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View From McDermott: Judicial Do's and Don'ts of ERISA Benefit Claim Administration – Follow the Rules!

By Michael T. Graham

When the Employee Retirement Income Security Act of 1974 (''ERISA'') was adopted, the Act and the regulations supporting it could be printed in a booklet that was less than a half-inch thick. Through the past four decades, Congress and federal agencies have added significantly to ERISA and its regulations.

Today, the Act and the regulations are typically reprinted in several book volumes that can be almost a *half of a foot* thick. With this increase in the volume of provisions and rules, the job of plan administrators to read, comprehend and then follow these rules, which can be very complex for certain types of ERISA benefit plans, has become very difficult.

Yes, ERISA does have certain benefits for plan administrators, such as nationwide administration rules that negate the need to transverse conflicting state legal requirements. However, the growing list of plan administrative rules that impact benefit plans—including broadening fiduciary rules for retirement plans and increasing compliance challenges with the myriad new rules under the Affordable Care Act—adds potential risk for plan administrators with government audits and with benefit challenges by participants and beneficiaries.

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Much has been written about the challenges that exist for ERISA plan fiduciaries related to their investment of plan assets or review of plan administration fees related to those investments, and those challenges will continue for the foreseeable future given recent decisions of the Supreme Court in *Dudenhoeffer* and *Tibble*.[1] However, before any litigation typically commences under ERISA, a claimant must exhaust their administrative claims review remedies under ERISA and the applicable benefit plan. In reviewing benefit claims, an ERISA plan administrator or their delegate must reasonably and timely jump through many hoops to decide benefit claims and notify the claimant of a benefit determination. If a plan administrator fails to clear any of these hoops (or just forgets to jump through them), the plan and the plan administrator can incur liabilities or waive defenses typically available in defending the claims in litigation.

This article analyzes court cases that discuss how plan administrators should properly decide and administer ERISA benefit claims and what liability should attach to poor claims administration. Based on this case review, this article then suggests best practices to avoid mishandling the ERISA claims review process.

Administrators Must Respond Timely to Requests for Plan and Claim Documents

One of the more ministerial acts that an ERISA plan administrator must perform is responding to a participant's or beneficiary's requests for plan documents. Under ERISA Section 104(b)(4), a plan administrator, upon a participant's or beneficiary's written request, must furnish a copy of a benefit plan's latest updated summary plan description, annual report, terminal report, trust agreement, contract, bargaining agreement or other documents under which the plan is established

[1] *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459, 58 EBC 1405 (U.S. 2014) (123 PBD, 6/26/14) ; *Tibble v. Edison Int'l*, 135 S. Ct. 1823, 59 EBC 2461 (U.S. 2015) (96 PBD, 5/19/15).

 ISSN

or administered.[2] Under ERISA Section 502(c), if a plan administrator does not satisfy Section 104(b)(4)'s production requirements within 30 days of the request, then a court may award a participant or beneficiary monetary damages, in the form of civil penalties against the plan administrator, for failing to comply with that notice provision.[3] The purpose behind this civil penalty provision is to incentivize a plan administrator to comply with their ERISA obligations. The court has discretion to award a civil penalty of $110 per day for any violation. When determining whether a penalty should be awarded, a court will typically consider whether a participant or beneficiary suffered any prejudice as a result of not receiving the requested document and will consider whether there are any mitigating factors in the plan administrator's failure to timely respond to the request.[5]

While most plan administrators properly and timely respond to document requests, sometimes these requests ''fall through the cracks'' of typical plan or claim administration. When these mistakes occur, they can result in substantial liability to the plan or the employer. One case where a court imposed the maximum civil penalty for a plan document production failure was *Cromer-Tyler v. Teitel*.[6] In *Cromer*, the plaintiff worked in the defendant's surgical practice and participated in the practice's money purchase pension plan. The plaintiff worked for Teitel for three years until the surgical practice terminated her employment when she elected not to purchase the practice. After her employment ended, the plaintiff received several forms from the practice relating to the plan as well as periodic benefit statements reflecting her benefit totals under the plan.

The plaintiff attempted to contact the plan's custodian to receive additional information about her benefits under the plan. Eventually, the custodian notified the plaintiff to contact Dr. Teitel, as the plan's administrator. The plaintiff then received a notice from Dr. Teitel, which informed her that she had no vested account balance in the plan at the time she terminated her employment. However, the plaintiff at no time was provided with a copy of the plan's governing document or the plan summary to assess her rights.

Although the plaintiff sent several additional requests for plan documents, none were provided. Ultimately, the plaintiff filed suit to recover the benefits she believed were due as well as civil penalties under ERISA Section 502(c) due to the plan administrator's failure to furnish the requested documents.

After a bench trial, the court determined that the plaintiff was entitled to vested benefits under the plan, and that the plan administrator failed to articulate the specific reasons under ERISA or the plan's terms that allegedly precluded her from receiving benefits. In addition, the court determined that, as plan administrator, Dr. Teitel failed to maintain plan records related to its operations, including plan documents, plan summaries or annual reports. The plaintiff did not receive copies of the plan documents until well after the litigation had commenced. The court determined that this untimely production of the requested plan documents prejudiced the plaintiff, and determined that the plan administrator had delayed providing the requested documents for 1,636 days.

While the court had discretion to award a penalty of *up to* $110 per day, it found that the plan administrator's violations were sufficiently severe to require the maximum award—$179,960 for the four and a half year delay in providing the requested documents. The plaintiff also was awarded attorneys' fees and costs of $55,678. In sum, the plan administrator's failure simply to provide a response to a document request amounted to over $225,000 in liability—a pretty high cost for failing to complete one of the simpler ERISA administration tasks.[7]

Plan administrators can easily avoid liability for failing to provide required plan documents if the proper safeguards are in place. A plan administrator should create specific guidelines for its representatives to identify plan document requests and then respond to those requests within the required 30-day time period required by ERISA. Some companies have even created litigation docket-like systems to insure that these requests—and the claims they are typically attached to—are timely addressed.

While mistakes in document production responses will always occur, either because of human error or systematic failures, it is important for the plan administrator to have *some* system in place to establish that it takes its administrative requirements seriously. In that event, it will be more difficult for a claimant or participant to prove the prejudice necessary to receive a maximum penalty award. As the *Cromer-Tyler* case shows, a failure to comply with even the most ministerial of tasks can result in significant liability.

Errors in the Claims Review Process Can Adversely Impact a Litigation Defense

ERISA Section 503 requires every employee benefit plan to provide adequate notice in writing to any participant or beneficiary whose benefit claim has been denied, setting forth the specific reasons for the denial and affording the participant or beneficiary a reasonable opportunity for a full and fair review of a denied

[2] *See* 29 U.S.C. § 1024(b)(4).

[3] *See* 29 U.S.C. § 1132(c). It must be noted that a plan administrator's failure to send a notice under the Consolidated Omnibus Budget Reconciliation Act (''COBRA'') related to a participant's right to continue group health care benefits is also subject to Section 502(c)'s civil penalty procedures. *See* 29 U.S.C. § 1132(a)(1)(A).

[5] *See e.g., McDowell v. Price*, 731 F.3d 775, 783 (8th Cir. 2013) (186 PBD, 9/25/13).

[6] *See Cromer-Tyler v. Teitel*, 2007 BL 97521, 41 EBC 2400 (M.D. Ala. Sept. 11, 2007).

[7] Recently, the civil penalty provisions have been expanded to requests for relevant plan documents in the benefit claim context. 29 C.F.R. § 2560-503-1 requires a plan administrator to provide a claimant, upon request, with the documents that are relevant to a denial benefit claim. However, this regulatory requirement is not referenced as a type of administrative failure for which a $110 a day civil penalty attaches. In fact, may courts have held that civil penalties are not available for § 2560-503-1 violations. *See, e.g., Wilczynski v. Lumbermans Mut. Cas. Co.*, 93 F.3d 397 (7th Cir. 1996); *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 20 EBC 2493 (4th Cir. 1996). However, last year in *Halo v. Yale Health Plan*, 49 F. Supp. 3d 240 (D. Conn. 2014), one district court decided to expand the civil penalty remedy to failures to provide relevant documents during a benefit claim review. It is unclear whether the *Halo* decision will start a trend toward liability for such requests. In any event, plan administrators should be aware that liability may result if such requests are not properly and timely addressed.

  ISSN

claim by the plan's named fiduciary.[8] The U.S. Department of Labor's regulations supporting ERISA Section 503 contain many specific requirements for a plan's claims review procedures, including the timing rules for deciding a claim or claim appeal, a description of the content that must be included in a claim or claim appeal determination, and a description of a claimant's right to receive all documents that are relevant to the claim determination.[9] As a general rule, a participant or beneficiary must exhaust a plan's claims review procedures before commencing a benefit challenge in court.[10] However, if a plan administrator fails to establish or follow the claims procedures in the plan or if those procedures do not comply with ERISA's claims regulations, the plan administrator may ***lose*** certain defenses in litigation, such as a failure to exhaust administrative remedies argument or the loss of deferential review typically available for exhausted benefit claim determinations. As discussed below, the loss of these defenses because of claim processing failures or irregularities can be the difference between winning and losing an ERISA benefit suit.

No Claims Decision Means No Deferential Review Standard in Litigation

As discussed above, if a plan administrator properly follows the plan's claims procedures and timely denies a benefit claim consistent with the claims regulations, then that determination will be given deference in litigation if the plan grants the plan administration sufficient authority to decide claims under the plan.[11] However, if the plan administrator does not properly process the claim, it may lose the deferential standard of review in litigation.

The court's decision in *Strom v. Siegel Fenchel & Peddy P.C. Profit Sharing Plan*[12] is a good example of the bad things that can happen when a plan administrator does not properly follow the claim rules. In *Strom*, a law firm secretary continued to work at the firm while going to law school. Eventually, she became an attorney and joined the firm in that capacity. Several years later, she was promoted to partner. The plaintiff ultimately decided to leave the firm and claimed an entitlement to a benefit sunder two of the firm's pension plans. She sought additional benefits for her time as a firm partner, arguing that certain plan amendments that eliminated an ''increased contribution'' for participants did not apply to her because she was a partner entitled to full benefits.

During the administrative claims process, the firm first denied her claim for cash balance plan benefits stating that she was not a partner or shareholder when the plan was effective. However, the firm failed to cite to any plan provision to support their denial.

In a later letter, the firm admitted that she was entitled to benefits but not the amount she sought. Again, the firm failed to cite any plan provision for its decision. The firm held an administrative hearing on her claim appeals. Ultimately, the firm determined that it could not conclusively resolve her claims after the hearing, and stated that it was tentatively denying her claim appeals. The plaintiff filed suit to challenge the benefit denials.

On appeal, the United States Court of Appeals for the Second Circuit determined first that the firm's claim determinations should have been reviewed *de novo*, and not under the deferential arbitrary and capricious standard, as the district court could not defer to a plan determination that was never in fact made or explained.[13] Moreover, the court found that the firm's explicit refusal to decide the claim required applying a *de novo* standard, as a non-decision cannot be deemed an exercise of discretion allowing for a deferential standard of review. As a result, the court determined that a nonexistent plan interpretation cannot be a reasonable one, and therefore found the firm's claim determinations to be unreasonable.[14]

This case is a very good example of the negative consequences that can occur when a plan administrator issues a final determination that violates ERISA's claims regulations—not only will the claim ''determination'' be reviewed under a heightened review standard, it might be rejected. Plan administrators must make a clear, final claim determination if they want to protect all defenses in future litigation that challenges the benefit claim decision.

Benefit Claim Process Inconsistencies May Impact Litigation Defenses

Not only must a plan administrator follow the general requirements of ERISA's claims regulations and the plan's terms in deciding a benefit claim, it must do so consistently for all claims and cannot act arbitrarily on any single claim. *Songer v. Reliance Standard Life Insurance Co.* is an example of such a case.[15] In *Songer*, a plan participant brought an ERISA action against a plan administrator, challenging the denial of his long-term disability benefit claim. In his original disability claim, the plaintiff listed only a back injury as his disability, and never mentioned a mental or nervous disorder as a supporting condition. The submitted physician's statement listed the plaintiff's back injury as the ''primary diagnosis,'' and only mentioned a mental or nervous condition in passing. Ultimately, the plan administrator denied the claim based on the mental or nervous ''diagnosis'' and completely discounted any back injury.

The plaintiff filed suit, and the court agreed that the plan administrator's opinion lacked consistency under the plan. Notably, the court found that, under the plan's terms, the plan administrator could have requested the plaintiff to be examined by an independent medical examiner, which it routinely did for such claims, but did not do so on the plaintiff's claim. Instead, the plan administrator rejected the submitted medical physician's opinion regarding the back injury, failed to consult with the plaintiff's treating physician about the alleged disability, and rejected the opinion of its own medical reviewer, provided by an in-house nurse, who opined that

[8] *See* 29 U.S.C. § 1133.
[9] *See* 29 C.F.R. § 2560.503-1.
[10] *See, e.g.*, *Amato v. Bernard*, 618 F.2d 559, 566-68, , 2 EBC 2536 (9th Cir. 1980).
[11] *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 10 EBC 1873 (1989).
[12] 497 F.3d 234 (2d Cir. 2007).
[13] *Id.* at 244.
[14] *Id.* at 244-45.
[15] 2015 BL 130908 (W.D. Pa. May 5, 2015).

the back injury was the sole alleged basis for the claim. As the court found, an ''administrator's reversal of its decision to award a claimant benefits without receiving new medical information to support this change in position is an irregularity that counsels towards finding an abuse of discretion.''[16]

This case shows how important it is for a plan administrator to consistently apply and interpret the plan's terms when deciding benefit claims. Prior plan administrative decisions set a precedent on a specific issue for future claim determinations. In *Songer*, the administrator's failure to utilize an independent medical examiner to review the claim file varied from the plan's typical procedures, and the lack of consistency between the final decision and the initial claim determination doomed the plan administrator's litigation defense.

Post-Hoc Claim Decision Rationales Are Not Permitted in Later Litigation

Under ERISA's claims regulations, a plan administrator must spell out all of the reasons for its decisions during the administrative review process, and it cannot save or hold back any rationales for a claim determination for later potential litigation. ERISA mandates that every benefit plan shall ''provide adequate notice in writing'' to a participant who is denied benefits under a plan, and must explain ''the specific reasons for such denial'' so as to ''afford a reasonable opportunity . . . for a full and fair review.''[17] As one court of appeals has explained, ''[o]ne of the main purposes for the requirement that the denial letter provide specific reasons is to provide claimants with enough information to prepare adequately for further administrative review or an appeal to the federal courts.''[18]

In the recent case of *Locklear v. Sun Life Assurance Co. of Canada*,[19] a plan administrator's failure to list all rationales for a claim decision undercut their defense of the claim in court.

In *Locklear*, the plaintiff's husband was killed in an automobile accident and filed a claim under her employer's accidental death insurance plan. The defendant paid the plaintiff benefits related to a life insurance plan, but requested additional information on the accidental death benefit claim. Ultimately, the accidental death plan benefit claim was denied because the defendant determined that the husband's death occurred during the commission of a crime—specifically, it found that the husband's attempt to pass a vehicle in a no-passing zone fit within the ''criminal act'' exclusion under the plan. The plaintiff filed suit.

During the defense of the litigation, the defendant raised an additional rationale in support of its claim denial not explained in the final claim appeal determination—that the husband's actions constituted reckless endangerment, which barred benefits under the plan. In addressing the administrator's rationales, the court found that the administrator was barred from raising a *post hoc* rationale for its claim denial for the first time in the litigation. The court determined that where an administrator possesses sufficient knowledge and information regarding an argument and failed to present it at the administrative level, the plan administrator is not permitted to later use the argument during the litigation.[20] The court reasoned that allowing *post hoc* justifications would discourage the ''meaningful dialogue'' between plan administrators and beneficiaries as ERISA intended. As a result, the court overturned the plan administrator's benefit denial.[21]

This decision, and others like it, should be a strong reminder to plan administrators to list all of their rationales for a claim determination during the administrative review process, or suffer losing such defenses if litigation subsequently arises. To protect against such a situation, plan administrators must be charged with undertaking a thorough investigation when conducting their administrative claim review, and seeking advice of either internal or outside counsel to insure that all possible bases for a claim denial are adequately explained to the claimant. Otherwise, even if a *post hoc* rationale provides strong evidence that a claim denial should be upheld, the courts likely will not even consider the new argument, which could result in a negative result for the employer that is unnecessary under the plan's terms or the law.

Conclusion

As the above case summaries establish, an administrator's failure to follow properly ERISA's and a benefit plan's administrative claim rules can doom a claim defense that otherwise would have been successful. Plan administrators therefore should review their current administrative benefit processes and insure that all hurdles are carefully crossed before providing a final claim determination. Also, administrators should not be shy to contact their in-house or outside counsel to make sure that all of ERISA's claims rules are being followed, especially on those claims where it is likely that litigation will result. A little extra work on the administrative end can often result in a successful defense of an ERISA claim, and can avoid additional court costs and attorneys' fees to defend a flawed processes.

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[16] *Id.* at *9-10 (citing *Haisley v. Sedgwick Claims Mgmt. Servs., Inc.*, 776 F. Supp. 2d 33, 48 (W.D. Pa 2011)).

[17] 29 U.S.C. § 1133.

[18] *Skretvedt v. E.I. DuPont de Nemours & Co.*, 268 F.3d 167, 26 EBC 2610 (3d Cir. 2001).

[19] *See* 2015 BL 127458 (M.D. Pa. May 1, 2015).

[20] *Id.* at *5-7.

[21] *Id.* at *7-9.

  ISSN