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Supreme Court to Address Proper ERISA Review Procedures: Practical Advice for Plan Administrators

By John R. Richards

Changes in the regulations governing the review of a request for benefits under a plan governed by the Employee Retirement Income Security Act of 1974 (“ERISA”) became effective a little over five years ago. However, the courts are still coming to grips with what the regulations require, and how a violation of the regulations impacts the adjudication of a claim for benefits. Circuits currently apply a mish-mash of standards and, as a result, the United States Supreme Court has announced that it intends to address at least a portion of the confusion that has resulted. Specifically, in *MetLife v. Glenn*¹ the Court will address two issues:

1. Did the Sixth Circuit err in holding, in conflict with two other circuits, that the fact that a claim administrator of an ERISA plan also funds plan benefits, without more, constitutes a “conflict of interest” that must be weighed in judicial review of an administrator’s benefit determination under *Firestone Tire & Rubber Co. v. Bruch*?²
2. If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?

¹ 461 F.3d 660 (6th Cir. 2006), *cert. granted*, No. 06-923, 2008 U.S. LEXIS 1101 (Jan. 18, 2008).

² 489 U.S. 101 (1989).

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While the *Glenn* decision will assist courts in adjudicating claims for benefits in the conflicted fiduciary arena, much will remain disjointed among the circuits. This article aims to assist counsel who represent employers that provide benefits to employees in multiple jurisdictions by addressing the common pitfalls in the day-to-day administration of benefit claims.

A. Protocol for Reviewing Appeals of Initial Adverse Benefit Determination

In general, an employee whose request for benefits has been denied is entitled to a “full and fair review of the claim and the adverse benefit determination” on appeal.³ The particulars of the review mandated under the Department of Labor (“DOL”) claim regulations (the “Regulations”),⁴ vary depending on the nature of the benefit claim, but the fundamental structure of the Regulations remains the same. Based on the Regulations, an administrator should abide by the following guidelines when reviewing an adverse benefit determination:

- The review should be conducted by a fiduciary of the plan who is a different person than the fiduciary who made the initial denial decision, and who is not a subordinate of the initial reviewer;
- Depending on the nature of the plan, claimants must receive between 60 and 180 days to appeal a benefit claim;
- Claimants should have a reasonable opportunity to submit written comments, documents, records, and other information relating to their claim for benefits;
- Claimants should be provided copies of information relevant to their appeal;
- If a denial is based on a medical judgment, the plan must consult with a “health care professional with

appropriate training and experience” in the field to which the claim relates;⁵

- To the extent that a plan consults with an expert, the plan should identify *all* experts consulted, regardless of the degree of reliance on any expert’s opinion;
- The senior plan administrator should respond to *all* arguments made in the appeal letter by taking into account all comments, documents, records, and 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; and
- The senior plan administrator should not give any deference to the initial adverse determination.⁶

B. Specifics of Review on Appeal

Claims review fiduciaries commonly review an appeal of an initial adverse determination with reference to the initial denial letter. The Regulations, however, explicitly state that the plan fiduciary on appeal may not “afford deference to the initial adverse benefit determination.”⁷ Thus, even though the plan fiduciary intuitively wants to include consideration of the grounds stated in the original denial letter that is the basis of the appeal, some courts have held that the Regulations preclude even consideration of the initial denial letter in connection with the appeal. In this context, the guidelines place fiduciaries in quite a predicament: (1) the regulations instruct a fiduciary to review the entire file on appeal, while also requiring the fiduciary not to give any deference to the initial denial letter, which may suggest that it did not review the entire file; and (2) if the required *de novo* review of the entire file leads a fiduciary on appeal to offer an entirely new, independent reason as to the basis of a denial, at least two circuits have found that the claimant

³ 29 C.F.R. § 2560.503-1(h)(2).

⁴ 29 C.F.R. § 2560.503-1.

⁵ 29 C.F.R. § 2560.503-1(h)(3)(iii).

⁶ 29 C.F.R. § 2560.503-1(h).

⁷ 29 C.F.R. § 2560.503-1(h)(3)(ii).

has arguably been denied due process, despite the fiduciary's compliance with the regulations.⁸

In the face of this apparent Catch-22, plan fiduciaries should consider informing the claimant of any additional bases for denying the claim and affording him or her the opportunity to respond with any additional evidence. As long as the fiduciary ensures that this process complies with the Regulations' time restraints, providing this additional opportunity avoids possible complications for the plan in the event of litigation.

C. The Importance of Compliance

In nearly all circuits, compliance with the Regulations impacts the standard of review a court applies to its adjudication of a benefit claim. Long ago, the Supreme Court held that where a plan affords the claim administrator discretion, its decision regarding benefit eligibility should stand unless the decision is "arbitrary and capricious."⁹ If a plan administrator fails to fully comply with mandated DOL protections, however, the Regulations suggest that an administrator's decision may not be entitled to deference.¹⁰ Courts have generally created the doctrine of "substantial compliance," however, which maintains a deferential standard of review.¹¹ Substantial compliance is a doctrine that "forgives technical noncompliance for purposes of review of a plan administrator's discretionary decision."¹² Some circuits, however, adjust the amount of deference if

⁸ See, e.g., *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (9th Cir. 2006) (stating "[w]hen an administrator tacks on a new reason for denying benefits in a final decision, thereby precluding the plan participant from responding to that rationale for denial at the administrative level, the administrator violates ERISA's procedures"); *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005) (finding that claimant did not receive a full and fair review if new information used by appeals committee emerges only with final denial); *Cook v. New York Times Co. Long-Term Disability Plan*, No. 02 Civ. 9154(GEL), 2004 U.S. Dist. LEXIS 1259 (S.D.N.Y. Jan. 30, 2004) (denial of appeal may not rely upon additional factors that were never communicated to the claimant).

⁹ *Bruch*, 489 U.S. at 109.

¹⁰ 29 C.F.R. § 2560.503-1.

¹¹ *Gatti v. Reliance Standard Life Ins. Co.*, 415 F.3d 978, 985 (9th Cir. 2005) (holding that "procedural violations of ERISA do not alter the standard of review unless those violations are so flagrant as to alter the substantive relationship between the employer and employee, thereby causing the beneficiary substantive harm").

¹² *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98, 107 (2d Cir. 2005).

there is evidence that a fiduciary has committed procedural irregularities.¹³

D. *MetLife v. Glenn*

Because the United States Supreme Court recently granted certiorari in *MetLife v. Glenn*,¹⁴ it will soon consider whether a plan fiduciary that acts as the claim administrator and also funds the plan benefits, without more, is operating under a "conflict of interest," and, if so, how the conflict of interest should be taken into account on judicial review of discretionary benefit determination. Thus, *Glenn* is an anticipated source of guidance for plan fiduciaries. If *Glenn* definitively answers questions regarding the standard of review that a court must employ in such instances, it may resolve the varying standards that exist among the circuits when plan fiduciaries fail to strictly comply with the DOL's regulations. *Glenn* will not address, however, collectively bargained arrangements or self-funded plans and administrative service agreements in which the entity that administers the claim is distinct from the entity that funds the benefits.

E. Conclusion

A plan administrator should not risk putting itself into a position where its plan determinations are subject to arguments that deference should be reduced due to lack of substantial adherence with the Regulations. Strictly following the DOL's regulations will maximize the likelihood that a discretionary administrator's decision receives deferential review. Finally, to the extent that a plan administrator bases its decision to confirm an adverse benefit determination on a reason other than the basis of the initial denial, it is advisable to provide the participant with the opportunity to respond prior to formally denying the request for benefits.

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¹³ *MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 478 (5th Cir. 2003) (employing a "sliding scale" to evaluating whether there was an abuse of discretion. This approach does not mark a change in the applicable standard, but only requires the court to reduce the amount of deference it provides to an administrator's decision").

¹⁴ No. 06-923, 2008 U.S. LEXIS 1101 (Jan. 18, 2008).