5 EBC 1215 (9th Cir. 1984)

[87] *Id.* (*citing Amaro v. Continental Can Co.*, 724 F.2d 747, 751, 5 EBC 1215 (9th Cir. 1984).

[88] *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 22 EBC 2221, 2231-32 (6th Cir. 1998) (futility claim sustained where retirees challenged insurer's methodology, which the court was "certain" the insurer would not reconsider); Futility was also found in *Dozier v. Sun Life Assur. Co. of Canada*, 466 F.3d 532, 39 EBC 2277 (6th Cir. 2006) where the court ruled that an appeal of the denial of a disability claim requiring an inability to engage in any occupation was excused where the claimant had already unsuccessfully appealed the denial of an "own occupation" disability claim. *Also see*, *Oliver v. Coca Cola Co.*, 497 F.3d 1181, 41 EBC 1856 (11th Cir. 2007) (denial of "own occupation" disability benefits excused requirement of exhausting claim for "any occupation" disability benefits which would have commenced at the end of the two year "own occupation" period); *DuPerry v. Life Ins. Co. of North America*, 632 F.3d 860, 50 EBC 1972 (4th Cir. 2011)(same). *But see*, *Stark v. PPB Am. Inc.,* 354 F.3d 666, 31 EBC 2864, 2866-67 (7th Cir. 2004) (futility not applicable even though the company official who discharged the participant would be on the committee considering the participant's claim, since it is hard to imagine that the factors present in the case would not be present in almost all cases). A court also found futility where the plaintiff was permitted an appeal but advised that it was doomed to fail. *Diaz v. United Agric. Employee Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1485 (9th Cir. 1995).

[89] *Henderson v. Bodine Aluminum,* 70 F.3d 958, 19 EBC 2265 (8th Cir. 1995)(medical emergency excused appeal).

[90] *Conley v. Pitney Bowes*, 34 F.3d 714, 18 EBC 2137 (8th Cir. 1994)(no duty to exhaust administrative remedies where, contrary to plan's requirements, initial claim letter failed to notify participant of appeal procedures).

[91] *Burke v. Kodak Retirement Income Plan*, 336 F.3d 103, 30 EBC 2345, 2347-49 (2d Cir. 2003); *cert. denied* 124 S.Ct. 1046, 31 EBC 2759 (U.S. 2004).

[92] Also see, *Gallegos v. UNUM*, 210 F.3d 803, 24 EBC 1677 (7th Cir. 2000)(invitation to appeal deemed precatory; however, once claimant chose to appeal, the claimant was bound by the plan's time limitations).

In *Curry v. Contract Fabricators Inc. Profit Sharing Plan*,[93] the defendant employer's benefit plan had established a facially valid claims procedure that included an appeals process. However, the defendant refused to provide the plaintiff with copies of the plan documents describing what remedies the plan made available and the reasons for denial of his claim. The Eleventh Circuit held that the plaintiff wasn't required to exhaust his administrative remedies, writing, "In this case, CFI controlled the plan's administrative review procedures and exercised its control to deny Curry meaningful access to those procedures. . . . When a plan administrator in control of the available review procedures denies a plaintiff meaningful access to those procedures, the district court has discretion not to require exhaustion."[94]

In some cases, the exhaustion requirement is held not to apply. For example, in a claim brought by a no-fault automobile insurer seeking under federal common law to hold a health benefit plan primarily liable under conflicting coordination of benefit provisions for medical expenses incurred by a car accident victim was not subject to the exhaustion requirement because the insurer was neither a plan insurer nor a plan beneficiary, and rather than being a claim for ERISA plan benefits, the case involved a claim for declaratory judgment and recoupment.[95] In another case, a federal district court found that a plan participant exhausted her plan remedies even though she sent letters to the wrong company officer, since the officer failed to forward the employee's letters to the correct individual or to instruct the employee where to send her requests for severance pay.[96] However, the failure to exhaust plan remedies isn't excused if such failure is due to the negligence of the participant's attorney.[97] Nor is exhaustion excused if the insurer loses the claim file.[98] Exhaustion may be excused based on mental incompetency, however.[99] Also, if only the summary plan description but not the plan itself contains a deadline for an appeal submission, the claimant may be excused from submitting a claim appeal later than the deadline set forth in the SPD.[100]

Failure to Comply With Claims Procedure Regulations

If a plan fails to establish or administer claims procedures in compliance with the DOL regulations, a claimant is deemed to have exhausted the administrative remedies available under the plan and is entitled to pursue any available remedies under ERISA—such as filing suit in federal court—on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.[101]

Although ERISA and DOL regulations require the plan to notify participants in writing of the exhaustion requirement, such notification must be comprehensible and give the participant all the information needed to bring a claim. This includes clear notification of the time limit for seeking administrative review.

In essence, a plan that fails to comply with the mandated claims procedure will lose its right to make the de novo determination regarding the claim.[102] Instead of reviewing the plan administrator's decision with an arbitrary and capricious standard of review, the federal trial court will begin its inquiry with a blank slate, using its own judgment in the place of the administrator's.

Practice Tip: To avoid claims of ineffective notification, plan communications informing participants of adverse determinations should include the following:

- precise language with a detailed and complete rationale setting forth the basis for the administrator's ruling;[103]
- statement of the reasoning behind the decision;
- listing of the exact nature of materials needed by the participant to provide an effective review;

[93] *Curry v. Contract Fabricators Inc. Profit Sharing Plan*, 891 F.2d 842, 11 EBC 2521 (11th Cir. 1990).

[94] *Curry*, 891 F.2d at 846-47.

[95] *Prudential Property & Cas. Ins. Co. v. Delfield Co. Group Health Plan*, 187 F.3d 637, 23 EBC 2220, 2222-23 (6th Cir. 1999).

[96] *Patterson v. J.P. Morgan Chase & Co.*, No. 01 Civ. 7513 (JSM), 27 EBC 1793, 2222-23 (S.D.N.Y. Feb. 11, 2002).

[97] *Gayle v. United Parcel Service, Inc.*, 401 F.3d 222, 34 EBC 1812 (4th Cir. 2005).

[98] *Schorsch v. Reliance Standard Life Ins. Co.*, 693 F.3d 734, 54 EBC 1016 (7th Cir. 2012).

[99] *See*, *Chapman v. ChoiceCare Long Island Term Disability Plan*, 288 F.3d. 506, 27 EBC 2505, 2508-10 (2d Cir. 2002)(participant's mental disorder precluded her from effectively communicating her wishes to her attorneys regarding her desire to appeal a benefits decision; hence, the attorneys' failure to file an appeal on behalf of the participant may be excused under the exhaustion doctrine); *Beasley v. Hartford Life & Accid. Insur. Co.*, No. 4:06CV00034-WRW, 2007 BL 236446 (E.D. Ark. March 29, 2007)(finding that the plaintiff substantially complied with the exhaustion requirement when she verbally attempted to appeal and the insurer was aware she had cognitive problems—the court found it was a breach of fiduciary duty not to consider the appeal).

[100] *Merigan v. Liberty Life Assur. Co. of Boston*, 826 F.Supp.2d 388, 52 EBC 2736 (D. Mass. 2011); *Kaufmann v. Prudential Ins. Co. of America*, 840 F.Supp.2d 495 (D.N.H. 2012).

[101] 29 C.F.R. § 2560.503-1(l).

[102] *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Protection Plan*, 349 F.3d 1098, 31 EBC 2622 (9th Cir. 2003). However, in *Gatti v. Reliance Standard Life Insur. Co.*, 409 F.3d 1061, 35 EBC 1006 (9th Cir. 2005), the Ninth Circuit ruled that only a substantive harm caused by wholesale and flagrant procedural violations would alter the standard of review. Similarly, in *Finley v. Hewlett Packard Co. Employee Benefits Org. Income Protection Plan*, 379 F.3d 1168, 33 EBC 1481 (10th Cir. 2004), the Tenth Circuit ruled that the claimant's failure to provide any meaningful new evidence or raise material issues on appeal will not affect the standard of review regardless of the tardiness of the claim appeal determination. In contrast, in *Kellogg v. Metropolitan Life Ins. Co.*, 549 F.2d 818, 45 EBC 2132 (10th Cir. 2008) the court ruled that a plan's failure to respond to the appeal submitted by the claimant created a deemed exhaustion of administrative remedies and triggered the loss of a deferential review.

[103] Courts will not permit plans to offer new reasons for the claim denial after appeals are exhausted. *See*, *Gallo v. Amoco Corp.*, 102 F.3d 918, 923, 20 EBC 2257 (7th Cir. 1996); *Glista v. Unum Life Insur. Co. of America*, 378 F.3d 113, 129, 33 EBC 1487 (1st Cir. 2004); *University Hosps. of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839, 23 EBC 2689 (6th Cir. 2000).

- specific notice of the time limit for submitting an appeal;
- name and address of office or individuals to whom the appeal should be sent; and
- notice that the participant will lose the right to file a judicial claim on the matter if he or she fails to file a timely appeal.

Standard of Court Review

The watershed case involving ERISA standards of review is the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch*.[104] There, the Supreme Court held that claim decisions would be subject to the de novo standard of judicial review unless the plan provides the plan administrator with appropriate discretionary authority to determine benefit eligibility or to construe plan terms. If the plan grants such authority, a court will not overturn a plan administrator's decision unless the court finds the administrator abused its discretion. [105]

Although there are no "magic words" that must be used in order to reserve discretionary authority, the Seventh Circuit has provided language that would unmistakably demonstrate such an intent: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."[106]

Moreover, courts have rejected calls for application of the abuse of discretion or arbitrary and capricious standard and instead have applied the de novo standard where the plan merely gave a general grant of administrative powers to trustees,[107] where the plan merely bestowed the right to make coverage determinations, but without any discretionary authority,[108] and where the plan's language indicating that the insurer "determines when all of the conditions for total disability are met" was held not to be a sufficiently clear indicator that discretion was reserved to the plan administrator or fiduciary to act as the arbiter for such claims.[109] In addition, the arbitrary and capricious standard of review was rejected by the Third Circuit where, even though the plan specifically gave the plan administrator discretion to make benefit determinations, the administrator failed to exercise its discretion. [110]

There exists a dispute in the federal circuit courts over whether, in the absence of an explicit reservation of discretionary authority, the de novo standard applies to all issues involving benefit denial or only to issues relating to plan interpretation. The Second, Third, Fourth, Seventh, Eighth and Ninth Circuits have ruled that the de novo standard applies to all issues arising when an ERISA claim denial is challenged under ERISA Section 502(a)(1)(B), including issues of fact. [111] However, the Fifth Circuit applies the de novo standard only to issues of plan interpretation, and applies the arbitrary and capricious standard to issues of fact.[112]

In addition, courts have applied a de novo standard where the case involved issues of statutory construction rather than questions of plan interpretation. [113]

Further, even if discretionary language is contained in the plan, in certain states that have rendered such

[104] *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 10 EBC 1873 (1989).

[105] Prior to *Firestone*, courts generally used the "arbitrary and capricious" standard to review ERISA plan benefit denials. In *Firestone*, however, the Supreme Court determined the "de novo" standard was appropriate, except in cases where the plan document grants the administrator discretionary decision-making authority. In such cases, the arbitrary and capricious standard is applied. Although most courts use the terms "arbitrary and capricious" and "abuse of discretion" interchangeably, the Fourth Circuit in *Booth v. Wal-Mart Stores Inc. Assocs. Health & Welfare Plan*, 201 F.3d 335, 24 EBC 2324, 2328 (4th Cir. 2000), held that the two standards were not equivalent and that the arbitrary and capricious standard is more deferential to the fiduciary than is the abuse of discretion standard, and furthermore that application of the arbitrary and capricious standard would be inconsistent with the purposes of ERISA.

[106] *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331, 24 EBC 1083 (7th Cir. 2000). Also see, *Feibusch v. Integrated Device Technology Inc. Employee Benefit Plan*, 463 F.3d 880, 38 EBC 2579 (9th Cir. 2006)(rejecting district court finding that plan language requiring submission of proof satisfactory to insurer denoted discretionary authority); *Kinstler v. First Reliance Standard Life Insurance Co.*, 181 F.3d 243, 23 EBC 1581 (2d Cir. 1999)(same); *Gross v. Sun Life Assur. Co. of Canada*, 734 F.3d 1, 57 EBC 1966 (1st Cir. 2013); *Cosey v. Prudential Ins. Co. of Amer.*, 735 F.3d 161, 56 EBC 2997 (4th Cir. 2013); *Viera v. Life Ins. Co. of North America*, 642 F.3d 407, 51 EBC 2097 (3d Cir. 2011). *But see*, *Prezioso v. Prudential Ins. Co. of America*, 2014 BL 93575, 57 EBC 2449 (8th Cir. April 4, 2014); *Frazier v. Life Ins. Co. of North America*, 725 F.3d 560, 56 EBC 1914 (6th Cir. 2013)(finding plan terms such as a requirement that the claimant submit "satisfactory proof" sufficient to trigger deferential review).

[107] *Luby v. Teamsters Health, Welfare & Pension Trust Funds,* 944 F.2d 1176, 14 EBC 1477, 1483-84 (3d Cir. 1991).

[108] *Tiemeyer v. Community Mut. Ins. Co.*, 8 F.3d 1094, 17 EBC 1489, 1492-93 (6th Cir. 1993), *cert. denied*, 511 U.S. 1005, 114 S. Ct. 1371, 17 EBC 2520 (1994).

[109] *Perugini-Christen v. Homestead Mortgage Co.*, 287 F.3d 624, 27 EBC 2434, 2435-36 (7th Cir. 2002) (rejecting plan administrator's assertion of discretionary authority and application of arbitrary and capricious review standard where the plan required the participant to "submit satisfactory proof of total disability" to administrator);*O'Sullivan v. Prudential Ins. Co. of Am.*, No. 00 Civ. 7915 (KNF), 26 EBC 2023, 2025-26 (S.D.N.Y. June 28, 2001); *contrast Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 381, 28 EBC 1213 (6th Cir. 1996) (finding same language granted plan administrator discretionary authority and thus deferential review).

[110] *Gritzer v. CBS Inc.*, 275 F.3d 291, 27 EBC 1271, 1273-74 (3d Cir. 2002).

[111] *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 23 EBC 1581, 1585-87 (2d Cir. 1999); *Luby v. Teamsters Health, Welfare & Pension Trust Funds,* 944 F.2d 1176, 14 EBC 1477, 1483-84 (3d Cir. 1991); *Reinking v. Philadelphia Am. Life Ins. Co.,* 910 F.2d 1210, 1213-14, 12 EBC 2222 (4th Cir. 1990); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379 n.2, 18 EBC 1186 (7th Cir. 1994); *Riedl v. General Am. Life Ins. Co.*, 248 F.3d 753, 25 EBC 2633 (8th Cir. 2001); *Walker v. American Home Shield Long Term Disability Plan*, 180 F.3d 1065, 23 EBC 1219, 1222-24 (9th Cir. 1999).

[112] *Pierre v. Connecticut Gen. Life Ins./Life Ins. Co. of No. Am.*, 932 F.2d 1552, 14 EBC 1896 (5th Cir. 1991).

[113] *Samaroo v. Samaroo*, 193 F.3d 185, 23 EBC 1761, 1764 (3d Cir. 1999).

clauses unlawful in insured plans, the insurer is stripped of its discretionary powers and the court applies a de novo standard of review. Several courts have upheld state laws prohibiting discretionary clauses, finding that such provisions are exempted from ERISA preemption.[114]

Conflict of Interest

In its *Firestone* ruling, the Supreme Court remarked, "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' "[115] The lower courts were left uncertain, though, as to what the Supreme Court meant by "conflict of interest" or how to take a conflict, if it found one, into consideration. The Third Circuit in *Pinto v. Reliance Standard Life Insurance Co.*,[116] identified three different approaches used by the federal circuits in dealing with a plan administrator's conflict:

- burden shifting,
- de novo review, and
- the sliding scale method.[117]

The Supreme Court resolved the issue in 2008 in *Metropolitan Life Insurance Co. v. Glenn*,[118] which recognized that insurers have an inherent conflict of interest when they serve both as a funding source for the payment of benefits and also determine whether benefits are payable. However, how the conflict is taken into consideration is another matter. The high court determined that no special rules would apply and that even if a conflict exists, the plan administrator would retain discretionary authority. However, the conflict would be given more consideration if it affected the outcome of the case and in situations where insurers had a history of biased claims adjudication or had no safeguards in place to insulate decisionmakers from financial considerations. Less consideration would be given if the decisionmaker is walled off from financial considerations.

Since the issuance of *Glenn*, the lower courts have tried to apply the ruling. The Ninth Circuit, which already had a ruling taking an approach similar to *Glenn*'s in *Abatie v. Alta Health & Life Insur. Co.*,[119] has since issued *Montour v. Hartford Life & Accid. Ins. Co.*,[120] which was critical of a disability insurer's reliance on "pure paper" reviewing doctors and on the insurer's disregard of a favorable Social Security finding. Other courts have found that even plans funded through trusts can be conflicted—*Durakovic v. Building Service 32BJ Pension Fund*.[121] A particular disability insurance company's history of biased claims adjudication was raised in several court rulings.[122] One of the most provocative post-*Glenn* rulings, though, is *Marrs v. Motorola, Inc.*,[123] which deemed *Glenn*'s "combination of factors" approach unworkable and suggested that the conflict be weighed only if the plaintiff is able to show a "likelihood" the conflict, either consciously or subconsciously, affected the claim determination. The law continues to develop on this issue.

Practice Tip: Because the conflict of interest will almost always be present, plan administrators should actively take steps to limit the potential for bias in claim adjudication. This can be accomplished in several ways"

- The individuals who process the claims shouldn't have access to financial information that might bias their analysis; i.e., the size or value of the claim.

- Such personnel shouldn't have their compensation determined based on financial considerations such as number of claims denied or terminated or financial sav-

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[114] *American Council of Life Insurers v. Ross*, 558 F.3d 600, 46 EBC 1385 (6th Cir. 2009); *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 47 EBC 2697 (9th Cir. 2009); *McClenahan v. Metropolitan Life Ins. Co.*, 621 F.Supp. 2d 1135, 46 EBC 2408 (D. Colo. 2009); *Murray v. Anderson Bjornstad Kane Jacobs, Inc.*, No. C10-484RSL, 2011 BL 37253 (W.D. Wash. Feb. 10, 2011); *Landree v. Prudential Ins. Co.*, 833 F.Supp. 2d 1266, 51 EBC 2412 (W.D. Wash. 2011)(upholding Washington ban on discretionary clauses); *Haines v. Reliance Standard Life Ins. Co.*, Docket # 35, (N.D. Ill. Sept. 9, 2010) (holding that Illinois Department of Insurance Bulletin explaining that regulation prohibiting discretionary clauses applied both to newly issued policies as well as renewed policies); *accord Ball v. Standard Ins. Co.*, No. 09 C 3668, 50 EBC 2066 (N.D. Ill. Feb. 23, 2011); *Curtis v. Hartford Life & Acc. Ins. Co.*, No. 1:11-cv-02448, 53 EBC 2109 (N.D. Ill. Jan. 18, 2012)(finding coverage issued and delivered in Illinois); *Zaccone v. Standard Ins. Co.*, No. 1:10-cv-00033, 57 EBC 1478 (N.D. Ill. May 1, 2013); *Schlattman v. United of Omaha Life Ins. Co.*, No. 1:12-cv-07487, 56 EBC 2508 (N.D. Ill. June 19, 2013); *Novak v. Life Ins. Co. of North America*, 956 F. Supp.2d 900 (N.D. Ill. 2013); *Breckenridge v. National Union Fire Ins. Co. of Pittsburgh Pa.*, No. 1:12-cv-11677-TLL-CEB, 54 EBC 1651 (E.D. Mich. Sept. 19, 2012); *Polnicky v. Liberty Life Assur. Co. of Boston*, No. 3:13-cv-01478-SI, 2013 BL 319339 (N.D. Cal. Nov. 18, 2013)(upholding Cal. Insur. Code § 10110.6); *Gonda v. Permanente Medical Group, Inc.*, No. 3:11-cv-01363-SC, 2014 BL 12769 (N.D. Cal. Jan. 16, 2014).

[115] 489 U.S. at 115 (citing Restatement (Second) of Trusts § 187, Comment d (1959)).

[116] *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 277, 24 EBC 1897 (3d Cir. 1999).

[117] *Pinto*, 24 EBC 1897, at 1909.

[118] 554 U.S. 105, 43 EBC 2921 (2008).

[119] 458 F.3d 955, 38 EBC 2262 (9th Cir. 2006).

[120] 582 F.3d 933, 47 EBC 2160 (9th Cir. 2009). In a later ruling, *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666 (9th Cir. 2011), the Ninth Circuit catalogued a number of issues that would lead a court to conclude a plan's decision was unreasonable, although the court acknowledged the task of "weighing" a conflict is metaphysical rather than a topic that can be defined with more definitiveness. The Seventh Circuit took a similar approach in relation to a disability insurer's disregard of a Social Security award in *Raybourne v. CIGNA Life Ins. Co. of N.Y.*, 700 F.3d 1076, 54 EBC 1577 (7th Cir. 2012).

[121] 609 F.3d 133, 49 EBC 1594 (2nd Cir. 2010).

[122] *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126, 45 EBC 1961 (2d Cir. 2008)(focusing on Unum's history of biased claims administration and in its emphasis on evidence supporting a claim denial to overturn Unum's determination); *Chronister v. Unum Life Ins. Co. of America*, 563 F.3d 773, 46 EBC 2389 (8th Cir. 2009)(citing Unum's history as a factor in assessing the claim); *Stephan v. Unum Life Ins. Co.*, 697 F.3d 917, 54 EBC 1887 (9th Cir. 2012)(same).

[123] 577 F.3d 783, 47 EBC 1641 (7th Cir. 2009).

ings. Instead, they should be rewarded only for their accuracy and thoroughness in processing claims.

● Obtain as much independent assessment and evaluation of claims as is possible. Retaining truly independent outside consultants can assure the legitimacy and sustainability of a claim decision, while reliance on biased in-house resources or vendors with a predilection to support claim denials should be avoided.

Scope of Court Review

ERISA cases are resolved under a deferential abuse of discretion standard or a de novo standard in which no deference is given to the claim determination. If a deferential standard of review applies, the court performs the following analysis:

> . . the fiduciary must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.' . . . In reviewing that explanation, we must 'consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.' . . . Normally, [a decision by a plan administrator] would be arbitrary and capricious if the [administrator] relied on factors which Congress had not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it] or is so implausible that it could not be ascribed to a difference in view or the product of [its] expertise.[124]

Another formulation of the same point is the view expressed by the Seventh Circuit which finds:

> a plan administrator's decision should not be overturned as long as (1) "it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome," (2) the decision "is based on a reasonable explanation of relevant plan documents," or (3) the administrator "has based its decision on a consideration of the relevant factors that encompass the important aspects of the problem." Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund, 900 F.2d 1138, 1142-43 (7th Cir. 1990) (citations omitted). Nevertheless, "[d]eferential review is not no review," and "deference need not be abject." Gallo v. Amoco Corp., 102 F.3d 918, 922 (7th Cir. 1996). In some cases, the plain language or structure of the plan or simple common sense will require the court to pronounce an administrator's determination arbitrary and capricious. Id.[125]

The Sixth Circuit has consistently required consideration of both the quality and quantity of the evidence presented and whether the plan administrator engaged in a "principled, deliberative reasoning process."[126] However the standard is phrased, though, the process doesn't involve weighing competing opinions; and so long as the determination has rational support in the evidence, the determination will be upheld according to multiple rulings.[127]

Most courts decide ERISA cases based solely on the claim record assembled prior to suit being filed, particularly if the claim is adjudicated under the deferential abuse of discretion standard of review.[128] However, if the case is decided under the de novo standard, the Seventh Circuit has held that the court should hold a trial.[129] Other circuits take a differing view and main-

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[124] *Motor Vehicle Manufacturers Assn. of the United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

[125] *Hess v. Hartford Life & Acc. Ins. Co.*, 274 F.3d 456, 461, 27 EBC 1205 (7th Cir. 2001)(finding denial of disability benefits arbitrary and capricious). Hess is also notable for pointing out "the fact that an administrator blatantly disregards an applicant's submissions can be evidence of arbitrary and capricious action." 274 F.3d at 463. The Seventh Circuit further clarified that standard in *Holmstrom v. Metro. Life Ins. Co.*, 615 F.3d 758, 766 n.5, 49 EBC 1954 (7th Cir. 2010), which explained:

> Beginning with *Fuller v. CBT Corp.*, 905 F.2d 1055 (7th Cir. 1990), we have sometimes described the arbitrary-and-capricious test as whether the administrator's decision was "downright unreasonable." Attorneys for ERISA plan administrators are fond of quoting this colloquial phrase in their briefs to this court and to district courts within the circuit. The phrase should not be understood as requiring a plaintiff to show that only a person who had lost complete touch with reality would have denied benefits. Rather, the phrase is merely a shorthand expression for a vast body of law applying the arbitrary-and-capricious standard in ways that include focus on procedural regularity, substantive merit, and faithful execution of fiduciary duties.

[126] *DeLisle v. Sun Life Assur. Co of Canada*, 558 F.3d 440, 46 EBC 1301 (6th Cir. 2009); *Schwalm v. Guardian Life Ins. Co. of America*, 626 F.3d 299 (6th Cir. 2010) (finding adverse determination supported by substantial evidence).

[127] *See, e.g., O'Hara v. National Union Fire Ins.*, 642 F.3d 110, 51 EBC 1097 (2nd Cir. 2011)(overturning district court finding for plaintiff); *Green v. Union Security Ins. Co.*, 646 F.3d 1042, 51 EBC 2175 (8th Cir. 2011)(overturning decision for plaintiff after finding that surveillance and other medical evidence reasonably supported insurer's determination).

[128] *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 23 EBC 2177 (7th Cir. 1999); *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017, 16 EBC 2625 (4th Cir. 1993); *see also Ferrari v. TIAA*, 278 F.3d 801, 27 EBC 1668 (8th Cir. 2002). According to *Quesinberry*, only exceptional circumstances in claims that receive a de novo review by the district court will justify receipt of additional evidence. The court catalogued those circumstances to include the following:

> claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.

987 F.2d at 1027. *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 28 EBC 1369 (10th Cir. 1996)(collects cases on whether, and under what circumstances, additional evidence may be submitted in court); *also see*, *Hall v. UNUM*, 300 F.3d 1197, 28 EBC 2441 (10th Cir. 2002); *Orndorf v. Paul Revere Life Insur. Co.*, 404 F.3d 510, 35 EBC 1785 (1st Cir. 2005)(no extra-record evidence admissible except to show bias; no trial allowed).

[129] Beginning with *Diaz v. Prudential Ins. Co. of America*, 499 F.3d 640, 41 EBC 1960 (7th Cir. 2007), the Seventh Circuit held

tain that even under the de novo standard, the court limits its review to the so-called "administrative record," and considers extra-record evidence only under extraordinary circumstances.[130]

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that under the de novo standard, the court doesn't review anything; the court's job is to consider all the evidence. Subsequently, in *Krolnik v. Prudential Ins. Co.*, 570 F.3d 841, 844, 47 EBC 1251 (7th Cir. 2009), the Seventh Circuit reiterated that "it would be best for judges and lawyers to stop thinking about 'de novo review'--with the implication that the judge is 'reviewing' someone else's action--and start thinking about independent decision, which is what Firestone requires."

[130] *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 35 EBC 1785 (1st Cir. 2005); *Jewell v. Life Ins. Co. of North America*, 508 F.3d 1303 (10th Cir. 2007); *Williams v. Metropolitan Life Ins. Co.*, 609, 609 F.3d 622, 49 EBC 1632 (4th Cir. 2010) (de novo review is "based solely on the existing administrative record"). The Ninth Circuit permits consideration of extra-record evidence but only if it is necessary for an informed review. *Mongeluzo v. Baxter Travenol*, 46 F.3d 938, 18 EBC 2771 (9th Cir. 1995); *Opeta v. Northwest Airlines Pension Plan*, 484 F.3d 1211, 40 EBC 2361 (9th Cir. 2007).