I. REASONABLE CLAIMS PROCEDURE

A. All Employee Benefit Plans Are Required To Have Reasonable Claims Procedures.


2. Every employee benefit plan must

   a) 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;

   b) Afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review of the decision by the appropriate named fiduciary. 29 U.S.C. § 1133.

   c) See Schmookier v. Empire Blue Cross and Blue Shield, 107 F.3d 4 (2nd Cir. 1997) (appeals process need not be provided in insurance contract, rather ERISA requires only “adequate notice” of claim adjudication and a “reasonable opportunity for a full and fair review).

3. The purpose of this administrative process is to reduce the number of frivolous law suits, to provide a non-adversarial framework for claims review, and to reduce the cost of benefit claim disputes. Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980).

B. Minimum Requirements Set Forth In 29 C.F.R. § 2560.503-1.

1. First, the plan’s claim procedure must be “reasonable.”

   a) Claims procedures are reasonable if they (i) are described in the summary plan description; (ii) do not contain unduly burdensome processing procedures; (iii) provide for timely notifying of participants of time limits in which a notice of claim denial must be furnished, time limits for filing a request for review, and time limits applying to decisions on review; and (iv) comply with the standard, for notice of claims denial and for review procedures as outlined in the regulations.
b) If the “reasonable” procedures have been met, a claim is deemed filed.

2. If the claims procedure is not “reasonable” the claim is deemed filed when a communication reasonably calculated to bring the claim to the attention of certain persons or entities specified in the regulations is made by either the claimant or his authorized representative.

3. Notice of claim denial must be clearly written in understandable language, must state specific reasons for the denial, must refer to specific plan provisions, must provide a description of additional material necessary to perfect the claim and must provide appropriate information on how to submit the claim for review. 29 C.F.R. § 2560.503-1 (f).

   a) See White v. Jacobs Engineering Group Long Term Disability Benefit Plan, 896 F.2d 344 (9th Cir. 1989) (when a benefits notice fails to explain the proper steps for appeal, the plans’s time limitation for appeal is not triggered).

4. Notice of claims denial must be furnished within 90 days of receipt of the claim for benefits unless special circumstances require a 90 day extension.

   a) Notice of such extension is required in writing prior to the end of the initial 90 day period, and shall indicate the special circumstances requiring the extension of time and the date by which the plan administrator expects to render a decision.

   b) Failure to comply with this regulation renders the claim denied, and the claimant is permitted to advance to the review stage. 29 C.F.R. §§ 2560.503-1(e) and (f).

5. Employees benefit plans must establish a reasonable procedure for appealing claims to an appropriate fiduciary or designated person in the plan.

   a) At a minimum, plan review procedures must permit a claimant or his representative to: (i) request a review in writing; (ii) review pertinent documents; and (iii) submit issues and comments in writing. 29 C.F.R. § 2560.503-1(g).

   b) The plan may establish a reasonable time by which a claimant must request a review of a denied claim, provided it is not less than 60 days. 29 C.F.R. § 2560.503-1(g). See Sarraf v. Standard Insurance Company 102 F.3d 991 (9th Cir. 1997) (holding that plaintiff’s failure to request in writing review of the Administrator’s adverse decision precludes the instant claims under the ERISA plan); White v. Jacobs Engineering Group Long Term Disability Plan, 896 F.2d 344 (9th Cir. 1989) (holding that a 60 day time to request a review is adequate even if it is only reflected in the SPD, not in the actual plan language).
c) The decision on review should be made “promptly” within 60 days unless special circumstances exist requiring an extension up to 120 days. The decision on review must be in writing, be written to be understood by claimant, refer to specific plan sections, and contain specific reasons for decision. 29 C.F.R. § 2560.503-1 (h).

6. The adequacy of plan denial letters has received considerable attention in the case law.

a) In *Schleibaum v. Kmart Corp.*, 153 F.3d 496, 1998 WL 531381 (7th Cir. 1998), a Section 503 violation occurred when the plan failed to provide a disability claimant with adequate notice of denial. Two consulry letters failed to detail any particular information claimant could submit to provide as additional evidence to perfect the claim. The district court held that plaintiff failed to mitigate damages and awarded plaintiff the amount of premiums that he would have paid for the life insurance benefits. The Seventh Circuit reversed on this point and held that mitigation of damages is not required where there is a violation of Section 503 of ERISA. The court remanded to determine what equitable remedy should be awarded, based upon the following factors: the likelihood that plaintiff had a legitimate disability benefit claim; whether the claim would have been granted but for the violation of Section 503; and whether a procedural error caused a substantive harm.


II. EXHAUSTION OF PLAN REMEDIES

A. No Express ERISA Provision Requires Exhaustion.

1. The civil enforcement provision of ERISA § 502, 29 U.S.C. § 1132 is silent regarding exhaustion of administrative remedies prior to filing suit.

2. Section 503, 29 U.S.C. § 1133, however, requires all welfare and pension plans to have appeal and claims procedures.

3. Section 503, coupled with the regulations, has allowed the courts to infer that Congress intended claimants to exhaust administrative procedures before going to court. See, e.g., *Amato v. Bernard*, 618 F.2d 559 (9th Cir. 1980).

4. The purposes behind exhaustion are: (1) to uphold Congress’ desire that ERISA trustees be responsible for their actions, not the federal courts; (2) to provide a sufficiently clear record of administrative action if litigation should ensue; and (3)
to assure that any judicial review of fiduciary action (or in action) is made under the arbitrary and capricious standard, not de novo. *Dention v. First Nat’l Bank*, 765 F.2d 1295, reh’g denied, 772 F.2d 904, (5th Cir. 1985); see also *Kennedy v. Empire Blue Cross and Blue Shield*, 989 F.2d 588, 594 (2nd Cir. 1993). However, as discussed below, the Supreme Court’s decision in *Firestone Tire and Rubber Company v. Bruch*, 109 S. Ct. 948 (1989), establishes that the arbitrary and capricious standard of review no longer automatically applies in reviewing a denial of benefits.

5. Section 502(a) has been interpreted as only requiring a claimant to exhaust a plan’s claims procedure; thus, exhaustion of specific issues or theories is not necessarily required. See *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182 (3d Cir. 713 F.2d 247 (7th Cir. 1983).

B. Generally, Courts Require Complainants To Exhaust Administrative Remedies As A Prerequisite To Filing Suit For ERISA Benefits.

C. The Circuits Are Divided On Whether A Complainant Must Exhaust Administrative Remedies Prior To Filing Suit For Violations Of Statutory Provisions of ERISA.

1. Exhaustion Required for Statutory Violations

   a) In *Radford v. General Dynamics Corp.*, 151 F.3d 396, (5th Cir. (1998), plaintiff alleged that pursuant to *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996), defendant’s misrepresentations entitled him to a greater pension benefit. The court assumed without deciding that in such a claim for benefits, based upon a breach of fiduciary duty theory, there was a duty to exhaust. The court next held that it applied the three and six year statute of limitations set forth in ERISA Section 413 to a *Varity* claim. Here, plaintiff initially exhausted remedies in 1989 but did not file suit until 1996. The court held that claim was time barred and that the period to sue was not tolled pending the exhaustion of administrative remedies. The court held that because the six year limitations period was a statute of repose, it serves as an absolute barrier to an untimely suit.

   See also: *Powell v. AT&T Communications, Inc.*, 938 F.2d 823 (7th Cir. 1991), *J.W. Counts v. American General Life and Accident Insurance Company*, 111 F.3d 105 (11th Cir. 1997).

2. Exhaustion Not Required for Statutory Violations.

Simmons v. Wilcox, 911 F.2d 1081 (5th Cir. 1990), Held v. Manufacturers Hanover Leasing Corp., 912 F.2d 1197, 1204-05 (10th Cir. 1990).

D. Courts Have Recognized Exceptions To The Exhaustion Requirement.

1. Three exceptions to the exhaustion requirement have been recognized: futility; denial of meaningful access to plan procedures; and irreparable harm.

a) Futility

(1) Cases dealing with futility include: McGraw v. The Prudential Insurance Company of America, 137 F.3d 1253 (10th Cir. 1998) (recognizing that the futility exception is limited to those instances where resort to administrative remedies would be “clearly useless”, but finding the record in the instant case clearly establishing futility in numerous respects); Robyns v. Reliance Standard Life Insurance Company, 130 F.2d 1231 (7th Cir. 1997) (plaintiff waived argument that exhaustion would have been futile by failing to raise it in the court below, however, even assuming it had been properly raised, the record did not show that requiring exhaustion would have been futile); Schmookler v. Empire Blue Cross and Blue Shield, 107 F.3d 4 (2nd Cir. 1997) (applicant failed to raise futility claim in the district court and thus waived it on appeal); Salus v. GTE Directories Service Corp., 104 F.3d 131, 138 (7th Cir. 1997) (district court’s finding that exhaustion of remedies would have been futile was upheld as such a decision is within the discretion of the trial court and will not be disturbed absent a clear abuse of discretion, i.e., lower court’s decision was “obviously in error”).

b) Denial of meaningful access to plan procedures

(1) Cases dealing with denial of meaningful access to plan procedures include: Atwood v. Newmont Gold Co., 45 F.3d 1317, 1325 (9th Cir. 1995) (rejecting plaintiff’s complaints of plan’s impermissible short time to file an appeal and plan’s failure to state plaintiff could submit evidence to challenge the denial, because plaintiff suffered no substantive harm and showed no substantive violation of ERISA); McKenzie v. Gen. Tel. Co., 41 F.3d 1310 (9th Cir. 1994), cert. denied, 115 S. Ct. 1697 (1995) (failure to provide disability plan claimant with SPD may be procedural violation, but it resulted in no substantive harm because plaintiff knew disability standards from correspondence with defendants); Conley v. Pitney Bowes, 34 F.3d 714 (8th Cir. 1994) (when, contrary to the requirements of the plan, the initial claim denial letter does
not inform the participants of appeal procedures, participant has no duty to exhaust plan’s administrative remedies).

E. Should A Reviewing Court Consider Evidence Not Presented To The Plan Administrator During The Administrative Process? Remand To Plan Administrator Found Appropriate.

1. In *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388 (5th Cir. 1998), the plan denied accident death and dismemberment benefits, relying upon evidence that decedent failed to enroll in the plan. During litigation, the plan advanced another reason to deny benefits, *i.e.*, decedent died because of a self-inflicted injury, that had not been subject to administrative review. The court held that the plan had not waived the opportunity to exhaust administrative remedies with respect to the issue of self-inflicted injury and remanded the matter to the plan administrator for additional development of a full factual record. The court summarized the rationale for claims and its regulations have been followed faithfully is a benefits decision that is thoroughly informed by the relevant facts and the terms of the plan and, if benefits are denied, includes an explanation of the denial that is adequate to insure meaningful review of that denial.” 147 F.3d at 395.

2. See also: *Massachusetts Casualty Insurance Company v. Reynolds*, 113 F.3d 1450 (6th Cir. 1997).

F. Should A Reviewing Court Consider Evidence Not Presented To The Plan Administrator During the Administrative Process? Evidence Not Presented To The Administrator Cannot Be Considered.

1. In *Brown V. Seitz Foods, Inc. Disability Benefit Plan*, 140 F.3d 1198 (8th Cir. 1998), the court conducted de novo review of the claim for disability benefits. During trial, plaintiff offered evidence not previously considered by the plan administrator. The court held that the district judge abused his discretion by admitting the evidence: “Having failed to take advantage of the opportunity to supplement the record for the Appeals Committee, or to explain this failure to do so, Brown’s offer of additional evidence outside the administrative record is nothing more than a last-grasp attempt to quarrel with [Continental’s] determination.” 140 F.3d at 1201.


G. Evidence not presented to the administrator can be considered.

1. In *Vega v. National Life Ins. Servs., Inc.* 145 F.3d 673 (5th Cir. 1998), the insurer denied a benefit claim for surgery because of an alleged falsification on the insurance
application concerning plaintiff’s pre-existing condition. The court reversed summary judgment for the insurer. In the lower court, the district judge refused to admit into evidence affidavits from physicians because the evidence was not made available to the plan administrator. The court held that the administrator was acting under the conflict of interest. In such situations the court opined the district judge must pause before limiting the evidence to that contained in the administrative record. Here because expert testimony was necessary to determine whether the surgery was the result of a pre-existing condition, the district judge erred by limiting the evidence.

See also: Kearney v. Standard Ins. Co., 144 F.3d 597 (9th Cir.), opinion withdrawn, rehearing en banc granted, 1998 WL 555432 (9th Cir. 1998).


III. STANDARD OF REVIEW IN BENEFITS CASES

A. ERISA Does Not Explicitly Contain A Legal Standard or Judicial Review of Benefit Claims Decisions.

B. Firestone Clarified The Appropriate Standard Of Review.

1. In Firestone Tire and Rubber Company v. Bruch, 109 S. Ct. 948 (1989), Firestone sold one of its divisions to Occidental Petroleum. Most employees of that division suffered no employment break and became Occidental employees. At the time of the sale Firestone maintained three “unfunded” pension and welfare benefits plans for its employees: a termination pay plan, a retirement pay plan, and a stock purchase plan.

2. Firestone’s transferred employees filed claims for termination pay, arguing the sale constituted a “reduction in force” within the meaning of the termination pay plan. Firestone denied the claims. The employees also sought information about the plans under ERISA’s disclosure provision, 29 U.S.C. § 1132(a)(1)(b). Firestone did not comply with their request, finding that they were not “participants” entitled to information.

3. The district court granted summary judgment for Firestone, holding the plan administrator did not act in an arbitrary or capricious fashion by denying the employees’ claims for termination pay. The Court also held that Firestone was not required to provide the information requested because plaintiffs were not plan

4. The Third Circuit reversed and remanded, explaining that, although most courts have reviewed the denial of benefits under an arbitrary and capricious standard, when the employer of an “unfunded” plan is both the administrator and fiduciary, a *de novo* standard should apply. Likewise, the court held the right to request and receive information about a ERISA plan extends to all who claim benefits under the plan. See *Bruch v. Firestone Tire and Rubber Company*, 828 F.2d 134 (3rd Cir. 1987).

5. On appeal, the Supreme Court explained that the principles of trust law provide the appropriate standard of review for actions involving ERISA benefits. Applying trust principles, the Court ruled that a deferential standard of review is applicable only where the plan language grants the plan administrator the power to construe uncertain terms or provides that eligibility determinations are to be given deference. Applying a *de novo* standard of review, the Court explained: “Firestone can seek no shelter in these principles of trust law, however, for there is no evidence that under Firestone’s termination pay plan the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference.”

6. The Supreme Court also rejected the Third Circuit’s expansive definition of “participant” in construing who is entitled to receive plan information under 29 U.S.C. § 1132 (a)(1)(b). The Court stated the term “participant” in the statute should be given its natural meaning, that is, an employee in or reasonably expected to be in covered employment. To establish that an employee may become eligible for benefits, the employee must have a colorable claim he will prevail in a suit for benefits or that eligibility requirements will be fulfilled in the future. The Court remanded the case for determination of whether the transferred employees fell under the definition of “participant” under the statute.

C. First Circuit

1. In *Terry v. Bayer Corp.*, 145 F.3d 28 (1st Cir. 1998), plaintiff filed a claim for disability benefits. During the claims review procedure, the third party administrator [TPA] determined plaintiff was no longer disabled. While plaintiff’s appeal was pending, the TPA terminated plaintiff’s disability benefits. After filing an out of time appeal, *i.e.*, plaintiff filed his appeal after the sixty day period elapsed, the benefit committee denied the claim. The court next held that the plan document afforded discretionary review powers upon the plan administrator and that the plan administrator had the authority under specific plan language to delegate its duties to the benefit committee. Accordingly, the court reviewed the benefit committee’s decision under an arbitrary and capricious standard of review. The court next noted that the benefit committee properly denied the claim on two independent grounds:
plaintiff failed to file his appeal within the sixty day period, and on the merits, plaintiff was not disabled. The court held that the same principles that required plaintiff to exhaust administrative remedies included the responsibility that the claimant file a timely appeal. The court noted that the plan committed no improprieties and provided notice of the right to appeal. The court also held that the evidence in the administrative record demonstrated he was able to perform any job for which he was qualified by his education, training, or experience. See also: Doe v. Travelers Ins. Co., 167 F.3d 53 (1st Cir. 1999), Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181 (1st Cir. 1998), Recupero v. New England Telephone and Telegraph Company, 118 F.3d 820 (1st Cir. 1997).

D. Second Circuit

In I.V. Services of America, Inc. v. Trustees of American Consulting Engineers Council Insurance Trust Fund, 136 F.3d 114, 1998 (2nd Cir. 1998), the court was faced with the issue of determining the Plan’s provision limiting coverage for medical drugs to those approved by the FDA for general uses in treating the injury or illness for which they are prescribed. In interpreting this provision, the court held that the doctrine of contra proferentem was applicable. Defendant argued against application of the doctrine because the contract was between an insurance company and a large group policyholder: two sophisticated entities of equal bargaining power. Rejecting this argument, the court noted that to accept defendant’s argument would “virtually eliminate the relevance of contra proferentem in any ERISA-governed group health/Life insurance Plan that is itself insured...We believe that application of [the contra proferentem] rule of interpretation to the de novo review of ERISA insurance plans is an appropriate implementation of the congressional expectation that the courts will develop a ‘federal common law of rights, and obligations under ERISA-regulated plans.’” 136 F.3D at 121. Ultimately, the court concluded that the ambiguous language of the Plan sufficed to raise issues of material fact such that summary judgment in favor of defendant was inappropriate and remanded the case to the district court. See also: Moriarty v. United Tech. represented Employees Retirement Plan, 157, 158 F.2d (2nd Cir. 1998), DeFelice v. American International Life Assurance Company of New York, 112 F.3d 61 (2nd Cir. 1997).

E. Third Circuit

In Mitchell v. Eastman Kodak Company, 113 F.3d 433 (3rd Cir. 1997), plaintiff, who suffered from chronic fatigue syndrome, brought the action against the plan administrator for long-term disability benefits. Upon de novo review, the district court granted plaintiff’s motion for summary judgment. The district court determined that “although the plan plainly vests discretionary authority in the plan administrator, de novo review was appropriate because the denial was based solely on a factual determination.” Defendant appealed, claiming the appropriate standard of review was
arbitrary and capricious. Although the court agreed with defendant that the appropriate standard of review was arbitrary and capricious, the court determined that even under this more deferential standard, the administrator’s decision was incorrect. See also: Fottav v. Trustees UMW Health Retirement Fund, 165 F.3d, 209 (3rd Cir. 1998), Dewitt v. Penn-Del Directory Corporation, 106 F.3d 514 (3rd Cir. 1997).

F. Fourth Circuit

1. In Martin v. Blue Cross & Blue Shield of Virginia, Inc., 115 F.3d 1201 (4th Cir. 1997), cert. denied, 118 S. Ct. 629, 139 L. Ed.2d 609 (1997), plaintiff sought coverage for autologous one marrow transplant procedure necessary for plaintiff’s epithelial ovarian cancer treatment. The district court determined that the summary plan description (SPD) controlled in the instant case rather than the plan itself and as such, reviewed the administrator’s decision to deny coverage de novo. The court of appeal, however, disagreed and determined that the SPD did not control. As such, de novo was the incorrect standard of review and the correct standard of review and the correct standard was abuse of discretion. The court also noted that because the administrator in the instant case labored under a conflict of interest, the standard of review would be modified, abuse of discretion. Normally, the district court’s application of the wrong standard of review would warrant reversal, but the court determined that, as a matter of law, the procedure sought be plaintiff was investigatory or experimental and thus remand was not necessary. See also: Baker v. Provident Life & Accident Ins. Co., 171 F.3d 939 (4th Cir. 1999), Sargent v. Holland, 114 F.3d 33 (4th Cir. 1997), Brogan v. Holland, 105 F.3d 158 (4th Cir. 1997).

G. Fifth Circuit

1. In Vega v. National Life Ins. Servs., Inc. 145 F.3d 673 (5th Cir. 1998), the insurer denied a benefit claim for surgery because of an alleged falsification on the insurance application concerning plaintiff’s pre-existing condition. Reversing summary judgment for defendant, the court noted that abuse of discretion standard applied, based upon the plan language. However, the court held defendant’s conflict of interest was a factor to consider in determining whether the administrator abused his discretion. The court held that affidavits not previously reviewed by the administrator should have ben admitted into evident. The court also held that where the administrator is acting under a conflict of interest, the duly arises to conduct a full and fair review of all pertinent information reasonably available to the administrator. Here, the administrator failed to interview the treating physician about whether the surgery was the result of a pre-existing condition; nor did the administrator contact plaintiff to determine information about her condition. The court remanded holding that the insurer had abused its discretion. See also: Threadfill v. Prudential Securities Group, inc., 145 F.3d 286 (5th Cir. 1998), Tolson v. Avondale Industries, Inc., 141
F.3d 604 (5th Cir. 1998), Spacek v. Maritime Association, ILA Pension Plan, 134 F.3d 283 (5th Cir. 1998).

5.  Dowden v. Blue Cross and Blue Shield of Texas, Inc., 126 F.3d 641 (5th Cir. 1997).

H. Sixth Circuit

In Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609 (6th Cir. 1998), the court applied de novo review and upheld the district court’s denial of disability benefits. The court held that there was no evidence in the administrative record demonstrating plaintiff was disabled. The court also held that under de novo review, because there was no “due process” challenge to the claims review procedure, the district court properly struck an affidavit never reviewed by the plan, offered to show that plaintiff was disabled. The court also held plaintiff could not assert a claim for equitable relief under Varity Corp. v. Howe, 116 S. Ct. 1065 (1996) because he had an adequate remedy under ERISA Section 502(a)(1)(B). The court next held that because this claim was one for denial of benefits, he was not entitled to a jury trial. Finally, by a two-one majority, the court rejected trial to the bench and summary judgment as the appropriate way to resolve ERISA benefit cases, where review is de novo. The court noted that under de novo review, evidence is limited to that considered by the plan, unless plaintiff raised a “due process” challenge to the exhaustion procedure. The court held that because evidence was limited to the administrative record, the procedure for a bench trial pursuant to Fed. R. Civ. P. 52 is inappropriate. The court next held that the summary judgment procedure, pursuant to Fed. R. Civ. P. 56 is also inappropriate because the standard there is whether there are any factual disputes that necessitate a trial. The court set forth the following guidelines for handling such a de novo review: 1) The district court should conduct de novo review based solely upon the administrative record and render findings of fact and conclusions of law; 2) The district court may consider evidence outside of the administrative record only if that evidence is offered in support of a procedural challenger to the administrator’s decision, such as an alleged lack of due process.


I. Seventh Circuit

In Ladd v. ITT Corp., 148 F.3d 753 (7th Cir. 1998), plaintiff sought disability benefits. The court held that the medical evidence supported a finding that her condition had deteriorated over time. The court also discussed estoppel concepts. The plan helped plaintiff obtain social security disability benefits. The court noted that her receipt of
social security disability benefits, together with the set off provisions of the plan, meant that the plan paid less money to plaintiff. Explaining their concern the court noted: “To lighten the cost to the employee welfare plan of Ladd’s disability, the defendants encouraged and supported her effort to demonstrate total disability to the Social Security Administration, going so far as to provide her with legal representation. To further lighten that cost, it then turned around and denied that Ladd was totally disabled, even though her condition had meanwhile deteriorated. In effect, having won once the defendant repudiated the basis of their first victory in order to win a second victory. This sequence casts additional doubt on the adequacy of their evaluation of Ladd’s claim, even if it does not provide an independent basis for rejecting that evaluation.” 148 F.3d at 756. See also: Grun v. Pneumo Abex Corp, 163 F.3d 411 (7th Cir. 1999), Mers v. Marriott International Group Accidental Death and Dismemberment Plan, 144 F.3d 1014 (7th Cir. 1998), Hightshue v. AIG Life Insurance Company, 135 F.3d 1144 (7th Cir. 1998), Santaella v. Metropolitan Life Insurance Company, 123 F.3d 656 (7th Cir. 1997), Brehmer v. Inland Steel Industries Pension Plan, 14 F.3d 656 (7th Cir. 1997), Chojnacki v. Georgia-Pacific Corporation, 108 F.3d 617 (7th Cir. 1998), Cvelbar v. CBI Illinois Incorporated, 106 F.3d 1368 (7th Cir 1997), cert. denied 118 S. Ct. 56, 139 L.Ed2d 20, (Oct. 6, 1997).

J. Eighth Circuit

In Farley v. Arkansas Blue Cross & Blue Shield, F.3e 774 (8th Cir. 1998), the court reversed summary judgment in favor of plaintiff because the record evidence clearly established a disqualifying pre-existing condition. The court noted that the parties agreed that the plan language provided discretionary authority. The court rejected the plaintiff’s attempt to lessen the degree of deference, holding that no conflict of interest existed. The court then held there was substantial evidence demonstrating a pre-existing condition based upon the treating physician’s notes prior to plaintiff’s coverage under the plan. See also: Marolt v. Alliant Techsystems, Inc., 146 F.3d 617 (8th Cir. 1998), Layes v. Mead Corporation, 132 F.3d 1246 (8th Cir. 1998), the plaintiff argued, relying on Buttram v. Central States, S.E. & S.W. Areas Health & Welfare Fund, 76 F.3d 896, 899-900 (8th Cir. 1996), Armstrong v. Aetna Life Insurance Co., 128 F.3d 1263 (8th Cir. 1997), Duffie v. Deere & Company, 111 F.3d 70 (8th Cir. 1997), Hutchins v. Champion International Corporation, 110 F.3d 1341 (8th Cir. 1997).

K. Ninth Circuit

1. In Kearney v. Standard Ins. Co., 144 F.3d 597 (9th Cir.), opinion withdrawn, rehearing en banc granted, 1998 WL 555432 (9th Cir. 1998), the court reversed summary judgment in favor of the insurer, ordered de novo review on remand, and ordered the district court to admit evidence not previously reviewed by the plan.
administrator. Plaintiff was a trial lawyer, who suffered a heart attack and required extensive open heart surgery. Plaintiff’s long term disability benefits were terminated when the insurer determined he was capable of returning to work. The court first held that the language stating the insurer would pay benefits “upon receipt of satisfactory written proof that you have become DISABLED...”, 144 F.3d at 604, was to imprecise and ambiguous to vest discretion in the plan administrator. But see, Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir. 1996). The court also held that de novo review was appropriate because defendant did not rebut evidence indicating its decision was affected by a conflict of interest. As evidence of conflict of interest, the court held that the insurer failed to conduct tests recommended by its own independent medical examiner. The court held that this case was appropriate under a conflict of interest, the claim turned on the interpretation of key plan provisions involving the material duties of a trial attorney, and the insurer was the plan’s payer and its administrator. The court remanded for consideration of the material issues of fact on the issue of plaintiff’s physical condition and the duties of a trial lawyer.

See also: Kearney v. Standard Insurance Co., 1999 U.S. App. Lexis 8099 (9th Cir. April 28, 1999), Estate of Shockley v. Alyeska Pipeline Service Company, 130 F.3d 403 (9th Cir. 1997), Richardson v. Pension Plan of Bethlehem Steel Corporation, 112 F.3d 982 (9th Cir. 1997).

L. Tenth Circuit

In Adams v. Cyprus Amax Minerals Co., 149 F.3d 1156 (10th Cir. 1998), the Tenth Circuit joined all other circuit courts that have considered the issue and held there was no right to jury trial under ERISA §502(a)(1)(B), seeking the award of benefits. The court held that an award of benefits did not constitute money damages, because plaintiffs had no right to damages in the form of benefits, until a court exercised its equitable powers to declare plaintiffs eligible for benefits; and described recovery of benefits as equitable/restitutionary relief versus legal/compensatory relief. The court concluded plaintiffs’ claim was analogous to an equitable action to enforce a trust.

See also: Dycus v. Pension Benefit Guaranty Corporation, 133 F.3d 1367 (10th Cir. 1998), Siemon v. AT&T Corp., 117 F.3d 1173 (10th Cir. 1997).

M. Eleventh Circuit

In Paramore v. Delta Air Lines, Inc., 129 F.3d 1446 (11th Cir. 1997), at issue was the appropriate standard of review to be given to the Administrative Committee’s factual determinations as incorporated in the Committee’s ultimate conclusion that plaintiff was not entitled to benefits. While consistently applying the arbitrary and capricious standard of review to eligibility determinations, the court had yet to conclusively determine the appropriate level of review for factual determinations. Noting unanimity among the other circuits regarding this issue and its prior decisions applying the abuse of discretion standard to determinations involving both plan interpretations
and factual findings, the court stated “where the plan affords the administrator discretion, the administrator’s fact-based determinations will not be disturbed if reasonable based on the information known to the administrator at the time the decision was rendered.” Id. at 1451. Applying this standard to the facts in the instant case, the court concluded that the defendant’s decision to deny plaintiff’s request for benefits was reasonable based on the facts known to it at the time. Defendant was not unreasonable in concluding plaintiff was not entitled to benefits after receiving conflicting medical information and evaluating that information.


N. D. C. Circuit

In Heller v. Fortis Benefits Ins. Co., 142 F.3d 487 (D.C. Cir. 1998), plaintiff sought disability benefits. The opinion never discusses the appropriate judicial standard of review, and instead focuses on alleged violations of Section 503, rejects an effort to create a factual dispute based upon evidence never presented to the plan, and affirms an order against plaintiff requiring restitution of benefits to the plan. The court affirmed summary judgment in favor of the plan holding that plaintiff was not entitled to receive disability benefits. The court held that there was sufficient evidence in the administrative record to demonstrate that plaintiff was ineligible for disability benefits because the doctors believed she was able to perform light duty and sedentary work. Plaintiff attempted to adduce medical information from her treating physician demonstrating the existence of a disputed material fact. The court held that because plaintiff did not appeal the claim denial and being this evidence to the attention of the plan, she could not now submit such medial evidence. The court next held that the right of restitution existed in favor of the plan. There was evidence in the administrative record that during the final year she received disability payments, plaintiff worked for her husband’s law firm. The court held that under the earnings clause of the plan, plaintiff had wrongfully received benefit payments and affirmed the restitution order holding that the district judge had not abused his discretion in ordering this restitution.

IV. CONFLICT OF INTEREST

A. Initial Case Law

1. In Firestone Tire & Rubber Company v. Bruch, 109 S. Ct. 948, 956-57 (1989), the Supreme Court held that, if a benefit plan gives discretion to an administrator or
fiduciary who is operating under a possible conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.

2. The leading case on the issue of conflict of interest is *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556 (11th Cir. 1990), cert. denied, 498 U.S. 1040, 111 S. Ct. 712, 112 L.Ed.2d 701 (1991). In *Brown*, the same entity acted as plan fiduciary and plan insurer. The Eleventh Circuit reaffirmed the principle that if plan language confers discretion on the fiduciary, a court should apply an arbitrary and capricious standard of review. The Court explained, however, that where a conflict of interest is present, “the area of discretion to which deference is paid must be confined narrowly to decisions for which a conflicted fiduciary can demonstrate that it is operating exclusively in the interests of the plan participants and beneficiaries.” The Court explained that the fiduciary “should bear the burden of dispelling the notion that its conflict of interest h[as] tainted its judgment. If the fiduciary carries this burden, the party challenging its action may still succeed if the action is arbitrary and capricious by other measures.”

B. First Circuit

In *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181 (1st Cir. 1998), the court reversed and entered judgment for defendant, denying plaintiff’s claim for disability benefits. In discussing the issue of conflict of interest, the court noted that a conflict may exist when the administrator has a personal interest contrary to the beneficiary’s. The court dismissed idea that merely because benefits are paid by Paul Revere, a conflict exists, holding: “...[H]aving a benefit plan is to please employees, not to result in an employer’s bad reputation. Indeed, we venture that an employer would not want to keep an overly right-fisted insurer. The conflict is not as serious as might appear at first blush.” 144 F.3d at 184 (citations omitted.) The court went on to hold that if a conflict existed, the arbitrary and capricious standard would still apply, but with more “bite.” The court stated the burden would be on the claimant to show that a benefit denial decision was improperly motivated. See also: *Whitney v. Empire Blue Cross and Blue Shield*, 106 F.3d 475 (2nd Cir. 1997), *Sullivan v. LTV Aerospace & Defensed Co.*, 82 F.3d 1251 (2nd Cir. 1996), *Zuckerbrod v. Phoenix Mutual Life Ins. Co.*, 78 F.3d 46 (2nd Cir. 1996), *Jordan v. Retirement Comm. of Rensselaer Pplytechnic Inst.*, 46 F.3d 1264, 1274 (2nd Cir. 1995).

3. Third Circuit

In *Mitchell v. Eastman Kodak Company*, 113 F.3d 433 (3rd Cir. 1997), the court, in a footnote, recognized the Supreme Court’s decision in *Bruch*, 489 U.S. at 108 that “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 factor in determining
that because there was no conflict of interest in the instant case, “heightened review of the Administrator’s decision” was not necessary.

C. Fourth Circuit

In *Ellis v. Metropolitan Life Insurance Company*, 126 F.3d 228 (4th Cir. 1997), the court reiterated that it has established a well-developed framework for considering conflicts of interest in a court’s reviewing analysis. Where the plan administrator is vested with discretion and is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.” The conflict of interest factor applies on a case by case basis to lessen the deference normally given to counteract any influence unduly resulting from the conflict. In the instant case, the court concluded that despite the conflict of interest present, the defendant did not abuse its discretion in denying plaintiff benefits as its decision was based on substantial evidence and a lengthy, thorough review and affirmed the district court. See also: *Baker v. Provident Life & Accident Ins. Co.*, 173 F.3d 939 (4th Cir. 1999), *Martin v. Blue Cross & Blue Shield of Virginia, Inc.*, 115 F.3d 1201 (4th Cir. 1997).

D. Fifth Circuit

In *Vega v. National Life Ins. Servs., Inc.*, 145 F.3d 673 (5th Cir. 1998), the insurer denied a benefit claim for surgery because of an alleged falsification on the insurance application concerning plaintiff’s pre-existing condition. Reversing summary judgment for defendant, the court noted the abuse of discretion standard applied, based upon the plan language. However, the court held defendant’s conflict of interest was a factor to consider in determining whether the administrator abused his discretion. The court noted that “[w]hen an insurer is vested with sole and complete discretion to decide whether it will pay a claim, it necessarily operates under a conflict of interest.” 145 F.3d at 677. The court held that such a conflict is a factor to consider in determining whether an administrator has abused his discretion. See also: *Branson v. Greyhound Lines, Inc., Amalgamated Council Retirement and Disability Plan*, 126 F.3d 747 (5th Cir. 1997).

E. Sixth Circuit

In *Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, (6th Cir. 1998), the court recognized that the trustees in the instant case were acting under a conflict of interest in that they were plan participants themselves and thus were members of the class to whom a non-vested suspense account would be distributed if not distributed to plaintiff. However, the court noted that such conflict does not mandate abolition of the arbitrary and capricious standard of review, but rather the application of that standard should be shaped by the circumstances inherent in the conflict. Ultimately,
the court stated “We are satisfied that we could not overturn the trustee’s decision (to deny benefits) without bending the standard entirely out of shape” and affirmed the district court’s summary judgment in favor of plaintiff. See also: Peruzzi v. Summa Medical Plan, 137 F.3d 431 (6th Cir. 1998), Fuller v. Retirement Plan for Salaried Employees of Brown & Williamson Tobacco, 105 F.3d 659 (6th Cir. 1997).

F. Seventh Circuit

In Mers v. Marriott International Group Accidental Death and Dismemberment Plan, 144 F.3d 1014 (7th Cir. 1998), the plaintiff sought application of a stricter version of the arbitrary and capricious standard because an inherent conflict of interest existed as the company sponsored plan allowed the insurance company to interpret its own policies. When an insurance company pays benefits out of its own assets, its fiduciary role lies in perpetual conflict with its profit-making role as a business. Rejecting the plaintiff’s claims in the instant case, the court noted that the existence of a potential conflict is not enough. The plaintiff must show, by providing specific evidence of actual bias, that there is a significant conflict. In the instant case, the court found that a decision by defendant to award benefits to plaintiff would have cost $200,000. Defendant was consistently named as one of the fifty largest corporations in Fortune 500. As such, “the impact of granting or denying benefits in this case is minuscule compared to...[defendant’s] bottom line.” 144 F.3d at 1020. Therefore, the court affirmed the district court’s judgment in favor of defendant. See also: Cozzie v. Metropolitan Life Ins. Co., 140 F.3d 1104 (7th Cir. 1998), Chojnacki v. Georgia Pacific Corporation, 108 F.3d 810 (7th Cir. 1997).

G. Eighth Circuit

In Farley v. Arkansas Blue Cross & Blue Shield, 147 F.3d 774 (8th Cir. 1998), the court reversed summary judgment in favor of plaintiff. Plaintiff argued that defendant had an inherent conflict of interest because of its desire to maintain competitive insurance rates encourages it to deny claims. The court rejected this argument noting ERISA specifically contemplates the appointment of fiduciaries who may not be completely neutral, i.e., employers may appoint their employees to serve as plan fiduciaries. See ERISA §408(c)(3). The court held that not every allegation of partiality results in a conflict analysis and that plaintiff has the burden of providing “...probative evidence demonstrating that a palpable conflict of interest existed, which caused a serious breach of the administrator’s fiduciary duty.” 147 F.3d at 776. The court held that market forces prevent insurers from summarily denying claims because of the difficulties such conduct would cause in retaining current customers and attracting new business. See also: Woo v. Deluxe Corp., 144 F.3d 1157 (8th Cir. 1998), Armstrong v. Aetna Life Insurance Co., 128 F.3d 1263 (8th Cir. 1997).
H. Ninth Circuit

In *Kearney v. Standard Ins. Co.*, 144 F.3d 597 (9th Cir.), opinion withdrawn, rehearing en banc granted, 1998 WL 555432 (9th Cir. 1998), the court reversed summary judgment in favor of the insurer, ordered *de novo* review on remand, and ordered the district court to admit evidence not previously reviewed by the plan administrator. Plaintiff was a trial lawyer, who suffered a heart attack and required extensive open heart surgery. Plaintiff’s long term disability benefits were terminated when the insurer determined he was capable of returning to work. The court held that *de novo* review was appropriate because defendant did not rebut evidence indicating its decision was affected by a conflict of interest. As evidence of conflict of interest, the court held that the insurer failed to conduct tests recommended by its own independent medical examiner. The court held that where conflict of interest exists, the less deferential standard of *de novo* review was appropriate. See also: *Lang v. Long Term Disability Plan of Sponsor Applied Remote Technology, Inc.*, 125 F.3d 794 (9th Cir. 1997), *Ellis v. Transamerica Occidental Life Insurance Company*, 108 F.3d 337 (9th Cir. 1997), cert. denied, 118 S. Ct. 170, 139 L.Ed.2d 113 (U.S. 1997), *Podolan v. Aetna Life Ins. Co.*, 107 F.3d 17 (9th Cir. 1997).

I. Tenth Circuit

In *Pitman v. Blue Cross & Blue Shield*, 24 F.3d 118, 123 (10th Cir. 1994) (where defendant functions as insurer and claims fiduciary, even if standard of review is arbitrary and capricious, conflict of interest exists and level of deferential review is lessened). See also: *Charter Canyon Treatment Center v. Pool Co.*, 153 F.3d 1132 (10th Cir. 1998).

J. Eleventh Circuit

In *Buckley v. Metropolitan Life*, 115 F.3d 936 (11th Cir. 1997), plaintiff alleged that a conflict of interest existed because defendant funded the plan and thus had a financial stake in minimizing benefits paid pursuant to the plan. The court disagreed, holding that no conflict of interest existed in the present case as benefits were paid from a trust funded through periodic, non-reversionary contributions by defendant. The defendant incurred no direct expense as a result of the allowance of benefits, nor did it benefit directly from the denial or discontinuation of benefits. See also: *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997).