American Bar Association

ERISA Litigation Seminar

Benefit Claims Litigation: Claims Standard of Review and Evidence

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STANDARD OF REVIEW

In many benefit claims cases governed by the ERISA statute, the most significant issue faced by the parties, which may very well determine the outcome of the litigation, will be the standard of review applied by the court. *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 109 S.Ct. 948 (1989) teaches that both insured and self-funded plans are subject to a default plenary or *de novo* standard of review; however, a deferential standard of review may be triggered by the incorporation of language in the plan or insurance policy reserving discretion to determine claims and to interpret policy terms.

The first question to ask is whether the governing plan instrument has even authorized the plan administrator's discretion. For example, in *Fitts v. Federal National Mortgage Assn.,* 236 F.3d 1 (D.C.Cir. 2000), the court ruled that since the governing plan document failed to delegate discretionary authority to the plan's disability insurer, the plenary standard of review applies. The same conclusions were reached in *Nelson v. E&G Energy Measurements Group, Inc.,* 37 F.3d 1384 (9th Cir. 1998) and in *Sanford v. Harvard Industries,* 262 F.3d 590 (6th Cir. 2001), both of which ruled that a benefit decision made by a party not explicitly clothed with discretion to determine benefits eligibility is reviewed *de novo. Also see, McKeehan v. CIGNA Life Ins. Co.,* 344 F.3d 789 (8th Cir. 2003); *Anderson v. Unum Life Insur.Co. of America,* 2006 U.S.Dist.LEXIS 8224 (M.D.Ala. 2/13/2006). However, in *Butts v. Continental Casualty Co.,* 357 F.3d 835 (8th Cir. 2004), the court granted discretion even when it was not clear that it had been delegated to an insurer. On a related issue, in *Spanos v. TJX Companies, Inc.,* 2002 U.S.Dist.LEXIS 17555 (D.Mass. 9/19/02), the court vacated an appeal decision made by the insurer on the ground that the summary plan description identified a different entity to which appeals should be made.

Another important consideration is whether there is a conflict between the plan document and the summary plan description as far as whether discretion has been reserved. The Seventh Circuit has stated that, when a conflict exists between the policy and a summary plan description, the terms of the policy control. *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703, 711 (7th Cir. 1999), *cert. denied*, 528 U.S. 1136, 120 S. Ct. 979 (2000). Hence, when an SPD invokes discretionary language while the plan itself is silent on the matter, the conflict may result in a denial of discretion. *Schwartz v. Prudential Ins. Co. of America,* 450 F.3d 697 (7th Cir. 2006); *Sperandeo v. Lorillard Tobacco Co., Inc.,* 460 F.3d 866 (7th Cir. 2006); *Shaw v. Connecticut General Life Ins. Co.,* 353 F.3d 1276 (11th Cir. 2003); *Reinertsen v. The Paul Revere Life Ins. Co.*, 127 F. Supp. 1021, 1030 (N.D. Ill. 2001). *Also see, Flood v. Long Term Disability Plan for First Data Corp.,* 2002 U.S.Dist.LEXIS 18183 (N.D.Ill. 9/27/02); *Billings v. Continental Casualty,* 2003 U.S.Dist.LEXIS 796 (N.D.Ill. 1/21/03); *Bolden v. Unum Life Ins. Co. of America,* 2003 U.S.Dist.LEXIS 3288 (N.D.Ill. 3/4/03)(language in "certificate" but not in policy; therefore, no discretion allowed); *Paulson v. Paul Revere Life Insur.Co.,* 323 F.Supp.2d 919 (S.D.Iowa 2004)(same); *Wolff v. Continental Casualty Co.,* 2004 U.S.Dist.LEXIS 24643

(N.D.Ill. 9/28/2004)(discretionary language in certificate insufficient); *Mullaly v. Boise Cascade Corp. Long Term Disability Plan,* 2005 U.S.Dist.LEXIS 387 (N.D.Ill. 1/11/2005)(same); *Akhtar v. Continental Casualty Co.,* 2002 U.S.Dist.LEXIS 5393 (N.D.Ill) (discretionary language in SPD insufficient). Finally, *Carter v. General Electric,* 2001 U.S.Dist.LEXIS 1724, 26 EBC 1166 (N.D.Ill.) explains:

> unless the Plan affirmatively grants discretion, the default rule of *de novo* review applies, even if the SPD provides otherwise. *See, e.g., Reinertsen v. Paul Revere Life Ins. Co*., 127 F.Supp.2d 1021, 2001 U.S.Dist.LEXIS 331, 2001 WL 40796 at *6-8 (N.D. Ill. 2001); *Clark v. Bank of New York,* 801 F. Supp. 1182, 1190 (S.D.N.Y. 1992). This makes sense because it is the Plan, not the SPD, that forms the contract between the administrator and the beneficiary. *See Herzberger,* 205 F.3d at 330) **14-*15.

Also see, *Olson v. Comfort Systems USA Short Term Disability Plan,* 407 F. Supp. 2d 995 (W.D.Wisc. 12/30/2005); *contra Ruiz v. Continental Casualty Co.,* 2005 U.S.App.LEXIS 4106 (7th Cir. 2005)(court ruled that language in certificate sufficient to grant discretion); *Sidou v. UnumProvident Corporation,* 2003 U.S.Dist.LEXIS 1937 (D.Me. 2/7/03); *Mizzell v. Paul Revere Insur.Co.,* 278 F. Supp. 2d 1146 (C.D.Cal. 8/25/03); *Wade v. Life Insur.Co. of North America,* 271 F.Supp.2d 307 (D.Maine 2003).

Futher, in Teplick v. Boeing Company Employee Health and Welfare Benefit Plan, 2004 U.S.Dist.LEXIS 8748 (D.Ore. 5/11/2004), the court held that the presence of discretionary language in an administrative services agreement is not enough to justify an arbitrary and capricious standard of review when such language does not exist in the plan itself. Similarly, in Ruttenberg v. United States Life Ins. Co. in the City of New York, 413 F.3d 652 (7th Cir. 2005), the court ruled that discretionary language found in the policy application but not in the policy itself was grounds for imposing a plenary standard of review. Further, in Barham v. Reliance Standard Life Ins. Co., 441 F.3d 581 (8th Cir. 2006), the court ruled that when the insurer certified a policy to the court that failed to contain discretionary language, a later unverified claim that a different policy with discretionary language was the correct plan was unavailing.

Where an entitlement to discretion is claimed, in order to ascertain whether the necessary language has been included in the plan, it is necessary to examine the governing plan documents. For example, in *Perez v. Aetna,* 150 F.3d 550 (6th Cir. 1998), the court found deference may be granted if the plan requires the submission of "satisfactory" proof of claim because such language implies deference to determine whether the evidence is indeed satisfactory. Several recent rulings have challenged that formulation, though. In *Kearney v. Standard Insurance Company,* 175 F.3d 1084 (9th Cir. 1999), the Ninth Circuit ruled *en banc* that merely reciting the claimant must submit "satisfactory" proof is not enough—for deference to be granted, the plan must be more specific in

containing language from which it can be determined that a reservation of discretion was intended. The Ninth Circuit also followed up with *Ingram v. Martin Marietta Long-Term Disability Income Plan for Salaried Employees of Transferred GE Operations,* 244 F.3d 1109, 1112-13 (9th Cir.2001). ("An allocation of decision-making authority to MetLife is not, without more, a grant of discretionary authority in making those decisions.") and *Feibusch v. Integrated Device Technology Inc. Employee Benefit Plan,* 463 F.3d 880 (9th Cir. 2006) which reaffirmed the necessity of clear and unambiguous language.

Like the Ninth Circuit, the Second Circuit, in *Kinstler v. First Reliance Standard Life Insurance Company,* 181 F.3d 243 (2d Cir. 1999), ruled the *de novo* standard applies both to plan interpretations and factual determinations in the absence of a specific reservation of discretion. *Kinstler,* which also involved a disability claim brought under ERISA, found that language in the plan requiring the insured to submit proof satisfactory to the insurer, was insufficient to reserve discretion. The court ruled its opinion was "re-enforced . . . by recognition of the relative ease with which ERISA plans may be worded explicitly to reserve to plan administrators the discretionary authority that will insulate all aspects of their decisions from *de novo* review." The court added:

> But a more fundamental point than this fine distinction about wording is that the word 'satisfactory,' whether in the phrase 'satisfactory proof' or the phrase 'proof satisfactory to [the decision-maker]' is an inadequate way to convey the idea that a plan administrator has discretion. Every plan that is administered requires submission of proof that will 'satisfy' the administrator. No plan provides benefits when the administrator thinks that benefits should not be paid! Thus, saying that proof must be satisfactory 'to the administrator' merely states the obvious point that the administrator is the decision-maker, at least in the first instance. Though we reiterate that no one word or phrase must always be used to confer discretionary authority, the administrator's burden to demonstrate insulation from *de novo* review requires either language stating that the award of benefits is within the discretion of the plan administrator or lanaguage that is plainly the functional equivalent of such wording. Since clear language can be readily drafted and included in policies, even in the context of collectively bargained benefit plan when the parties really intend to subject claim denials to judicial review under a deferential standard, courts should require clear language and decline to search in semantic swamps for arguable grants of discretion. 181 F.3d at 252.

The Seventh Circuit has proven to be the most influential on this issue, though. In *Herzberger v. Standard Insurance Co.,* 205 F.3d 327 (7th Cir. 2000), the court reminded litigants that a *de novo* standard of review is the default rule; and in the absence of clearcut language reserving discretion, there can be no deviation from a plenary standard of review. To clarify what language would be

necessary to create a deferential standard of review, the court went to far as to suggest appropriate "safe harbor" language:

> We should do what we can to clarify the rights and duties of the parties to ERISA plans. Judges are quick to say what is prohibited, but perhaps too slow to say what is permitted and by doing so dispel legal risk. We have therefore drafted, and commend to employers, the following "safe harbor" language for inclusion in ERISA plans: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."
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> Equally clearly, the presumption of plenary review is not rebutted by the plan's stating merely that benefits will be paid only if the plan administrator determines they are due, or only if the applicant submits satisfactory proof of his entitlement to them.
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> We hold that the mere fact that a plan requires a determination of eligibility or entitlement by the administrator, or requires proof or satisfactory proof of the applicant's claim, or requires both a determination and proof (or satisfactory proof), does not give the employee adequate notice that the plan administrator is to make a judgment largely insulated from judicial review by reason of being discretionary.
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> An ERISA plan can stipulate for deferential review; it might be entirely rational for an employee to accede to and even prefer such a plan--it might be cheaper. But the stipulation must be clear, and cannot merely be assumed from language that in the closely related setting of insurance contracts has never been thought to entitle the insurer to exercise a discretionary judgment in determining whether to pay an insured's claim. An employer should not be allowed to get credit with its employees for having an ERISA plan that confers solid rights on them and later, when an employee seeks to enforce the right, pull a discretionary judicial review rabbit out of his hat. The employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly. 205 F.3d at 332-333.

Although some question remained after *Herzberger* whether a deferential review is triggered by plan/policy language stating that the insured must submit

proof "satisfactory to us," in *Perugini-Christen v. Homestead Mortgage Co. (Reliance Standard Life Ins. Co.),* 287 F.3d 624 (7th Cir. 2002), the Seventh Circuit clarified its earlier ruling and unequivocally joined the Second and Ninth Circuits in ruling that such language is too ambiguous to reserve discretion and thereby trigger an arbitrary and capricious standard of review. The Seventh Circuit reaffirmed that point and explicitly reversed two earlier cases that left some doubt in *Diaz v. Prudential Ins. Co. of America,* 422 F.3d 635 (7th Cir. 2005); *also see Patton v. MFS/Sun Life Financial Distributors, Inc.,* 480 F.3d 478 (7th Cir. 3/12/2007).

However, the Tenth and First Circuits have adhered to determinations deeming language requiring proof satisfactory to the insurer sufficient to trigger an arbitrary and capricious standard of review. *Nance v. Sun Life Assurance Co. of Canada,* 294 F.3d 1263 (10th Cir. 2002)(requirement of submission of proof satisfactory to named insurer sufficient to trigger deferential standard of review); *Brigham v. Sun Life of Canada,* 317 F.3d 72 (1st Cir. 2003)(same).

Also open to question is whether plan amendments can trigger a deferential standard of review if they occur after a claimant qualifies for benefits. According to *DiGiovanni v. Guardian Life Ins. Co. of America,* 2002 U.S.Dist.LEXIS 12380 (D.Mass. 6/28/02), post-disability amendments that would trigger a deferential standard of review are effective to do so. Likewise, in both *Hackett v. Xerox,* 315 F.3d 771 (7th Cir. 2003) and *Grosz-Salomon v. Paul Revere,* 237 F.3d 1154 (9th Cir. 2001) courts of appeals allowed plan amendments that introduced a reservation of discretion to control since welfare plans are not generally vested and can be amended. To the contrary, both *Gibbs v. CIGNA Corp.,* 440 F.3d 571 (2nd Cir. 2006) and *Filipowicz v. American Stores Benefit Plans Committee,* 56 F.3d 807, 815 (7th Cir. 1995) hold that while welfare benefits may be modified, such changes will not affect a beneficiary whose right to receive benefits has accrued prior to the modification. Other Circuits have reached the same conclusion: *Confer v. Custom Engineering Co.,* 952 F.2d 41 (3d Cir. 1991); *Member Services Life Ins. Co. v. American Natl. Bank & Trust Co. of Sapulpa,* 130 F.3d 950 (10th Cir. 1998); and *Barker v. Ceridian Corp.,* 122 F.3d 628 (8th Cir. 1997). *Also see, Mueller v. CNA Group Life Ins. Co.,* 2004 U.S.Dist.LEXIS 9271 (N.D.Cal. 5/24/2004) where the court ruled the amendment was not properly effected, therefore the earlier plan language which contained no grant of deference controlled; *accord Smith v. Reliance Standard Life Ins. Co.,* 2004 U.S.Dist.LEXIS 11533 (D.Colo. 6/16/2004); *Hartranft v. Hartford Life and Accident Ins. Co.,* 2004 U.S.Dist.LEXIS 21088 (D.Conn. 9/30/2004).

There is currently a proposal before the National Association of Insurance Commissions to prohibit discretionary clauses in disability insurance policies; and the NAIC has promulgated a model law that is slowly gaining acceptance in several states. NAIC, Accident And Health Insurance Consumer Protection - 42-1 Prohibition On The Use Of Discretionary Clauses Model Act. *See, See, e.g.,* 50 Ill.Admin.Code §2001.1, *et seq.* (29 Ill.Reg. 10172 (July 15, 2005)); Me. Rev. Stat. Ann. tit. 24-A § 4303(11); *Letter Opinion per CIC § 12921.9: Discretionary*

Clauses (February 26, 2004), *available at* http://www.insurance.ca.gov/0200-industry/0300-insurers/0200-bulletins/bulletin-notices-commiss-Opinion/upload/Opinion-February-26-2004.pdf (last visited July 11, 2006); Indiana Insurance Bulletin 103 (5/8/01)(health insurance); Hawaii Insurance Commissioner Memorandum 2004-13H (health insurance); Utah Ins. Dept. Bull. 2002-7 (accident and health insurance); State of New York Insurance Department, Circular Letter No. 8 (March 27, 2006).

To date, though, most of the litigation as to whether the opinions of the state insurance regulators are sufficient to bar discretionary clauses has gone in favor of the insurers. *Firestone v. Acuson Corp. Long Term Disability Plan,* 326 F.Supp.2d 1040 (N.D.Cal. 7/2/2004) was the first reported decision ruling that the California action was insufficient to affect policies that had already been approved by the state. Two other rulings concur: In *Hansen v. Unum Life Ins. Co. of America,* 2004 U.S.Dist.LEXIS 22995 (N.D.Cal. 10/21/2004), the court concurred with *Firestone* in holding that it lacked the authority to invalidate a provision of an insurance policy that had been approved for sale by the State of California. The court determined that the California law relating to approval of policies by the Department of Insurance lacked a private cause of action that the plaintiff could enforce. The court also ruled that the ERISA law preempted the plaintiff's claims and that the challenge to the policy approval was not based on a law specifically directed to insurers, but was based on general legal principles. The court explained, "To hold that a statute such as Cal Ins. Code 10291.5(b)(13) 'regulates insurance' would permit the legislature to avoid the broad preemptive force of ERISA merely by codifying any generally applicable law within the Insurance code." *34. In a footnote, however, the court did express the following caveat: "The court does not address whether the state legislature, by statute, or the insurance commissioner, under the authority granted him under the insurance code, may expressly prohibit insurance companies from including discretionary clauses in disability insurance policies sold in this state. The court merely holds that a private action for reformation under § 10291.5(b) is preempted by ERISA." fn.9 at *34. *Also see, Washington v. Standard Ins. Co.,* 2004 U.S.Dist.LEXIS 22975 (N.D.Cal. 7/27/2004). Nonetheless, in *Fenberg v. Cowden Automotive Long Term Disability Plan,* 2004 U.S.Dist.LEXIS 22927 (N.D.Cal. 11/2/2004), the court reached a contrary conclusion, finding that the opinion of the insurance commissioner is saved from ERISA preemption.

Even if the plan contains sufficient language to lead to a deferential standard of review, that standard is not always absolute. In *Firestone Tire & Rubber Co. v. Bruch*, the Court briefly discussed the possibility of a conflict of interest that exists where the plan administrator is also the payor of benefits, holding that such a conflict "must be weighed as a factor in determining whether there is an abuse of discretion." 489 U.S. at 115.

When faced with such a conflict, the Second Circuit applies a two part analysis. In *Sullivan v. LTV Aerospace,* 82 F.3d 1251, 1256 (2d Cir. 1996), the

court held it must first be determined whether the administrator's determination is reasonable. The court must then inquire whether the administrator was influenced by the conflict. If so, the presumption of deference falls away and the court reviews the decision *de novo.*

The Seventh Circuit has expressed varying opinions on the conflict of interest issue. For example, in *Hightshue v. AIG Life Ins. Co.,* 135 F.3d 1144, 1148 (7th Cir. 1998), a disability benefit case involving a claim of disability due to "environmental illness," the court recognized the potential for a conflict of interest, and stated:

> We recognize that AIG has a conflict of interest, because of its interests as both claims administrator and insurer. See, e.g., *Donato [v. Metropolitan Life Insurance Co.]*, 19 F.3d at 379 n. 3. *Firestone* noted that the existence of a conflict of interest must be considered in determining whether the fiduciary acted arbitrarily and capriciously. 489 U.S. at 115, 109 S.Ct. at 956-57. When it is "possible to question the fiduciaries' loyalty, they are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to insure that they act in the best interests of the plan beneficiaries." *Leigh v. Engle*, 727 F.2d 113, 125-26 (7th Cir.1984). Seeking independent expert advice is evidence of a thorough investigation, and provided that the fiduciary has investigated the expert's qualifications, has provided the expert with complete and accurate information, and determined that reliance on the expert's advice is reasonably justified under the circumstances, the fiduciary's decision will be respected, despite the conflict of interest. *Howard v. Shay*, 100 F.3d 1484, 1488 (9th Cir.1996).

A few months later, though, the Seventh Circuit held in *Mers v. Marriott Intern. Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998), a life insurance benefits case, that merely because an insurer is both claim administrator and claim payor, a conflict of interest cannot be presumed. Therefore, absent specific proof of actual bias, the court will not reduce the degree of deference accorded the benefits administration decision. That ruling was later reaffirmed in *Perlman v. Swiss Bank Corporation,* 195 F.3d 975 (7th Cir. 1999), which found there was no reason to suspect partiality; and that actual bias had to be proven. Accord: *Leipzig v. AIG Life Insur.Co.,* 326 F.3d 406 (7th Cir. 2004); *Kobs v. United Wisconsin Insur.Co.,* 400 F.3d 1036 (7th Cir. 2005); *Rud v. Liberty Life Assur.Co.,* 438 F.3d 772 (7th Cir. 2006).

There has been criticism of the Seventh Circuit's approach, however. In *Pinto v. Reliance Standard Life Insurance Company,* 214 F.3d 377 (3d Cir. 2000), the court expressed concern that an insured plan may have greater financial disincentives to pay benefits than a self-insured plan established as a trust. Thus, in such cases, courts should apply a "continuum" or "sliding scale"

that treats a review as "more penetrating the greater the suspicion of partiality [and] less penetrating the smaller the suspicions." *Doe v. Group Hospitalization & Medical Services*, 3 F.3d 80, 86 (4th Cir. 1993); *Chambers v. Family Health Plan Corporation,* 100 F.3d 818 (10th Cir. 1996). Following *Pinto,* in *Glowitz v. Fortis Insur.Co.,* 2004 U.S.Dist.LEXIS 5488 (E.D.Pa. 3/29/2004) the court ruled that an insurer's inherent financial conflict encouraging claim denials, coupled with citation of the wrong definition of disability and the absence of an independent evaluation, mandated heightened scrutiny. Further, in *Kosiba v. Merck & Co.,* 384 F.3d 58 (3d Cir. 2004), the court ruled that in additional financial conflicts, evidence of procedural bias could lower the standard of review. There, the court found a request for a medical examination only after benefits had been terminated when the evidence at the time of termination was all unequivocal in its support for ongoing disability showed a procedural bias.

Yet other courts find such conflicts render the plan's decisions "presumptively void." In *Brown v. Blue Cross and Blue Shield*, 898 F.2d 1556 (11th Cir. 1990); *cert. denied* 498 U.S. 1040 (1991), the court explained the "presumptively void" standard by ruling that in the presence of a substantial conflict of interest,

> the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.

898 F.2d at 1566-67; *also see*, *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995)(court "should not defer to the administrator's presumptively void decision.")(reversed by *Abatie v. Alta Health & Life Insur.Co.,* 458 F.3d 955 (9th Cir. 8/15/06) which held that conflicts must be weighed in all cases) *Denmark v. Liberty Life Assur.Co. of Boston,* 481 F.3d 16 (1st Cir. 2007) (also invites an *en banc* review); Post v. Hartford Ins. Co., 2007 U.S. App. LEXIS 21911 (ed Cir. 9/13/2007)(court reiterated sliding scale approach and examined two types of conflicts: structural and procedural). Also, in *Wible v. Aetna Life Insur.Co.,* 375 F.Supp.2d 956 (C.D.Cal. 2005), the court ruled the insurer's conflict was proven and diminished the standard of review to *de novo* despite discretionary language in the policy); *Kotrosits v. GATX Corp.*, 970 F.2d 1165, 1173 (3d Cir. 1992); *cert. denied* 506 U.S. 1021 (conflict of interest "counsels in favor of withholding deference"); *Shipp v. Provident Life & Accident Insur.Co.,* 214 F. Supp. 2d 1241 (M.D.Ala. 2002)(once decision is shown to be flawed applying *de novo* review, burden shifts to plan administrator to prove decision not result of conflict of interest and benefits entire group of participants and beneficiaries. The ability to offer lower cost insurance is not enough since duty runs to participants, not plan sponsors). The Eleventh Circuit also held that even

the use of a third party administrator will not obviate a conflict if the plan retains control over payment of benefits. *Williams v. BellSouth Telecommunications, Inc.,* 373 F.2d 1132 (11th Cir. 6/16/2004). However, in *Finley v. Hewlett Packard,* 379 F.3d 1168 (10th Cir. 2004), the court ruled that employment of a third party administrator paid on a flat fee basis obviates any potential conflict.

A different approach was taken in *Fought v. Unum Life Insur.Co. of America,* 357 F.3d 1173 (10th Cir. 2004); vacated and replaced by *Fought v. Unum Life Insur.Co. of America,* 379 F.3d 997 (10th Cir. 2004), where the court ruled the conflict of interest required the burden of proof to shift to the insurer to demonstrate, by a preponderance of the evidence, that its decision was reasonable. The Supreme Court has asked the Solicitor General to furnish its views on the conflict of interest doctrine as part of the Court's consideration of *Glenn v. MetLife,* 461 F.3d 660 (6th Cir. 2006) on a petition for certiorari.

At least one court has questioned whether deference is ever appropriate in cases involving factual determinations. In *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991), the court explained:

> Plan administrators are not government agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting or other training preparing them for their responsible position, often without any experience in or understanding of the complex problems arising under ERISA, and, as this case demonstrates, little knowledge of the rules of evidence or legal procedures to assist them in factfinding.

944 F.2d at 1183. The court further justified its position as being consistent with ERISA's goals: "to protect the interests of plan members and their beneficiaries. We believe these interests are better served when plan administrator's factual determinations are accorded no deference, but subject to *de novo* review." *Id.* At 1183-1184. *Ramsey v. Hercules, Inc.,* 77 F.3d 199, 204 (7th Cir. 1996) similarly determined that ERISA claims are not analogous to administrative law claims:

> Crucial differences exist between findings of fact made by a private entity such as a plan administrator, and findings made by duly authorized administrative law judges, agencies, or federal district courts. Underlying the deferential review that fact findings of the latter bodies enjoy is a well established set of procedural protections that stem from the Constitution and individual statutes. Plan administrators, in contrast, neither enjoy the acknowledged expertise that justifies deferential review for agency cases, see Luby, 944 F.3d at 1183, nor are they unbiased fact finders like the courts. Indeed, when the initial decision in an agency lacks the

> crucial procedural safeguards, the Administrative Procedure Act requires the federal courts to review both fact and law *de novo*.

However, neither *Luby* nor *Ramsey* express the position of the majority of courts, which are willing to defer to decisions made by insurers/plan administrators if the appropriate plan/policy language is present.

SCOPE AND NATURE OF REVIEW

The Meaning of the *De Novo* Standard

The Seventh Circuit recently explained the *de novo* standard in *Diaz v. Prudential Ins .Co. of America,* 2007 U.S.App.LEXIS 20067 (7th Cir. 8/23/2007), where the court pointed out,

> The district court's task in engaging in *de novo* consideration of the decision of the plan administrator is not the same as its job in reviewing administrative determinations on the basis of the record the agency compiled under the substantial evidence rule, as it might do in a Social Security benefits case. See *Ramsey v. Hercules Inc.*, 77 F.3d 199, 205 (7th Cir. 1996). Some of the confusion in this area may be attributable to the common phrase " *de novo* review" used in connection with ERISA cases. In fact, in these cases the district courts are not *reviewing* anything; they are making an independent decision about the employee's entitlement to benefits. In the administrative arena, the court normally will be required to defer to the agency's findings of fact; when *de novo* consideration is appropriate in an ERISA case, in contrast, the court can and must come to an independent decision on both the legal and factual issues that form the basis of the claim. What happened before the Plan administrator or ERISA fiduciary is irrelevant. See *Patton v. MFS/Sun Life Financial Distributors, Inc.*, 480 F.3d 478, 485-86 (7th Cir. 2007). That means that the question before the district court was not whether Prudential gave Diaz a full and fair hearing or undertook a selective review of the evidence; rather, it was the ultimate question whether Diaz was entitled to the benefits he sought under the plan. See *Wilczynski v. Kemper Nat. Ins. Companies*, 178 F.3d 933, 934-45 (7th Cir. 1999).

*8-*9 (emphasis in original). Other cases such as *Orndorf v. Paul Revere Life Ins. Co.,* 404 F.3d 510, 518 (1st Cir. 2005) take the position, though, that the *de novo* standard is nonetheless a review proceeding. *Orndorf* explains:

> Some courts have stated that "factual findings" made by the administrative decision maker are reviewed *de novo* and have suggested that this warrants the introduction of new evidence to the trial court, perhaps in the form of an evidentiary hearing or a trial *de*

> *novo*. *See Luby v. Teamsters Health, Welfare, & Pension Trust Funds,* 944 F.2d 1176, 1184-85 (3d Cir. 1991). Where review is properly confined to the administrative record before the ERISA plan administrator, as we explain below is the case here, there are no disputed issues of fact for the court to resolve.
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> Review of the ultimate conclusion of whether the evidence supports the finding of a disability does not itself warrant introduction of new evidence about historical facts. *See Masella v. Blue Cross & Blue Shield, Inc*., 936 F.2d 98, 104 (2d Cir. 1991). Nor does it warrant calling as witnesses those persons whose opinions and diagnosis or expert testimony and reports are in the administrative record. Rather, *de novo* review generally consists of the court's independent weighing of the facts and opinions in that record to determine whether the claimant has met his burden of showing he is disabled within the meaning of the policy. While the court does not ignore facts in the record, *see Recupero v. New Eng. Tel. & Tel. Co.*, 118 F.3d 820, 830 (1st Cir. 1997), the court grants no deference to administrators' opinions or conclusions based on these facts.

The Meaning of "Abuse of Discretion" and "Arbitrary and Capricious"

If a deferential standard of review applies, the court engages in 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.

Motor Vehicle Manufacturers Assn. of the United States, Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43, 103 S.Ct. 2856 (1983).

The Seventh Circuit has rephrased the Supreme Court's formulation as follows:

> 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*.

Hess v. Hartford Life & Acc. Ins. Co., 274 F.3d 456, 461 (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. Likewise, the Sixth Circuit has pointed out in *McDonald v. Western-Southern Life Ins. Co.,* 347 F.3d 161, 172-3 (6th Cir. 2003), that a court's review

> inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan was able to find a single piece of evidence-no matter how obscure or untrustworthy-to support a denial of a claim for ERISA benefits. (citing *Hackett v. Xerox Corp. Long-Term Disability Income Plan,* 315 F.3d 771 (7th Cir. 2003)*, supra.*)

The deferential standard of review also examines a decision to determine if it was reached in good faith. According to *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1566 n.11 (11th Cir. 1990), an ERISA benefit plan fiduciary is required to make

> an honest effort to ascertain the facts upon which its exercise must rest and an honest determination from such ascertained facts. . . If [the fiduciary] knew of matters concerning which honesty would require investigation, and failed to act, or if it knew of matters which would honestly compel a given determination and it announced to the contrary, it cannot, in law be regarded as having exercised good faith, and its action would be arbitrary. Thus, an improper motive sufficient to set aside a fiduciary's decision may be inferred from the fiduciary's failure to investigate or to interpret honestly evidence that greatly preponderates in one direction.

See also, Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 807-808 (10th Cir. 2004) which explained:

> Aetna's position seems to be that as a plan fiduciary, it plays a role like that of a judge in a purely adversarial proceeding, 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 the evidence suggests the possibility of a legitimate claim. The authority just cited suggests that Aetna has the wrong model.
>
> *   *   *
>
> While a fiduciary has a duty to protect the plan's assets against spurious claims, it also has a duty to see that those entitled to benefits receive them. It must consider the interests of deserving beneficiaries as it would its own. An ERISA fiduciary presented with a claim that a little more evidence may prove valid should seek to get to the truth of the matter. *See Toland*, 499 F. Supp. at 1193 (relying on analogous principles governing judicial review of administrative agency decisions).

Another example of what constitutes an abuse of discretion is where an ERISA plan administrator makes a decision that "conflicts with the plain language of the plan." *Saffle v. Sierra Pacific Power Company,* 85 F.3d 455, 458 (9th Cir. 1996)(citing *Taft v. Equitable Life Assurance Soc.*, 9 F.3d 1469, 1472 (9th Cir. 1993)). In *Saffle,* the insurer was held to have abused its discretion by reading into the disability plan a disqualification from receipt of benefits if a "reasonable accommodation" offered by an employer would allow the employee to work. However, if the employee refuses an actual accommodation that had been offered, benefits may be terminated. *Ross v. Indiana State Teacher's Ass'n Ins. Trust,* 159 F.3d 1001 (7th Cir. 1998).

The Ninth Circuit explained the arbitrary and capricious standard of review in *Boyd v. Bert Bell/Pete Rozelle NFL Players Retirement Plan,* 410 F.3d 1173 (9th Cir. 2005) as the equivalent of the clearly erroneous standard of appellate review – requiring a conclusion by the reviewing court "that the entire record leads to a 'definite and firm conviction that a mistake has been committed'" before a benefit denial is overturned. There, the court allowed the plan to rely on one medical opinion even though there were other opinions presented, and held,

> Boyd's claim is not saved by relying on what he characterizes as the medical experts who expressed the opinion that Boyd's disability does arise from his League football activities. An ERISA administrator's exercise of its discretion to adjudicate claims is not a mere exercise in expert poll-taking. We hold that a mere tally of experts is insufficient to demonstrate that an ERISA fiduciary has abused its discretion, for even a single persuasive medical opinion may constitute substantial evidence upon which a plan administrator may rely in adjudicating a claim.

The “Evidence” Reviewed

Most ERISA cases are decided based solely on the claim record made prior to suit being filed. *Quesinberry v. Life Insurance Company of North America,* 987 F.2d 1017 (4th Cir. 1993)(also see: *Ferrari v. TIAA,* 278 F.3d 801 (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 Corporation*, 100 F.3d 818 (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 (10th Cir. 2002). Other cases on this issue include; *Muller v. First Unum Life Insurance Company,* 341 F.3d 119 (2d Cir. 2003)(only unusual circumstances justify reopening claim record following appeals); *Locher v. Unum Life Ins. Co. of America,* 389 F.3d 288 (2d Cir. 2004)(insurer conflict of interest with uncertain claim review process justified receipt of additional evidence). Despite the foregoing, though, in *Kearney v. Standard Insurance Company,* 175 F.3d 1084 (9th Cir. 1999), the Ninth Circuit ruled that in cases reviewed under the *de novo* standard, it would be within the court’s discretion as to whether it would allow admission of additional evidence. In *Shipp v. Provident Life & Accident Ins. Co.,* 214 F. Supp. 2d 1241 (M.D.Ala. 2002), the court also allowed introduction of an expert’s affidavit under a heightened arbitrary and capricious standard of review in order to help the court understand a complex vocational issue. *Also see, Paese v. Hartford Life and Accident Ins. Co.,* 2004 U.S.Dist.LEXIS 6040 (S.D.N.Y. 4/9/2004)(court found “good cause” for the admission of report of independent medical examination outside the claim record in cases where the plan administrator is not “disinterested.”); *aff’d Paese v. Hartford Life and Accident Ins. Co.,* 449 F.3d 435 (2nd Cir. 2006). However, in *Opeta v. Northwest Airlines Pension Plan for Contract Employees,* 484 F.3d 1211 (9th Cir. 2007), the Ninth Circuit ruled that the district court erred in admitting evidence outside the claim record which was used to surprise a witness.

Even after appeals have been exhausted, additional evidence may be submitted. According to *Vega v. National Life Ins.Servs.,* 188 F.3d 287, 300 (5th Cir. 1999), evidence can be submitted at any time up to the date a lawsuit is filed. *Also see, Shannon v. Jack Eckerd Corp.,* 113 F.3d 208 (11th Cir. 1997); *Bucci v. Blue Cross-Blue Shield of Conn.,* 764 F.Supp. 728 (D.Conn. 1991); *Worford v. Monarch Dental Associates, L.P.,* 2007 U.S.Dist.LEXIS 20029 (N.D.Tex. 3/21/2007)(following *Vega*); *Carrington v. Hartford Life & Acc. Ins. Co.,* 2007 U.S.Dist.LEXIS 55623 (E.D.La. 7/27/2007)(same); *Abate v. Hartford,* 471 F.Supp.2d 724 (E.D.Tex. 2006)(same). Also, according to *Russo v. Hartford Life and Accident Insur.Co.,* 2002 U.S. Dist. Lexis 26566 (S.D.Cal.), the insurer cannot close the record to the insured but keep it open for itself (citing *Killian v. Healthsource Provident Administrators, Inc.,* 152 F.3d 514 (6th Cir. 1998)) The court also required the insurer to share with the claimant any information developed during the course of claim administration.

In a variation on this issue, in *Neiheisel v. AK Steel Corporation,* 2005 U.S.Dist.LEXIS 4639 (S.D. Ohio 2/17/2005), the court found the plan had no authority to conduct an examination during appeal – the plan was permitted only to consult with a health care professional). *Sidou v. Unum Provident Corp.,* 245 F.Supp.2d 207, 216 (D.Me. 2003) similarly ruled, "any relative utility in conducting an examination should have been apparent to [the insurer well before the denial]" and finding that it is "simply unreasonable" to request an examination following the denial. *Further, see Reipsa v. Metropolitan Life Insur.Co.,* 2002 U.S. Dist. LEXIS 13188 (N.D.Ill. 2002)(good faith requires the insurer, which must act as a fiduciary, to review additional material evidence-failure to do so requires remand); *Jones v. Reliance Standard Life Insur.Co.,* 2003 U.S.Dist.LEXIS 12713 (N.D.Ill. 7/24/03)(insurer required to consider evidence from Social Security record even after appeals exhausted); *Sloan v. Hartford Life and Accident Ins.Co.,* 475 F.3d 999 (8th Cir. 2007)(court ruled that admission of social security decision and evidence from that proceeding proper when hearing held after conclusion of all pre-suit appeals and good cause justified admitting evidence); *Harden v. American Express Financial Corp.,* 384 F.3d 498 (8th Cir. 2004)(misleading insured that believe that insurer was obtaining Social Security claim records justified a remand). *Also see, Schlegel v. Life Ins. Co. of North America,* 2003 U.S.Dist.LEXIS 10811 (E.D.Pa. 6/9/03). However, *Nance v. Sun Life Assurance Co. of Canada,* 293 F.3d 1263 (10th Cir. 7/2/2002), held that later submitted evidence would not be considered. *Accord, Alford v. DCH Foundation Group Long-Term Disability Plan,* 311 F.3d 955 (9th Cir. 2002); *Pelletier v. Reliance Standard Life Insur.Co.,* 2002 U.S.Dist.LEXIS 18443 (D.Me. 9/27/02); *Kazenas v. Oracle Corporation's Long Term Disability Plan,* 2004 U.S.Dist.LEXIS 4806 (N.D.Ill. 3/24/2004).

Discovery

As a result of limited scope of review, discovery in ERISA litigation is often significantly restricted by the courts. Because the only evidence being reviewed in most ERISA claims is the claim record, courts find no reason to allow

discovery except on the issue of whether the insurer is acting under a conflict of interest. *Tremain v. Bell Industries,* 196 F.3d 970 (9th Cir. 1999); *Calvert v. Firstar Finance, Inc.,* 409 F.3d 286 (6th Cir. 2004)(court encouraged discovery on bias). *Sheehan v. Metropolitan Life Ins. Co.,* 2002 U.S.Dist.LEXIS 11789 (S.D.N.Y. 6/28/2002); *Waggener v. Unum Life Insur.Co. of America,* 2002 U.S.Dist.LEXIS 22697 (S.D.Cal. 11/6/02)(In both *Sheehan* and *Waggener* the court did allow significant discovery relating to conflict of interest). *Also see, Medford v. Metropolitan Life Ins. Co.,* 2003 U.S.Dist.LEXIS 2288 (D.Nev. 2/10/03); *Galm v. Eaton Corp.,* 360 F.Supp.2d 978 (N.D.Iowa 3/1/2005); *Pulliam v. Continental Casualty Co.,* 2003 U.S.Dist.LEXIS 10010 (D.D.C. 1/24/03)(discovery allowed as to incentive based compensation paid to insurance company personnel). *Also see, Woodward v. Reliance Standard Life Ins. Co.,* 2003 U.S.Dist.LEXIS 19206 (N.D.Fla. 3/11/03)(allowing discovery on a variety of topics); *Bennett v. Unum Life Ins. Co. of America,* 321 F.Supp.2d 925 (E.D.Tenn. 2/26/04)(same); *Fish v. Unum Life Ins. Co. of America,* 222 FRD 699 (M.D.Fla. 8/19/2005)(court recognized impropriety of characterizing ERISA cases as appellate review proceedings; discovery allowed to enable plaintiff to challenge the reasonableness of the insurer's decision); *Harris v. J.B. Hunt Transport, Inc.,* 2005 U.S.Dist.LEXIS 41082 (E.D.Texas 12/29/2005)(court allowed discovery relating to conflict of interest and qualifications of consultant); *Nagele v. Electronic Data Sys. Corp.,* 193 F.R.D. 94 (W.D.N.Y. 2000)(wide-ranging discussion on inappropriateness of denying discovery in ERISA cases); *Jacobs v. Xerox Corp. Long Term Disability Income Plan,* 2004 U.S.Dist.LEXIS 4355 (N.D.Ill. 3/19/2004)(discovery allowed on claims separate and apart from underlying benefit claim); *Semien v. Life Ins. Co. of North America,* 2004 U.S.Dist.LEXIS 6759 (N.D.Ill. 4/20/2004)(same), *aff'd* 436 F.3d 805 (7th Cir. 2006); *Brown v. Hartford Life and Accident Ins. Co.,* 2004 U.S.Dist.LEXIS 5059 (N.D.Cal. 1/16/2004)(no discovery allowed even as to potential conflict of interest); *Stanley v. Metropolitan Life Ins. Co.,* 312 F.Supp.2d 786 (E.D.Va. 1/29/2004)(same).

The ERISA claim regulations allow the claimant access to any instruments under which the plan is administered. In accordance with that ruling, although *Cohen v. Metropolitan Life Ins. Co.,* 2003 U.S.Dist.LEXIS 4468 (S.D.N.Y. 3/26/03) allowed discovery of an insurer's "best practices" manual, it was required to be produced under a confidentiality restriction. However, in *Palmiotti v. Metropolitan Life Ins. Co.,* 2005 U.S.Dist.LEXIS 3626 (S.D.N.Y. 3/9/2005), the court required production of a claim manual without confidentiality restrictions in compliance with the ERISA claim regulations (rev'd - *Palmiotti v. Metropolitan Life Ins. Co.,* 2006 U.S.Dist.LEXIS 8031 (S.D.N.Y. 3/2/2006)(court ordered protective order to retain confidentiality). *But see, Levy v. INA Life Ins. Co. of N.Y.,* 2006 U.S.Dist.LEXIS 83060 (S.D.N.Y. 11/14/2006)(ordering production without a protective order). In *Cannon v. Unum Life Ins. Co. of America,* 219 F.R.D. 211 (D.Me. 1/23/2004), though, the court went even further in allowing discovery as to oral communications between the claim handlers, as well as discovery as to internal policies and guidelines relating to how the mental and

nervous limitation in the insurance policy is applied as to claims involving dementia.

In *Patton v. MFS/Sun Life Financial Distributors, Inc.,* 480 F.3d 478 (7th Cir. 3/12/2007), the court also allowed discovery to explain inconsistencies in the evidence.

Moreover, in the Seventh Circuit, according to *Perlman v. Swiss Bank Corp.,* 195 F.3d 975 (7th Cir. 1999), discovery is disallowed on most issues, although the court held

> discovery may be appropriate to investigate a claim that the plan's administrator did not do what it said it did--that, for example, the application was thrown in the trash rather than evaluated on the merits. But when there can be no doubt that the application was given a genuine evaluation, judicial review is limited to the evidence that was submitted in support of the application for benefits, and the mental processes of the plan's administrator are not legitimate grounds of inquiry any more than they would be if the decision maker were an administrative agency. 195 F.3d at 982.

The court's ruling on generally disallowing discovery may have been based on a crucial error, though, which was pointed out in a later decision, *Herzberger v. Standard Insurance Co.,* 205 F.3d 327 (7th Cir. 2000). In *Herzberger,* the court noted, "What may have misled courts in some cases is the analogy between judicial review of an ERISA plan administrator's decision to deny disability benefits and judicial review of the denial of such benefits by the Social Security Administration." 205 F.3d at 332. *Herzberger* explained that Social Security and ERISA cases are not analogous because:

> The Social Security Administration is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by plan administrators. *Id.*

See also, M. Casciari, "'Similarly Situated' Discovery in ERISA Section 502(a)(1)(B) Benefit Denial Cases Decided Under The Arbitrary and Capricious Standard of Review," Benefits Law Journal (Winter 2004).

The general rule limiting discovery to matters within the administrative record raises a question under Fed. R. Civ. P. 26(a)(1)(E)(i), which exempts from Rule 26's initial disclosure requirement all actions for review on an administrative record. Unfortunately, there is almost no authority applying this rule to ERISA matters, and in a number of reported cases, the parties exchanged initial disclosures in denial of benefits cases without dispute before moving on to more

significant matters. Only one case discusses the rule in the ERISA context, and then almost as an aside. In *Crume v. Metropolitan Life Insurance*, 388 F.Supp.2d 1342 (M.D. Fla. 2005), the plaintiff sought to depose the employee who made the decision to deny her benefits after her administrative appeal. The defendant objected, arguing that the Court's review of the denial decision should be limited to the administrative record and noting that Fed. R. Civ. P. 26(a)(1)(e)(i) similarly exempts actions on an administrative record from the requirements of initial disclosures. The Court declined to treat ERISA matters in the same way as other matters reviewed on the administrative record, such as social security appeals. In doing so, it explained that in a social security matter, the decision to be reviewed is from a trained and neutral administrative law judge. In an ERISA action over a denial of benefits, the protections of an agency proceeding are not present. Therefore, the court held that the plaintiff should be allowed to explore whether the defendant had a reasonable basis for its decision, and it allowed the deposition to go forward.

Under the *de novo* standard, *Burns v. American United Life Ins. Co.,* 2006 U.S.Dist.LEXIS 20096 (S.D.Ill. 4/17/2006) approved of discovery, although it also ruled that discovery on bias or conflict would be irrelevant if the *de novo* standard applied. *Also see, Marantz v. Permanent Medical Group Inc. Long Term Disability Plan,* 2006 U.S.Dist.LEXIS 87258 (N.D.Ill. 11/29/2006) and *Patton v. MFS/Sun Life Financial Distributors, Inc.,* 480 F.3d 478 (7th Cir. 2007)(discovery allowed under *de novo* review to clarify discrepancy in evidence).

Rule 52 Versus Summary Judgment

Although many ERISA cases are resolved on summary judgment, for cases brought under the *de novo* standard, the growing trend is to utilize Rule 52 of the Federal Rules of Civil Procedure for the entry of findings of fact and conclusions of law based on the court's review of the claim file and consideration and weighing of the evidence. This procedure was recommended in *Kearney v. Standard Insurance Co.,* 175 F.3d 1084 (9th Cir. 1999) and *Wilkins v. Baptist Healthcare Sys. Inc.,* 150 F.3d 609 (6th Cir. 1998), and other courts have followed suit. The Seventh Circuit, in *Hess v. Hartford,* 274 F.3d 456 (7th Cir. 2001); and in *LaBarge v. Life Insurance Company of North America,* 2001 WL 109527 (N.D.Ill. 2001), also approved conducting a "paper trial" and entering findings of fact and conclusions of law. Likewise, the Second Circuit also approves of such a procedure. *Muller v. First Unum Life Insurance Company,* 341 F.3d 119 (2d Cir. 2003).

However, in the absence of clear case law directing lower courts to apply such a procedure, without the parties' stipulation to a paper trial, summary judgment is improper when the evidence is in conflict. *Shaw v. Connecticut General Life Ins. Co.,* 353 F.3d 1276 (11th Cir. 12/19/03); *Coles v. LaSalle Partners Inc. Disability Plan,* 2003 U.S.Dist.LEXIS 18731 (N.D.Ill. 10/20/03); also see *Crespo v. Unum Life Ins. Co. of America,* 294 F. Supp. 2d 980 (N.D.Ill. 12/18/03).

Jury Trials

Under the present state of the law, the courts have held that the ERISA statute's silence regarding the availability of jury trials precludes the right to trial by jury. The reasoning of the courts is that ERISA claims are equitable in nature, rather than legal; and that many of the issues require a judge's determination, such as whether the plan administrator's decision was arbitrary and capricious or an abuse of discretion. Among the principal cases on this point are *Wardle v. Central States, Southeast and Southwest Areas Pension Fund*, 627 F.2d 820 (7th Cir. 1983) and *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251 (2d Cir. 1996), which catalogued similar decisions from other circuits and found that a jury trial is inappropriate due to the difficulty a jury would have in interpreting a deferential review standard and because "the presumption of correctness that attaches to a private administrative action here is incompatible with a jury trial scheme." 82 F.3d at 1258. *Also see*, *Thomas v. Oregon Fruit Products Company*, 228 F.3d 991 (9th Cir. 2000); *Geiger v. UNUM Life Ins. Co.,* 2002 U.S.Dist.LEXIS 16209 (N.D.Ohio 8/7/02)(jury trial inappropriate because relief is equitable); *Mathews v. Sears Pension Plan*, 144 F.3d 461, 468 (7th Cir. 1998) ("[T]here is no right to a jury trial in an ERISA case.").

However, *Bona v. Barasch,* 2003 U.S. Dist. LEXIS 4186; 30 Employee Benefits Cas. (BNA) 1874 (3/20/03) found a right to a jury trial for benefit claims based on the Supreme Court's ruling in *Great West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204, 122 S. Ct. 708, 151 L. Ed. 2d 635 (2002) which drew a distinction between "equitable" claims brought pursuant to §502(a)(3) of ERISA and "legal" claims that might be found to exist pursuant to §502(a)(1)(B). The court elaborated:

> Although [*Great-West v. Knudson*] did not deal with the right to a jury trial per se, the Supreme Court's explication of the distinction between law and equity, discussed in detail in Part III, is relevant here as well. As I concluded in Part III, the monetary relief sought by plaintiffs in this case cannot be characterized as equitable relief under *Great-West*. Rather, plaintiffs seek damages from the trustees on behalf of the Employee Benefit Funds. Because they seek money damages rather than an equitable remedy, both Miranda and Individual Plaintiffs are entitled to a jury trial on their ERISA claims. Cf. White v. Martin, 2002 U.S. Dist. LEXIS 6899, 2002 WL 598432, at *4 (D. Minn. Apr. 12, 2002) (concluding that a plaintiff seeking equitable restitution is not entitled to a jury trial in a suit based on section 502(a)(2) but implying that after *Great-West* a plaintiff seeking money damages under ERISA would be entitled to a jury trial). *102-*103.

Also see, Lamberty v. Premier Mill Work and Lumber Co., Inc., 329 F.Supp.2d 737 (E.D.Va. 8/5/2004). Accordingly, the question of whether jury trials are available in long term disability benefit cases remains an open issue since the

cases disallowing jury trials all preceded *Knudson.* Nonetheless, without considering the effect of *Knudson,* several district court rulings persist in denying jury trials: *Dwyer v. Unum Life Ins. Co. of America,* 2003 U.S.Dist.LEXIS 21521 (N.D.Ill. 12/1/03) ruled that there is no right to a jury trial in an ERISA benefit case; *Coburn v. Continental Casualty Co.,* 2003 U.S.Dist.LEXIS 24950 (N.D.Ind. 6/5/2003); and *Allison v. Unum Life Ins. Co.,* 2005 U.S.Dist.LEXIS 3465 (E.D.N.Y. 2/11/2005) Further complicating the issue is the fact that four provisions in ERISA expressly allow "legal" relief: Section 502(g)(2)(E) and Section 4301(a)(1), which allow claims dealing with employer collective bargaining agreements and withdrawal liability obligations to multi-employer benefit plans, and Section 104(a)(5)(C) and Section 4003(e)(1), allowing certain Secretary of Labor and Pension Benefit Guaranty Corporation claims. 29 U.S.C. §§ 1132(g)(2)(E), 1451(a)(1), 1024(a)(5)(C) and 1303(e)(1) (2007). In the context of a very carefully crafted statute, a reasonable inference one can draw from Congress's failure to use the word "legal" in Section 502(a)(1)(B) and its use of that word in four other sections is that Congress did not intend to provide legal relief under Section 502(a)(1)(B). If Section 502(a)(1)(B) does not allow legal relief, then it would not permit a jury trial. It is worth noting, however, that the Seventh Circuit recently held that Section 4003(e)(1), 29 U.S.C. § 1451(a)(1), does not permit a jury trial even though it explicitly refers to "legal" or equitable relief. *McDougall v. Pioneer Ranch Limited Partnership*, No. 06-3757, 2007 WL 2004094 at *3 (7th Cir. July 12, 2007) (relying on *Mathews v. Sears Pension Plan*, 144 F.3d 461, 468 (7th Cir. 1998), the majority said that "the general rule in ERISA cases is that there is no right to a jury trial.").

ERISA Litigation and Due Process

The Supreme Court remarked in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 114 (1989), that benefit claimants should not receive less protection "than they enjoyed before ERISA was enacted." As discussed above, lawsuits over ERISA benefit claims have been transformed by the arbitrary and capricious standard of review into quasi-administrative law proceedings. *See, Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990)(adopting administrative procedures in ERISA litigation and declaring that such claims involve review of a record); *also see* Mark D. DeBofsky, "The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims, 37 J.Marshall L.Rev. 727 (2004)(critical of use of administrative proceedings in ERISA cases).

Despite judicial warnings about the inaptness of such a paradigm due to the absence of procedural protections in ERISA claims, biased decision makers, and the lack of specialized expertise, in a recent ruling, the Seventh Circuit maintained that "ERISA provides a limited Article III review." *Semien v. Life Insurance Co. of North America,* 436 F.3d 805, 813 (7th Cir.), *cert. denied* 166 L.Ed.2d 251 (2006).

Plaintiffs have argued that there may be reasons to doubt the propriety of the current regime. In the first place, Congress authorized the right to bring a

"civil action," not a claim for administrative review. *Chandler v. Roudebush,* 425 U.S. 840 (1976), which involved a claim brought by a federal employee alleging discrimination in employment pursuant to § 717(c) of the Civil Rights Act, reinforces the distinction. Resolving a split in the Circuits as to whether the civil action authorized by that statute was limited to a review of administrative proceedings conducted prior to suit, the Supreme Court ruled, "where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like 'substantial evidence,' which has "become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." 425 U.S. at 862 n.37. Since the term "substantial evidence" cannot be found in the ERISA statute, plaintiffs have challenged ERISA cases as review proceedings.

If one were to assume the appropriateness of an administrative law paradigm, the leading case on the admissibility of evidence in such proceedings raises doubts as to the validity of proceedings which allow reviewing doctors' opinions to be accepted without question. *See, e.g., Davis v. Unum Life Ins. Co. of America,* 444 F.3d 569, 579 (7th Cir.); *cert. denied* 166 L.Ed.2d 147 (2006)("It is enough, in situations such as this, for the doctors to review the file and render a professional, medical opinion."). In *Richardson v. Perales,* 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971), the Supreme Court ruled that Social Security disability claimants' rights to due process are preserved only where an examining doctor's report is presented to an unbiased tribunal and the claimant retains the right to cross-examination. ERISA claims, in contrast, are often resolved based on reports from non-percipient witnesses, and there is no opportunity or right to cross-examination.

The absence of due process protections is a serious concern to plaintiffs. In addition to *Perales, Concrete Pipe and Products of California, Inc. v. Construction Laborers Pension Trust for Southern California,* 508 U.S. 602, 113 S.Ct. 2264, 124 L.Ed.2d 539 (1993), establishes a basis for raising a due process challenge to the manner in which ERISA claims are adjudicated. *Concrete Pipe,* which dealt with the assessment of pension withdrawal liability under the Multiemployer Pension Plan Amendments Act of 1980, 94 Stat. 1208; 29 U.S.C. §1461, resulted in a conclusion that any due process infirmities in the initial assessment of liability were cured by a subsequent plenary adjudication before an arbitrator. However, the Court cited *Withrow* v. *Larkin*, 421 U.S. 35, 58, 43 L. Ed. 2d 712, 95 S. Ct. 1456 (1975) for the proposition that if the initial factual decision "foreclosed fair and effective consideration at a subsequent adversary hearing leading to ultimate decision, a substantial due process question would be raised." The Court focused on the Due Process Clause requirement of an "impartial adjudication in the first instance;" otherwise, the court is to "conduct a *de novo* review of all factual and legal issues." 508 U.S. at 618.

Further, although ERISA claims involve private disputes, which normally would not implicate the Due Process clause of the United States Constitution, the state action requirement for due process challenges may be established by the

statute itself which also creates the property right at issue. Because courts are giving deference to factual adjudications made by insurers or employers, under the principles established in *Logan v. Zimmerman Brush Co.,* 455 U.S. 422, 430 (1982), which ruled that under the Due Process Clause, "[a] claimant has more than an abstract desire or interest in redressing his grievance…," a civil action lacking any meaningful tools upon which to challenge the benefit determination is Constitutionally infirm.

On the other hand, defendants argue that the statute's regulatory scheme does not come into play unless and until, the employer *voluntarily* chooses to establish an ERISA plan, and that this voluntary scheme necessarily limits ERISA remedies. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983). To encourage employers to establish ERISA plans, Congress devised the ERISA statutory scheme to limit remedies associated with fiduciary or other breaches of ERISA standards. The legislative history of ERISA proves this point: "It is axiomatic to anyone who has worked for any time in this area that pension plans cannot be expected to develop if costs are made overly burdensome, particularly for employers who generally foot most of the bill. This would be self-defeating and would be unfavorable rather than helpful to the employees for whose benefit this legislation is designed." H.R. CONF. REP. No. 93-1280 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5167, *and in* 3 LEGISLATIVE HISTORY OF ERISA at 4673 (1976) (statement of Rep. Ullman, Member, House Comm. On Ways and Means). This statutory scheme is more than unique; it is "comprehensive and reticulated," *Nachman v. PBGC*, 446 U.S. 359, 361 (1982), and one with which this Court is "reluctant to tamper." *Russell*, 473 U.S. at 147.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court recognized the importance of limited remedies in the ERISA statutory scheme: "[T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Id.* at 54. Likewise, in *Mertens v. Hewitt Assocs.*, the Court remarked: "ERISA is an enormously complex and detailed statute that resolve[s] innumerable disputes between powerful competing interests – not all in favor of potential plaintiffs." 508 U.S. at 262-63. Congress clearly decided when it enacted ERISA that creating a civil enforcement scheme of specific remedies will serve the greater good of encouraging private sector employers to establish employee benefits plans and to enhance the benefits provided under those plans. Thus, the limited nature of ERISA remedies and attendant procedures does not necessarily mean that the statutory scheme is unfair or constitutionally infirm.