ERISA BENEFITS
CLAIMS AND THE
STANDARD OF REVIEW

GLENN:
THE AFTERMATH

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STANDARD OF REVIEW

In many ERISA benefit claims cases, the court’s initial determination of the applicable standard of review may very well determine the outcome of the litigation. As a default, both insured and self-funded plans are subject to a plenary, *de novo* standard of review. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989). Plan language reserving the administrator’s discretion to determine claims and interpret policy terms, however, may trigger a deferential, abuse of discretion standard, in which the court will determine whether the administrator’s conduct was arbitrary and capricious. *Id.*

Accordingly, a crucial initial determination is whether the governing plan instrument has authorized the plan administrator’s discretion. For example, in *Fitts v. Federal National Mortgage Association*, 236 F.3d 1 (D.C. Cir. 2000), the court applied the plenary, *de novo* standard of review because the governing plan document failed to delegate discretionary authority to the plan’s disability insurer. Likewise, in *Nelson v. E&G Energy Measurements Group, Inc.*, 37 F.3d 1384 (9th Cir. 1998) and *Sanford v. Harvard Industries*, 262 F.3d 590 (6th Cir. 2001), the courts ruled that benefits decisions made by a party not explicitly granted discretion to determine benefits eligibility are reviewed *de novo*. *See also* *McKeehan v. CIGNA Life Ins. Co.*, 344 F.3d 789 (8th Cir. 2003); *Anderson v. Unum Life Ins. Co. of Am.*, 2006 U.S. Dist. LEXIS 8224 (M.D. Ala. Feb. 13, 2006). On the other hand, in *Butts v. Continental Casualty Co.*, 357 F.3d 835, 838 (8th Cir. 2004), the court rejected a plaintiff’s argument that plan language granting discretion was insufficient to trigger abuse of discretion review because the delegation of discretion was unclear.

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 N.Y., 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.


Courts have likewise ruled that discretionary language found in other plan-related documents is insufficient to trigger abuse of discretion review. For example, in Teplick v. Boeing Co. Employee Health & Welfare Benefit Plan, 2004 U.S. Dist. LEXIS 8748 (D. Or. May 11, 2004), the court held that the presence of discretionary language in an administrative services agreement is insufficient to trigger abuse of discretion review when such language does not exist in the plan itself. Similarly, in Ruttenberg v. United States Life Insurance Co., 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. Finally, in Barham v. Reliance Standard Life Insurance 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. Accordingly, where a reservation of discretion is claimed, the governing plan documents are most critical.

Courts will consider, however, not only whether discretionary language exists, but whether such language is sufficient to trigger abuse of discretion review. A split of authority exists concerning what constitutes sufficient language to reserve discretion. For example, in Perez v. Aetna, 150 F.3d 550 (6th Cir. 1998), the court held that deferential review is appropriate where the plan requires the submission of “satisfactory” proof of a claim, because such language suggests discretion to evaluate a claim. On the other hand, several subsequent rulings have challenged that formulation and held that language must be more explicit to trigger abuse of discretion review. For example, in Kearney v. Standard Insurance Company, 175 F.3d 1084 (9th Cir. 1999), the Ninth Circuit ruled en banc that merely reciting that the claimant must submit “satisfactory” proof is insufficient to establish discretion, holding that the plan must contain explicit language reserving discretion. The Ninth Circuit reaffirmed the necessary of clear and unambiguous language in 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 … 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) (applying de novo review because policy did not “unambiguously” grant discretion).

Likewise, the Second Circuit, in Kinstler v. First Reliance Standard Life Insurance Company, 181 F.3d 243 (2d Cir. 1999), ruled that the de novo standard applies both to plan interpretations and factual determinations in the absence of a specific reservation of discretion. In Kinstler, the Second Circuit ruled that plan language requiring the insured to submit satisfactory proof satisfactory was insufficient to reserve discretion. Id. at 250-51. The court ruled that 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.” Id. at 251. 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 language 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.

Id. at 252.

The Seventh Circuit has proven to be particularly influential on this issue, even suggesting satisfactory plan language sufficient to reserve discretion. In Herzberger v. Standard Insurance Co., 205 F.3d 327 (7th Cir. 2000), the court reiterated that a de novo standard of review is the default rule in the absence of clear language reserving discretion. To clarify what language would be necessary to create a deferential standard of review, the court suggested 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.

After suggesting safe harbor language in Herzberger, the Seventh Circuit clarified its earlier ruling and unequivocally joined the Second and Ninth Circuits in ruling that language requiring “satisfactory” evidence of a claim is too ambiguous to reserve discretion. Perugini-Christen v. Homestead Mortgage Co. (Reliance Standard Life Ins. Co.), 287 F.3d 624 (7th Cir. 2002). The Seventh Circuit reaffirmed that point and explicitly reversed two earlier cases that left some doubt in Diaz v. Prudential Insurance Co. of America, 422 F.3d 635 (7th Cir. 2005); see also, Patton v. MFS/Sun Life Financial Distrib., Inc., 480 F.3d 478 (7th Cir. 2007).

Like the Sixth Circuit, however, the Tenth and First Circuits have held that language requiring proof satisfactory to the insurer may be sufficient to trigger abuse of
discretion review. See Nance v. Sun Life Assurance Co. of Canada, 294 F.3d 1263 (10th Cir. 2002); Brigham v. Sun Life of Can., 317 F.3d 72 (1st Cir. 2003).

Another issue open to question is whether plan amendments can trigger a deferential standard of review if they occur after a claimant qualifies for benefits. Some courts, such as DiGiovanni v. Guardian Life Insurance Co. of America, 2002 U.S. Dist. LEXIS 12380 (D. Mass. June 28, 2002), have held that 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. On the other hand, other courts, notably 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), have held 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. See, e.g., Confer v. Custom Eng’g Co., 952 F.2d 41 (3d Cir. 1991); Member Services Life Ins. Co. v. Am. Nat’l. Bank & Trust Co. of Sapulpa, 130 F.3d 950 (10th Cir. 1998); Barker v. Ceridian Corp., 122 F.3d 628 (8th Cir. 1997). See also, Mueller v. CNA Group Life Ins. Co., 2004 U.S. Dist. LEXIS 9271 (N.D. Cal. May 24, 2004) (ruling that the amendment was not properly effected, and 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. June 16, 2004); Hartranft v. Hartford Life and Accident Ins. Co., 2004 U.S. Dist. LEXIS 21088 (D. Conn. Sept. 30, 2004).

Even if the plan contains sufficient language to lead to a deferential standard of review, the administrator’s conflict of interest may be a factor in determining whether it abused its discretion. In Firestone Tire & Rubber Co. v. Bruch, the Supreme 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

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as a factor in determining whether there is an abuse of discretion.” 489 U.S. at 115. Recently, the Supreme Court clarified the role such conflicts play in determining the appropriate standard of review in *Metropolitan Life Ins. Co. v. Glenn* (“Glenn”), 128 S. Ct. 2343 (2008). There, the Supreme Court held that a financial conflict “is clear where it is the employer that both funds the plan and evaluates the claims.” 128 S.Ct. 2343 (2008).

Addressing a conflict among the Circuits, the Glenn Court ruled that such a conflict does not preclude application of the abuse of discretion standard. Instead, courts should apply the abuse of discretion standard where appropriately reserved by a plan administrator, but the conflict must be weighed as a “factor” in determining whether the administrator acted in an arbitrary and capricious manner. *Id.* at 2351. In so holding, the Court elaborated that a conflict may serve as a “tiebreaker” in a close case, and would be more important where there is likelihood that the factor affected the benefits decision, “including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.” *Id.* The Court further held that the conflict could prove less important if an insurance company takes active steps to wall off claims administrators from those interested in firm finances or by penalizing inaccurate decision-making. *Id.* Specifically, in Glenn, the Court found the conflict should be weighed more heavily where 1) the insurer reaped the benefit of a Social Security offset then terminated benefits under a less-rigorous standard, 2) deemphasized medical reports that favored a disability determination, and 3) failed to provide its reviewers with all of the relevant medical evidence.

In the wake of Glenn, a number of Circuit courts have altered their standards of addressing conflicts of interest in benefit claims cases. For instance, the First Circuit held that Glenn was generally harmonious with its previous holdings, but explicitly invalidated its “market forces rationale,” which in some instances permitted courts to “disregard a structural conflict without further analysis.” *Denmark v. Liberty Life Assur. Co.*, 566 F.3d 1, 20 (1st Cir. 2009). Instead, courts must consider the conflict of interest as a factor in determining whether an administrator abused its discretion. *Id.*

The Second Circuit determined that its previous standard for evaluating conflict of interest, *i.e.*, ignoring the conflict unless it actually tainted the decision-making process, was “inconsistent” with Glenn and must be abandoned. *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126 (2nd Cir. 2008). After applying the new Glenn standard, the court found that insurer abused its discretion in denying benefits to the plaintiff, who was a colon and liver cancer survivor who suffered long-term adverse effects such as acute renal impairment. The court found that the insurer engaged in “deceptive” claims administration by ignoring plaintiff’s medical reports, and that Unum has a well-documented history of biased claims administration. Accordingly, the Second Circuit ruled the insurer’s “history of deception and abusive tactics to be additional evidence that it was influenced by its conflict of interest as both plan administrator and payor in denying [the plaintiff’s] claim for benefits.” *Id.* at 133. See also *Hobson v. Metro Life Ins. Co.*, 574 F.3d 75, __, 2009 U.S. App. LEXIS 16677, at *13 (2009) (“a plan under which an administrator both evaluates and pays benefits claims creates the kind of conflict of interest that courts must take into account and
Likewise, the Fourth Circuit held that its previous methodology for modifying an abuse of discretion standard of review could not stand after Glenn. Champion v. Black & Decker (U.S.) Inc., 550 F.3d 353, 359 (4th Cir. 2008). In Champion, the court ruled that a financial conflict of interest should be weighed as a factor in determining the reasonableness of the decision in light of eight “relevant factors:” “(1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the material considered to make the decision and the degree to which they support it; (4) whether the fiduciary’s interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan; (5) whether the decision-making process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretionl and (8) the fiduciary’s motives and any conflict of interest it may have.” Id. After applying these factors, the court determined that the conflict was so insignificant that it approached the “vanishing point,” and affirmed the district court’s decision that the plan did not abuse its discretion in terminating plaintiff’s disability benefits after 30 months of payment. Id.

The Fifth Circuit found the plaintiff had to demonstrate that the administrator’s decision was “tainted by a ‘substantial’ conflict of interest. [Defendant’s] dual role as administrator and insurer created only a minimal conflict, not a substantial one.” Dunn v. GE Group Life Assur. Co., 289 Fed. Appx. 778, 782 (5th Cir. 2008). Therefore, it would defer to the administrator’s decision, even if it was “wrong.” Id. In applying Glenn, the Fifth Circuit has ruled that the existence of a conflict is a factor to be applied within the traditional abuse of discretion review “along with all of the other relevant factors.” Holland v. Int’l Paper Co., No. 08-30967, 2009 U.S. App. LEXIS 15863, at *17 (July 16, 2009).

The Seventh Circuit likewise ruled that Glenn does not permit a new standard of review (i.e., a heightened arbitrary and capricious standard) for claims involving a conflict of interest. Leger v. Tribune Co. Long Term Disability Benefit Plan, 557 F.3d 823, 831 (7th Cir. 2009). Instead, the Seventh Circuit held that a conflict of interest must be considered within the traditional abuse of discretion review “along with all of the other relevant factors.” Id. To that end, the Seventh Circuit has recently held that “[i]t is thus not the existence of a conflict of interest--which is a given in almost all ERISA cases--but the gravity of the conflict, as inferred from the circumstances, that is critical.” Marrs v. Motorola, Inc., No. 08-2451, 2009 U.S. Dist. LEXIS 18129, at *17 (7th Cir. Aug. 14, 2009). In Leger, the court further found Glenn did not decide cases in which the administrator and the payor are two separate entities. 557 F.3d at 831. Even where a dual role existed and thus a conflict of interest, the Seventh Circuit did not find “the other factors to be closely balanced,” and therefore declined to reconsider its decision because the conflict of interest analysis would not service as a “tiebreaker.” Gutta v. Standard Select Trust Ins. Plans, 285 Fed. Appx. 302, 303 (7th Cir. 2008).
The Eighth Circuit acknowledged that Glenn invalidated its previous precedent that conflicts of interest may not be assumed. *Wakkinen v. UNUM Life Ins. Co. of America*, 531 F.3d 575, 581 (8th Cir. 2008). Instead, “a plan administrator which both evaluates claims for benefits and pays benefits claims (as Unum does) is operating under a conflict of interest. The rules holds true for both employers and insurers who hold dual roles.” *Id*. The court nonetheless found that there was not a sufficiently close balance for the conflict to act as a “tiebreaker.” See also *Jones v. Mountaire Corp.*, 542 F.3d 234 (8th Cir. 2008) (holding that the application of the *de novo* standard of review when a conflict was found was inappropriate after Glenn). In another recent decision, *Chronister v. Unum Life Ins. Co. of Am.*, 563 F.3d 773, 776 (8th Cir. 2009), the Eighth Circuit held that a conflict of interest, including the insurer’s “history of biased claims administration,” contributed to a finding of abuse of discretion. (quoting Glenn, 128 S. Ct. at 2351).

The Eleventh Circuit acknowledged that “Glenn implicitly overrules and conflicts with our precedent” on the standard of review applicable in cases involving a conflict of interest. *Doyle v. Liberty Life Assur. Co. of Boston*, 542 F.3d 1352, 1359 (11th Cir. 2008). The court found that post-Glenn “the existence of a conflict of interest should merely be a factor for the district court to take into account when determining whether an administrator’s decision was arbitrary and capricious,” and will not shift the burden to the administrator to prove that the conflict did not impact its decision, nor will it alter the standard of review to *de novo*. Combining its prior precedent with the holding of Glenn, the Eleventh Circuit recently applied a six-step analysis to review claim decisions within the appropriate standard of review:

(1) Apply the *de novo* standard to determine whether the claim administrator’s benefits-denial decision is "wrong" (i.e., the court disagrees with the administrator’s decision); if it is not, then end the inquiry and affirm the decision.

(2) If the administrator’s decision in fact is "de novo wrong," then determine whether he was vested with discretion in reviewing claims; if not, end judicial inquiry and reverse the decision.

(3) If the administrator’s decision is "de novo wrong" and he was vested with discretion in reviewing claims, then determine whether "reasonable" grounds supported it (hence, review his decision under the more deferential arbitrary and capricious standard).

(4) If no reasonable grounds exist, then end the inquiry and reverse the administrator’s decision; if reasonable grounds do exist, then determine if he operated under a conflict of interest.

(5) If there is no conflict, then end the inquiry and affirm the decision.

(6) If there is a conflict of interest, then apply heightened arbitrary and capricious review to the decision to affirm or deny it.
Ruple v. Hartford Life & Accident Ins. Co., No. 09-11287, 2009 U.S. App. LEXIS 18017, at *15-16 (11th Cir. Aug. 11, 2009). In Ruple, because the court found that the insurer’s conduct was not de novo “wrong,” the inquiry ended at the initial step and the court did not determine the appropriate standard of review. Id., at *16, n. 2. In Creel v. Wachovia Corp., No. 08-10961, 2009 U.S. App. LEXIS 1733, at *20 (Jan. 27, 2009), which recited the same, six-step analysis, the Eleventh Circuit held that, while the analysis remains applicable, the final step is invalidated by Glenn, which precludes any “heightened” arbitrary and capricious review. Instead, any conflict of interest must be incorporated as a factor within the standard abuse of discretion review. Id.

Although numerous Circuit courts have modified their approach to claims involving a conflict of interest in an effort to comply with Glenn, a split of authorities is beginning to emerge in the applicability of the Supreme Court’s decision to cases involving employee benefits funded by a trust. The Fourth and Eleventh Circuits have held that Glenn does not apply, that is no structural conflict of interest exists, when benefits are funded from a trust. In Lance v. Retirement Plan of Int’l Paper Co., No. 08-1295, 2009 U.S. App. LEXIS 11460, at *10 (4th Cir. May 29, 2009), the Fourth Circuit held that “[b]ecause the Plan’s benefits are funded by a separate trust to which International Paper does not have access for its own purposes, the Plan does not have significant incentives to benefit itself by denying benefits.” Likewise, in White v. Coca-Cola Co., 542 F.3d 848, 858 (11th Cir. 2008), cert. denied 129 S. Ct. 1910, the Eleventh Circuit held that no conflict of interest exists where benefits are paid by a trust which also pays the third party administrator that administers benefits claims. (“Our circuit law is clear that no conflict of interest exists where benefits are paid from a trust that is funded through periodic contributions so that the provider incurs no immediate expense as a result of paying benefits.”) (quoting Gilley v. Monsanto Co., Inc., 490 F.3d 848, 856 (11th Cir. 2007)).

On the other hand, the Third and Ninth Circuits have held that a conflict of interest may exist even if benefits are paid from a trust. In Burke v. Pitney Bowes Inc. Long Term Disability Plan, 544 F.3d 1016, 1026 (9th Cir. 2008), the Ninth Circuit held that a conflict of interest exists because “even when benefits are paid out of a trust, instead of directly by an employer, the employer has a financial incentive to deny claims because every dollar not paid in benefits is a dollar that will not need to be contributed to fund the Trust.” Likewise, in Michaels v. Equitable Life Ins. Soc’y, 305 Fed. Appx. 896, 902-03 (3d Cir. 2009), the Third Circuit found a conflict of interest existed despite the fact that benefits were funded by a trust set up by the employer.

A recent Fifth Circuit decision, Holland v. Int’l Paper Co., No. 08-30967, 2009 U.S. App. LEXIS 15863, at *18-20 (July 16, 2009), set forth a possible middle ground. In Holland, the court held that a conflict of interest exists under Glenn whenever the employer makes claims decisions and funds benefits, even through a trust, but ruled that the conflict was not “a significant factor.” The Fifth Circuit held that “the irrevocable funding of the trust diminishes the importance of
the conflict and the likelihood that it affected the [Plan] Administrator’s benefits decisions,” because “a decision to pay benefits does not directly affect [the employer’s] bottom line.” Id. Accordingly, the court ruled that “the creation of the trust diminishes, but does not entirely negate, the impact of the conflict.” Id., at *21.

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 Am.*, 499 F.3d 640 (7th Cir. 2007):

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).

499 F.3d at 643 (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 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.

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.

See also, Jewell v. Life Ins. Co. of North America, 508 F.3d 1303 (10th Cir. 2007)(setting forth evidentiary standards for court’s “de novo review”).

The Meaning of “Abuse of Discretion” and “Arbitrary and Capricious”

If a deferential standard of review applies, the court engages in the following analysis:

[T]he 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.


Highlighting the deferential nature of abuse of discretion review, 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. Cent.
States, Se. and Sw. Areas Health & Welfare Fund, 900 F.2d 1138, 1142-43 (7th Cir. 1990) (citations omitted). Nevertheless, “[d]eerential 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). In Hess, the Seventh Circuit ruled that “the fact that an administrator blatantly disregards an applicant’s submissions can be evidence of arbitrary and capricious action.” 274 F.3d at 463.

Noting that abuse of discretion review remains a case-by-case, factual inquiry, the Sixth Circuit held 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))

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.

In Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 807-808 (10th Cir. 2004), the Tenth Circuit similarly 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).

Abuse of discretion also occurs where an ERISA plan administrator makes a decision that “conflicts with the plain language of the plan.” Saffle v. Sierra Pac. Power Co., 85 F.3d 455, 458 (9th Cir. 1996) (citing Taft v. Equitable Life Assurance Soc’y, 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, 1179 (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 that was opposed by several competing medical opinions, 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.

Id.

The “Evidence” Reviewed

Regardless of the applicable standard of review, most ERISA cases are decided based solely on the claim record made prior to suit being filed. Quesinberry v. Life Ins. C. of N. Am., 987 F.2d 1017 (4th Cir. 1993); see also, 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. See also, *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206, 522 F.3d 863 (as amended) (9th Cir. 2008); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 966-67 (9th Cir. 2006) (en banc); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818 (10th Cir. 1996) (collects cases on whether, and under what circumstances, additional evidence may be submitted in court); *Hall v. UNUM*, 300 F.3d 1197 (10th Cir. 2002); *Muller v. First Unum Life Ins. Co.*, 341 F.3d 119 (2d Cir. 2003) (only unusual circumstances justify reopening claim record following appeals); *Locher v. Unum Life Ins. Co. of Am.*, 389 F.3d 288 (2d Cir. 2004) (insurer conflict of interest with uncertain claim review process justified receipt of additional evidence). Despite the foregoing, in *Kearney v. Standard Insurance Co.*, 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 Insurance 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. See also, *Paese v. Hartford Life and Accident Ins. Co.*, 2004 U.S. Dist. LEXIS 6040 (S.D.N.Y. Apr. 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.

An administrator’s right to supplement the record is more limited in some instances. In Neiheisel v. AK Steel Corp., 2005 U.S. Dist. LEXIS 4639 (S.D. Ohio Feb. 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 that “any relative utility in conducting an examination should have been apparent to [the insurer well before the denial]” and found that it is “simply unreasonable” to request an examination following the denial. See also, Reipsa v. Met. Life Ins. 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 Ins. Co., 2003 U.S. Dist. LEXIS 12713 (N.D. Ill. July 24, 2003) (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. Am. Express Fin. Corp., 384 F.3d 498 (8th Cir. 2004) (misleading insured to believe that insurer was obtaining Social Security claim records justified a remand). However, Nance v. Sun Life Assurance Co. of Canada, 294 F.3d 1263 (10th Cir. 2002), held that later submitted evidence would not be considered. Accord Alford v. DCH Found. Group Long-Term Disability Plan, 311 F.3d 955 (9th Cir. 2002); Pelletier v. Reliance Standard Life Ins. Co., 2002 U.S. Dist. LEXIS 18443 (D. Me. Sept. 27, 2002); Schlegel v. Life Ins. Co. of N. Am., 2003 U.S. Dist. LEXIS 10811 (E.D. Pa. June 9, 2003); Kazenas v. Oracle Corporation’s Long Term Disability Plan, 2004 U.S. Dist. LEXIS 4806 (N.D. Ill. Mar. 24, 2004).

Discovery


Courts considering ERISA discovery disputes in the aftermath of *Glenn* have reached very different decisions. For example, *Hogan-Cross v. Metro. Life Ins. Co.*, 568 F. Supp. 2d 410 (S.D.N.Y. 2008) determined the “notion that discovery is inappropriate in this case because ‘there is no evidence in the administrative record of any actual conflict,’ a dubious proposition to begin with before *Glenn*, is misguided. The question here, as in all cases, is whether the discovery sought is relevant in itself or ‘appears reasonably calculated to lead to the discovery of admissible evidence.’” *Id.* at 413-414. Two rulings from within the Seventh Circuit have also found that *Glenn* overrules that Circuit’s prior rulings disallowing discovery. *Gessling v. Group Long Term Disability Plan for Employees of Sprint/United Management Co.*, 2008 U.S. Dist. LEXIS 96623 (S.D. Ind. November 26, 2008); *Fischer v. Life Ins.Co. of North America*, 2009 U.S. Dist. LEXIS 22487 (S.D. Ind. March 19, 2009).

Other post-*Glenn* discovery rulings of note include *Denmark v. Liberty Life Assur. Co.*, 566 F.3d 1, 23-25 (1st Cir. 2009) (holding that “conflict-oriented discovery” may be particularly appropriate, but must be used sparingly to not disturb record); *Thomas v. Kimberly-Clark Corp.*, No. 07-3899, 2008 U.S. Dist. LEXIS 94989, at *17-18 (E.D. Pa. Nov. 20, 2008) (declining to permit additional discovery because it did not relate to conflict of interest); *Weeks v. UNUM Group*, 585 F. Supp. 2d 1305, 1316 (denying motion for additional discovery because denial letter sufficiently detailed); *Burgio v. Prudential Life Ins.Co. of Am.*, 253 F.R.D. 219 (E.D.N.Y. 2008) (allowing more detailed information about the sponsor’s past relationships with medical professionals who reviewed his application for LTD benefits; an in camera review of communications with third party vendors; information as to whether any of the individuals involved in determining the claim received any financial incentives during the relevant period and the bases thereof; and some deposition testimony as to evidence of conflict); *Winterbauer v. Life Ins. Co. of N. Am.*, No. 4:07 CV 1026, 2008 U.S. Dist. LEXIS 83712 (E.D. Mo. Oct. 20, 2008) (requiring “good cause” to obtain extensive discovery stating: “Permitting extensive discovery in the ERISA context would increase both the


To a large extent, the different outcomes reflect the courts’ varying interpretations of *Glenn* itself. While some courts have found *Glenn* did not change the discovery rules surrounding ERISA benefit cases, other courts have reached the exact opposite conclusion. Simply put, *Glenn’s* effect on the discovery rules for ERISA cases remains unclear.

The ERISA claim regulations allow the claimant access to any instruments under which the plan is administered. Accordingly, although *Cohen v. Metropolitan Life*
Insurance Co., 2003 U.S. Dist. LEXIS 4468 (S.D.N.Y. Mar. 26, 2003) allowed discovery of an insurer’s “best practices” manual, it was required to be produced under a confidentiality restriction. And in Palmiotti v. Metropolitan Life Insurance Co., 2005 U.S. Dist. LEXIS 3626 (S.D.N.Y. Mar. 9, 2005), the court required production of a claim manual without confidentiality restrictions in compliance with the ERISA claim regulations, but this decision was overruled by Palmiotti v. Metro. Life Ins. Co., 2006 U.S. Dist. LEXIS 8031 (S.D.N.Y. Mar. 2, 2006), in which the court issued a 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. Nov. 14, 2006) (ordering production without a protective order). In addition, Jacoby v. Hartford Life and Accid. Insur. Co., 254 F.R.D. 477 (S.D.N.Y. 2009) ordered production of Hartford’s internal procedures manuals and encouraged Hartford to produce contracts and other documents showing the insurer’s relationship with organizations that are frequently retained to perform file reviews. Further, in Cannon v. Unum Life Insurance Co. of America, 219 F.R.D. 211 (D. Me. 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. 2007), the court also allowed discovery under the de novo standard to explain inconsistencies in the evidence.

However, the majority rule with respect to discovery under the abuse of discretion standard remains the rule articulated in Perlman v. Swiss Bank Corp., 195 F.3d 975 (7th Cir. 1999), where 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 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 two cases
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. A similar ruling was issued in Hamma v. Intel Corp., 2008 U.S.Dist.LEXIS
22670 (E.D.Cal. March 4, 2008).

U.S. Dist. LEXIS 20096 (S.D. Ill. Apr. 17, 2006) approved of discovery, although it also
ruled that discovery on bias or conflict would be irrelevant if the de novo standard
applied. See also, Marantz v. Permanent Med. Group, Inc. Long Term Disability Plan,
review to clarify discrepancy in evidence); Patton v. MFS/Sun Life Fin. Distributors, Inc.,
480 F.3d 478 (7th Cir. 2007) (same).