

Benefit Claims:

**A Primer on Claims Procedures
and Benefit Claims Litigation**

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I. Introduction

This paper describes the required claims procedures for “employee benefit plans” covered by ERISA and litigation that may be brought pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to recover benefits from such plans. ERISA generally covers any employee benefit plan maintained by an employer engaged in commerce or in any industry or activity affecting commerce, or by any labor organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce, or by both. ERISA § 4(a), 29 U.S.C. § 1003(a).

However, certain employee benefits are not provided pursuant to an “employee benefit plan” as that term is defined in ERISA § 3(3). See also ERISA §§ 3(1) and (2), 29 U.S.C. §§ 1002(1) and (2). For example, bonus plans, overtime, paid holidays, severance pay arrangements not requiring on-going administration, childcare, and employee discounts are not employee benefit plans, and vacation leave, sick leave, personal leave, jury duty pay, training, short-term disability, and tuition reimbursement are not employee benefit plans if paid out of an employer’s general assets. 29 C.F.R. § 2510.3-1(h).

In addition, there are some “employee benefit plans” that are not covered by ERISA. This includes most governmental plans; church plans; plans maintained solely for complying with workers’ compensation, unemployment or disability insurance laws; plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; and unfunded excess benefit plans. ERISA § 4(b), 29 U.S.C. § 1003(b). Benefits that are not provided by employee benefit plans covered by ERISA are not subject to ERISA’s claims procedures and are not addressed in this paper.

When your client, whether a plan participant, a plan beneficiary or a plan administrator, seeks your advice regarding a claim for benefits under an ERISA plan, your first inclination may be to refer to the law or the regulations governing ERISA plans. Following such an inclination may result in a waste of valuable resources, particularly if you later determine that the benefit at issue is not provided by the plan or that the answer to the question is clearly provided by the plan document. While it may appear obvious, some attorneys may not know or may forget, that they should review the actual documents that govern the plan before referring to any other source. This is the case because correctly drafted plan documents govern substantive entitlement to benefits and prescribe the plan’s claim and appeal procedures. ERISA requires plan fiduciaries to administer the plan in accordance with the documents and instruments governing the plan, insofar as such documents and instruments are consistent with ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D). The document or documents governing an ERISA plan may consist of a plan document, a summary plan description, a trust agreement, and/or another document containing policies and procedures.¹ Most plan documents will contain language giving the plan

¹ If the plan does not have the required governing documents, this raises other serious issues for the plan which will not be covered by this paper. ERISA § 102 requires plans to make available to participants and beneficiaries a summary plan description containing information that describes the benefits provided by the plan in a manner that is understood by the average participant. See also ERISA § 104(b), 29 U.S.C. § 1024(b), and 29 C.F.R. 2520.104b-2.

administrator discretionary authority to decide claims for benefits. The importance of such language will be explained in the section of this paper discussing the standard of review used by courts in deciding employee benefit claim cases.

II. Claims Procedures

A. The Law. ERISA § 503, 29 U.S.C. § 1133, requires every employee benefit plan to:

1. provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
2. afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

B. The Regulations. Except as specifically provided in 29 C.F.R. § 2560.503-1, every employee benefit plan described in ERISA § 4(a) and not exempted under section 4(b) must establish and maintain “reasonable” claims procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (“claims procedures”). 29 C.F.R. § 2560.503-1(a) and (b).

According to the regulations, the claims procedures for a plan will be deemed to be “reasonable” only if:

1. The claims procedures satisfy the timing requirements for initial benefit determination notices, provide initial benefit determination notices in the proper manner with the required content, contain an appeals process that provides a claimant a reasonable opportunity for full and fair review, provide for timely notification of decisions on appeal, and provide notification of benefit appeal determinations in the proper manner with the required content;
2. A description of all claims procedures and the applicable time frames are included as part of the plan’s summary plan description;
3. The claims procedures do not contain any provision, and are not administered in any way, that unduly inhibits or hampers the initiation or processing of claims for benefits;
4. The claims procedures do not preclude an authorized representative of a claimant from acting on his behalf in pursuing a claim or appeal; and
5. The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing plan document and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

See 29 C.F.R. § 2560.503-1(b)(1)-(6). There are additional special requirements that group health plan claims procedures must satisfy to be deemed reasonable. *See* 29 C.F.R. § 2560.503-1(c). Disability benefits also are subject to special requirements. *See* 29 C.F.R. § 2560.503-1(d).

C. Types of Claims. A claim for benefits is a request for a plan benefit or benefits, made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. 29 C.F.R. § 2560.503-1(e).

1. Group Health Plan Claims: A "group health plan" is an employee welfare benefit plan within the meaning of ERISA § 3(1) that provides "medical care" within the meaning of ERISA § 733(a), 29 U.S.C. § 1191b(a).² Claims for benefits from a "group health plan" include urgent care claims, concurrent care claims, pre-service care claims, and post-service care claims.

a. An urgent care claim is a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. 29 C.F.R. § 2560.503-1(m)(i). An individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine determines whether a claim is an urgent care claim. 29 C.F.R. § 2560.503-1(m)(1)(ii). However, any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care must be treated as a claim for urgent care. 29 C.F.R. § 2560.503-1(m)(1)(iii).

b. A concurrent care claim results when a group health plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments. 29 C.F.R. § 2560.503-1(f)(2)(ii).

c. A pre-service claim is any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or part, on approval of the benefit in advance of obtaining medical care. 29 C.F.R. § 2560.503-1(m)(2).

d. A post-service claim is any claim for a benefit under a group health plan that is not a pre-service claim. 29 C.F.R. § 2560.503-1(m)(3).

² 29 CFR § 2560.503-1(m)(6). The term "medical care" means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; amounts paid for transportation primarily for and essential to medical care; and amounts paid for insurance covering medical care. ERISA § 733(a)(2).

2. Disability Claims: Disability claims are those that require the claimant to establish that he or she is disabled in order to get the benefit, such as those for long-term disability and disability pension benefits. Note that a short-term disability program is considered a payroll practice not subject to ERISA if the benefits are paid from the employer's general assets.

3. Pension Claims: Examples of pension benefit claims are claims provided by multiemployer defined benefit plans, multiple employer defined benefit plans, single employer defined benefit plans, cash balance plans, single employer 401(k) plans, multiple employer 401(k) plans, multiemployer 401(k) plans, profit sharing plans, employee stock ownership plans, and money purchase pension plans. See ERISA § 3(2), 29 U.S.C. § 1002(a), and 29 U.S.C. § 2510.3-2.

D. Initial Benefit Determinations

1. For all claims, except those relating to group health plans and disability claims, if a claim is *wholly or partially denied*, the plan administrator must notify the claimant of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan. If the plan administrator determines that special circumstances require an extension of time for processing the claim, written notice of an extension must be furnished to the claimant prior to the termination of the initial 90-day period. The extension must not exceed a period of 90 days from the end of the initial 90-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination. 29 C.F.R. § 2560.503-1(f)(1).

2. If the claim is a claim involving urgent care, the plan administrator must notify the claimant of the plan's benefit determination (*whether adverse or not*) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan. If the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the plan administrator must notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant must be given at least 48 hours to provide the specified information. The plan administrator must notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the plan's receipt of the specified information or the end of the period given to the claimant to provide the specified additional information. 29 C.F.R. 2560.503-1(f)((2)(i).

3. Any reduction or termination by the plan of a concurrent care claim (other than by plan amendment or termination) before the end of a previously approved period of time or number of treatments will constitute an adverse benefit determination and the plan administrator must notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse determination before the benefit is reduced or terminated. Sometimes a request by a claimant to extend the course of

treatment beyond the period of time or number of treatments must be treated as a claim for urgent care and decided accordingly. 29 C.F.R. §§ 2560.503-1(f)(2)(ii)(A) and (B).

4. With respect to a pre-service claim, the plan administrator must notify the claimant of the plan's benefit determination (*whether adverse or not*) within a reasonable period of time appropriate for the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. If such extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant must be given at least 45 days from receipt of the notice to provide the specified information. 29 C.F.R. § 2560.503-1(f)(2)(iii)(A).

5. In the case of a post-service claim, the plan administrator must notify the claimant of the plan's *adverse* benefit determination within a reasonable time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days. The requirements set forth above for an extension of time to decide a pre-service claim apply. 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).

6. If the claim is for disability benefits, the plan administrator must notify the claimant of the plan's *adverse* benefit determination not later than 45 days after receipt of the claim by the plan. This period may be extended twice for up to 30 days for each extension. The requirements set forth above for an extension of time to decide a pre-service claim apply. 29 C.F.R. § 2560.503-1(f)(3).

E. Appeals of Adverse Benefit Determinations

1. 29 U.S.C. § 2560.503-1(h) requires every employee benefit plan to establish and maintain a procedure by which a claimant will have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a "*full and fair review*" of the claim and the adverse benefit determination.

a. For all claims except those for group health plan benefits and disability benefits, a plan's claim procedures will be deemed to provide a claimant with a reasonable opportunity for a full and fair review only if the claims procedures:

i. provide claimants at least 60 days following receipt of a notification of an adverse benefit determination to file an appeal;

ii. provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

iii. provide that a claimant will be provided, upon request and free of charge, all documents, records, and other information relevant to the claimant's claim for benefits;

iv. provide for a review that takes into account all comments, documents, records, or other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

29 C.F.R. § 2560.503-1(h)(2).

b. *Group health plan* claims procedures will be deemed to provide a full and fair review if, in addition to complying with the references stated above, the claims procedures:

i. provide claimants at least 180 days to appeal;

ii. provide for a review that does not give deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse determination that is the subject of the appeal, nor the subordinate of such individual;

iii. provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

iv. provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination;

v. provide that the healthcare professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the initial determination, nor the subordinate of any such individual; and

vi. provide, in the case of an urgent care claim, for an expedited review process that allows for oral submission of the request for review and communication by telephone, facsimile, electronic mail, etc.

29 C.F.R. § 2560.503-1(h)(3).

c. *Disability benefit plan* claims procedures will be deemed to provide a reasonable opportunity for a full and fair review if they comply with all

the requirements set forth above for group health plans, with the exception of the requirement for an expedited review process. 29 C.F.R. § 2560.503-1(h)(4).

2. Timelines for Notifying Claimants of Appeals Decisions

a. If a plan has designated a committee or board of trustees as the appropriate named fiduciary and that committee or board holds regularly scheduled meetings at least quarterly, different timelines may be applied to all appeals except those for urgent care and pre-service care. 29 C.F.R. §§ 2560.503-1(i)(1)(ii), (i)(2)(iii)(B), and (i)(3)(ii).

b. In all other cases, if an appeal does not involve a claim for disability plan benefits, urgent care, or pre-service care, the plan administrator must notify the claimant of the determination on appeal within a reasonable period of time, but not later than 60 days after receipt of the request for review. 29 C.F.R. § 2560.503-1(i)(1)(i). If the plan administrator determines that special circumstances require an extension of time for processing the appeal, written notice must be given to the claimant prior to the termination of the initial 60-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review. The extension must not exceed a period of 60 days from the end of the initial period.

c. The plan administrator must notify the claimant of an urgent care claim of the plan's appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review. 29 C.F.R. § 2560.503-1(i)(2)(i).

d. If the appeal involves a pre-service claim, the plan administrator must notify the claimant within a reasonable period of time appropriate to the medical circumstances. If there is only one level of appeal, notice must be provided no later than 30 days after receipt of the request for review. If the plan provides for two levels of appeal, notice for each level must be provided within 15 days of receipt of each request for review. 29 C.F.R. § 2560.503-1(i)(2)(ii).

e. For appeals involving post-service claims, the plan administrator must notify the claimant within a reasonable period of time. If the plan provides for one level of appeal, notice must be provided no later than 60 days of receipt of the appeal. If there are 2 levels of appeal, notice for each level must be provided within 30 days of the receipt of each request for review.

3. Manner and Content of Appeal Decision Notifications

a. The plan administrator must provide a claimant with written or electronic notification of the plan's decision regarding the claimant's appeal. 29 C.F.R. § 2560.503-1(j). Electronic notification must comply with 29 C.F.R. § 2520.014b-1 (c)(1)(i), (iii), and (iv).

b. If the plan had made an adverse benefit determination, the notification must set forth, in a manner calculated to be understood by the claimant:

- i. the specific reason(s) for the adverse determination;
- ii. reference to the specific plan provisions on which the benefit determination is based;
- iii. a statement that the claimant is entitled to receive, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
- iv. a statement describing any voluntary appeal procedure offered by the plan and the claimant's right to obtain the information about such procedures, and a statement of claimant's right to bring action under ERISA § 502(a);
- v. in the case of a group health plan or a plan providing disability benefits, the plan must also notify the claimant: of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination and advise the claimant that a copy of the internal rule, guideline, or protocol will be provided free of charge upon request; either an explanation of the scientific or clinical judgment for any adverse determination based on medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

4. Relevant Documents on Appeal. A document, record, or other information is considered relevant to a claim if it:

- a. was relied upon in making the benefit determination;
- b. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- c. demonstrates compliance with the administrative processes and safeguards in making benefit determinations as required by 29 C.F.R. § 2560.503-1(b)(5); or
- d. in the case of group health plan or disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied

treatment option or benefit for the claimant's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

29 C.F.R. § 2560.503-1(m)(8).

III. Benefit Claims Litigation

A. Exhaustion. As a general rule, a participant or beneficiary must exhaust a plan's claims process before commencing a court action pursuant to ERISA § 502(a)(1). *E.g.*, *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 825-26 (1st Cir. 1988); *Communications Workers of Am. v. AT&T*, 431-34 (D.C. Cir. 1994); *Makar v. Health Care Corp.*, 872 F.2d 80, 82-83 (4th Cir. 1989); *Diaz v. United Agric. Employee Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1483-84 (9th Cir. 1995). However, if the plan fails to establish or follow claims procedures consistent with the regulations, a claimant may be deemed to have exhausted the administrative remedies available under the plan and be entitled to pursue any available remedies under ERISA § 502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. 29 C.F.R. § 2560.503-1(l).

ERISA does not provide a statute of limitations for benefit claim cases. When applying the most analogous state law limitations period, courts typically look to the statute of limitations applicable to contract claims. A plan itself also may provide its own limitations period, as long as it is reasonable.

B. Still Not Too Late to Avoid Litigation. Everyone involved should understand that not every error made by a plan during the claims process requires litigation in order to make the participant or beneficiary whole. In most cases, a claimant will not be awarded benefits from the plan simply by proving that the plan did not maintain or did not adhere to, reasonable claims procedures. In such cases, the courts usually remand to the plan administrator to reconsider the claim.

Ideally, all parties involved will seek to resolve disputed claims without commencing litigation. The following actions by the plan may lead to an amicable resolution without litigation: allow the claimant to fully express his concerns to the plan administrator; carefully review all facts and circumstances relating to the adverse benefit determination; if the plan made a mistake, admit it, fix it and apologize to the claimant; and take steps to ensure that the mistake will not be made again.

As the Ninth Circuit has observed:

What the [claims] regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language with specific reference to the plan provisions that form the basis of the denial. If the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters.

Booton v. Lockheed, 110 F.3d. 1461, 1463 (9th Cir. 1997).³ While the Ninth Circuit’s “what we got here ... is a failure to communicate” quote from Cool Hand Luke may appear humorous, *Id.* at 1464, it highlights the very serious point that failure to properly communicate often leads to unnecessary litigation.

Of course, there are times when the parties simply cannot agree. Then, we must be prepared to represent our respective clients in any litigation that ensues. Civil actions for benefits from employee benefit plans governed by ERISA must be brought under ERISA § 502, 29 U.S.C. § 1132. ERISA contains a broad preemption provision that, with limited exceptions, preempts all state laws that “relate to” an employee benefit plan. ERISA § 514(a), 29 U.S.C. § 1144(a). Thus, state common law claims such as those for breach of contract, fraud, and promissory estoppel are ordinarily preempted by ERISA. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (state law claims for tortious breach of contract, fraud, and breach of fiduciary duty arising from denial of benefits preempted).

C. Parties. Plan participants and beneficiaries are empowered to bring civil actions pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to recover benefits from employee benefit plans. A “participant” is any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such labor organization, or whose beneficiaries may be eligible to receive such benefits. ERISA § 3(7), 29 U.S.C. § 1002(7). A “beneficiary” is a person designated by a participant, or by the terms of an employee benefit plan, who is or may become, entitled to a benefit thereunder. ERISA § 3(8), 29 U.S.C. § 1002(8). Participant status is typically determined as of the time the suit is filed.

The Supreme Court granted certiorari and rendered its decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), in part, to resolve the conflicts among the Courts of Appeals as to the interpretation of the term “participant” in ERISA § 3(7). The Court held that the term “participant” is naturally read to mean either “employees in, or reasonably expected to be in, currently covered employment” or former employees who “have a reasonable expectation of returning to covered employment” or who have a “colorable claim” to vested benefits. *Bruch*, 489 U.S. at 117. In addition, the Court held that in order to establish that he or she “may become eligible” for benefits, a claimant must have a colorable claim that (1) he or she will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future. *Id.* at 117-118.

If a participant or beneficiary has properly assigned welfare plan benefits to it, a healthcare provider may also have standing to bring a civil action under ERISA § 502(a)(1)(B). *See, e.g., Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1988). Unlike welfare benefits, pension benefits may not be assigned to service providers. ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1).

³ This very short decision, which reads like a comedy of errors, should be read for its concise exploration of blunders that must be avoided in the claims process. *See also, Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206, 1213 (9th Cir. 2008).

ERISA § 502(d)(1) provides that an employee benefit plan may be sued under ERISA § 502(a)(1)(B) as an entity. ERISA also provides that any money judgment under Title I of ERISA against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity. ERISA § 502(d)(2). Therefore, courts often dismiss all other defendants from 502(a)(1)(B) cases. *See e.g., Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir. 1988); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997). *See also Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002).

D. Service. Service of summons, subpoena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the plan. ERISA § 502(d)(1), U.S.C. § 1132(d)(1). In a case where a plan has not designated in the summary plan description an individual as agent for service of legal process, service upon the Secretary of Labor shall constitute service. *Id.* The Secretary of Labor, not later than 15 days after receipt of service, shall notify the administrator or any trustee of receipt of such service. *Id.*

E. Jurisdiction. State courts of competent jurisdiction and district courts of the United States have concurrent jurisdiction for actions under ERISA § 502(a)(1)(B). ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1). Either court will determine the action based on federal law. The United States district courts have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided in ERISA § 502(a). ERISA § 502(f), 29 U.S.C. § 1132(f).

If a claim for benefits is brought in state court, the defendant may seek removal to the appropriate United States district court on the basis of federal question jurisdiction. 28 U.S.C. §§ 1441, 1446. *See, e.g., Cruthis v. Metro. Life Ins. Co.*, 356 F.3d 816, 818 (7th Cir. 2004). This is true even if the complaint, on its face, raises only state law claims. *E.g., Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987) (complete preemption doctrine).

F. Venue. When an action is brought in federal court, it may be brought in the district where the plan is administered, where the alleged fiduciary breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or can be found. ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2). This venue provision sometimes results in cases of “forum shopping.” Then again, 28 U.S.C. § 1404(a) allows either party to file a motion to transfer to another division or district where the case could properly have been brought on the grounds that such a transfer is required for the convenience of parties and witness.

G. Standard of Review. The “standard of review” refers to the legal standard applied by the courts in reviewing a plan administrator’s decision denying a claim for benefits. The standard of review often is critical to the outcome of claim for benefits litigation.

ERISA itself does not specify the standard of review to be applied. In *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), the Supreme Court held that “a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to

determine eligibility for benefits or to construe the terms of the plan.” *Bruch*, 489 U.S. at 115. Thus, under *Bruch*, the standard of review depends upon what the governing plan documents provide. If the plan documents give the appropriate claim fiduciary discretionary authority to interpret the plan’s terms and determine eligibility for benefits, then generally an arbitrary and capricious standard of review will be applied and the administrator’s decision will be upheld unless it constitutes an abuse of discretion. If the plan documents do not grant such discretion, then the denial of benefits will be reviewed *de novo*.

The “arbitrary and capricious” standard also is referred to as the “abuse of discretion” standard. Generally, this means that the decision will be upheld if it is supported by substantial evidence and based upon a reasonable interpretation of the plan’s terms. *See, e.g., Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998); *Celardo v. GNY Auto. Dealers Health & Welfare Trust*, 318 F.3d 142, 146 (2d Cir. 2003); *Herman v. Central States, Southeast and Southwest Areas Pension Fund*, 423 F.3d 684, 692 (7th Cir. 2005). Thus, an abuse of discretion may be found to have occurred when, for example, the administrator failed to investigate the facts or obtain enough information to make an informed decision, ignored critical evidence or arguments presented by the claimant, or interpreted the plan in a manner that conflicts with the plain language of the governing plan documents.

Any delegation of discretionary authority must be made in accordance with ERISA Section 405(c), 29 U.S.C. § 1105(c). That provision states that a plan may expressly provide for procedures for allocating fiduciary responsibilities among named fiduciaries and for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities, other than trustee responsibilities under the plan. In the absence of evidence of an effective delegation of authority to the decision-maker, a *de novo* standard of review will be applied. *See, e.g., Nichols v. Prudential Ins. Co. of America*, 406 F.3d 98, 108 (2d Cir. 2005).

The Supreme Court recently addressed the question of what impact a conflict of interest plays in applying the standard of review. In *Metropolitan Life Insurance Co. v. Glenn*, No. 06-923 (June 19, 2008), the Supreme Court addressed this question in the context of a fully insured long-term disability benefits plan where MetLife served as both the claims administrator and insurer of the benefits. The Court held that if an administrator both makes eligibility determinations and pay the benefits out of its own funds, a conflict of interest exists. The Court rejected the argument that a *de novo* or lesser standard of review should be applied when a conflict exists. Slip op. at 9. Rather, the conflict is “one factor among many that a reviewing judge must take into account” in applying the arbitrary and capricious standard of review. Slip op. at 10. The weight to be given the factor in any given case will depend on the nature and extent of the conflict. Slip op. at 10-11.

If the plan’s terms do not give the administrator discretionary authority to construe the plan’s terms or determine eligibility for benefits, denials of benefits are reviewed under a *de novo* standard of review. Under this standard, the reviewing court generally is not required to give any deference to the claims fiduciary’s determination.

H. Scope of Review. The “scope of review” refers to the information a court will consider in reviewing a claim denial. When reviewing a claim denial under an arbitrary and capricious standard of review, the courts generally will not consider any evidence not presented

to the administrator as part of the plan's claim review process. *See, e.g., Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981-82 (7th Cir. 1999); *Chalmers v. Family Health Plan Corp.*, 100 F.3d 818, 823-24 (10th Cir. 1996). Somewhat more flexibility is employed when the standard of review is *de novo*, but even then most courts have held that additional evidence should be considered only in exceptional circumstances. *See, e.g., DeFelice v. American Int'l Life Assurance Co. of NY*, 112 F.3d 61, 65 (2d Cir. 1997); *Quesinberry v. Life Insurance Company of North America*, 987 F.2d 1017, 1021-27 (4th Cir. 1993).

I. Discovery. Since the scope of review is generally limited, there is typically little or no discovery in cases involving claims for benefits from employee benefit plans. *See, e.g., Perlman v. Swiss Bank Corp.*, 195 F.3d at 982. In most cases, the claims record is the only evidence being reviewed. However, if there are questions as to whether the decision-maker had a conflict of interest, this may open the door to discovery regarding the nature and extent of the conflict. *See, e.g., Tremain v. Bell Indus.*, 196 F.3d 970 (9th Cir. 1999).

J. Rule 52 v. Summary Judgment. Claim for benefits cases often are resolved on cross motions for summary judgment, with the contents of the administrative record undisputed and the parties presenting arguments based upon that record. However, a number of courts suggested that it is more appropriate, especially when the standard of review is *de novo*, for the court to enter findings of fact and conclusions of law pursuant to Rule 52 of the Federal Rules of Civil Procedure based upon the stipulated administrative record. *See Muller v. First Unum Life Ins. Co.*, 341 F.3d 119, 124 (2d Cir. 2003); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1094-95 (9th Cir. 1999); *cf. Shaw v. Connecticut General Life Ins. Co.*, 353 F.3d 1276, 1286 (11th Cir. 2003) (summary judgment not appropriate under *de novo* review because whether plaintiff was "disabled" was a disputed issue of material fact).

K. Jury Trial. Most courts have held that there is no right to a jury trial in actions brought solely to recover ERISA benefits. The rationale for this holding is that such claims are equitable, and not legal, in nature. *See, e.g., Turner v. CF & I Steel Corp.*, 770 F.2d 43, 46-47 (3rd Cir. 1985); *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1006-7 (4th Cir. 1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1357 (9th Cir. 1984); *Wardle v. Central States, Southeast and Southwest Areas Pension Fund*, 627 F.2d 820, 830 (7th Cir. 1980); *Thomas v. Oregon Fruit Prods Co.*, 228 F.3d 991, 995-97 (9th Cir. 2000).

L. Relief. Pursuant to ERISA § 502(a)(1)(B), if the claimant is successful, courts grant benefits allowed under the terms of the plan. Compensatory, consequential and punitive damages are not allowed in ERISA § 502(a)(1)(B) actions. *See, e.g., Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985) ("the statutory provision . . . says nothing about the recovery of extra-contractual damages, or about the possible consequences of delay in the plan administrators' processing of a disputed claim").

In any action for benefits under an ERISA plan, the court in its discretion may allow reasonable attorney's fees and costs of action to either party. ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(1). Because the awarding of attorney's fees is discretionary, the prevailing party is not

automatically entitled to attorney's fees. In determining whether to grant attorney's fees, the courts customarily apply the five factor test first espoused in *Eaves v. Penn*, 587 F.2d 453 (10th Cir. 1978):

- (1) degree of opposing parties' culpability or bad faith;
- (2) ability of opposing parties to satisfy an award of attorneys' fees;
- (3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;
- (4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and
- (5) the relative merits of the parties' positions.

See, e.g., Quisenberry v. Life Ins. Co, 987 F.2d 1017, 1028-29 (4th Cir. 1993).

In cases "where the fee award would be paid out of the plan assets and not 'out of the pockets of the people responsible for the denial of benefits' the ability-to-pay factor might favor a denial of attorneys' fees and the deterrent effect considered in factor three would also be diminished." *Quisenberry* at 1030 (quoting *Bittner v. Sadoff & Rudoy Indus.*, 728 F.2d 820, 829 (7th Cir. 1984)).

Prejudgment interest often is awarded to prevailing claimants. "ERISA does not specifically provide for prejudgment interest and, absent a statutory mandate, the award of prejudgment interest is discretionary with the trial court." *Quisenberry*, 987 F.2d at 1030.

ERISA also does not specifically provide for post-judgment interest. The general federal post-judgment interest statute applies to judgments in ERISA claims for benefits. *Quisenberry*, 987 F.2d at 1031; *see also I.A.M. Nat'l Pension Fund v. Slyman Indus., Inc.*, 901 F.2d 127, 130 (D.C. Cir. 1990).

IV. Conclusion

Although ERISA clearly sets forth the requirements for processing benefit claims and appeals, at times plan administrators fail to fully adhere to those requirements or participants are dissatisfied with the administrator's determinations. Such failures or dissatisfaction may lead to litigation against employee benefit plans. Before litigation begins, plan administrators should attempt to resolve participant disputes and participants must exhaust plan administrative processes. After litigation begins, the parties must ensure that they are in the proper venue; that they have included all proper parties; that they understand the standard of review the court will likely apply; and that they know their rights to discovery, jury trial, and relief.