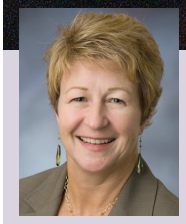
Understanding the Intricacies

By Chrys A. Martin

Effective Arbitration of ERISA Claims Disputes



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When an ERISA benefit plan participant or beneficiary asks a court or arbitrator to step into a claims dispute, language in the plan documents can make a difference in how the dispute is reviewed—and how likely it is that the claims determination will stand.

Plan administrators can assure more effective and efficient arbitration of Employee Retirement Income Security Act (ERISA) welfare and pension plan benefit disputes by:

- Carefully crafting arbitration clauses;
- Creating plan documents with appropriate discretionary language; and
- Administering claims in compliance with ERISA and plan procedural requirements.

It is also important to select an arbitrator with expertise in ERISA to ensure that claims disputes will be handled properly during arbitration.

ERISA Legal Principles

In benefits claims, the outcome is frequently determined by the *standard of review*—the level of judicial scrutiny—that the court or arbitrator applies to the plan's decisions. ERISA does not set forth a standard of review; it has been left to the courts to develop the standard of review through case law.

In the foundational case *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the U.S. Supreme Court explained that when a plan confers discretion on the plan administrator to interpret the terms of the plan and decide questions of eligibility, the standard of review is the deferential "abuse of discretion" (sometimes phrased as *arbitrary and capricious*). *However, the grant of discretion must be clear and unequivocal, otherwise the standard of review is de novo.* Under the discretionary standard, a court or arbitrator must generally defer to the administrator's determinations unless they are unreasonable or irrational. *See, e.g.*, *McDaniel v. Chevron Corp.*, 203 F.3d 1099, 1113 (9th Cir. 2000) ("A plan administrator's decision to deny benefits must be upheld under the abuse of discretion standard if it is based upon a reasonable interpretation of the plan's terms and if it was made in good faith."); and *Fuller v. CBT Corp.*, 905 F.2d 1056, 1058 (7th Cir. 1990) (abuse of discretion where decision is "not just clearly incorrect but downright unreasonable").

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The standard of review is also critical in determining the scope of the arbitration hearing or judicial proceeding. Typically, the discretionary review is limited to the administrative record developed in the claims process—*i.e.*, the proceeding does not feature new evidence, witnesses or plan interpretations. *See*, *e.g.*, *Banuelos v. Construction Laborers' Trust Funds for S. Cal.*, 382 F.3d 897, 904 (9th Cir. 2004) ("This court has clearly established that the abuse of discretion standard permits the district court to review only the evidence presented to the [plan] trustees."). In court, the case is decided on cross-motions for summary judgment based on the "record"—the claims administration file. In arbitration, these decisions should similarly be made through a non-evidentiary hearing and review of the record unless there is good reason, as discussed below, to supplement the record with discovery.

In contrast, if plan documents do not give the plan administrator the discretion to interpret the plan and decide eligibility, the standard of review is the far more searching de novo (in other words, from the beginning). This standard accords no deference to the administrator's decision, and the court "simply proceeds to evaluate whether the plan administrator correctly or incorrectly denied benefits." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006) (en banc). The arbitrator can substitute his or her judgment for that of plan trustees.

It is critical that the arbitrator have a strong working knowledge of ERISA law to determine the proper standard of review to use during the arbitration. The arbitrator must also then determine, under ERISA and plan terms, the scope of review—*i.e.*, whether there will be an evidentiary hearing to supplement the record with additional documents and witnesses, or will the matter be heard only on the record.

Standard of Review

ERISA allows beneficiaries to seek judicial review of plan determinations such as benefit denials. A plan participant or beneficiary may bring an action in federal court "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." ERISA §502(a)(1)(B); 29 U.S.C. §1132(a)(1)(B).

Many plans, especially Taft-Hartley trusts, contain mandatory arbitration clauses. Under these plans, benefits claims must be adjudicated before an arbitrator rather than in court. More single employer plans should evaluate the use of arbitration to provide a quick and less costly alternative for the employer and its employees who do not need to retain expensive legal representation during an arbitration proceeding. However, the complex standards and scope of review and other ERISA procedural rules still apply, so it is critical that plans and participants select an arbitrator well-versed in the law of ERISA. Otherwise, plans could face costly and extensive arbitration proceedings instead of the intended fast, efficient resolution of claims appeals.

Scope of Review

The fact finder may also, under appropriate circumstances detailed below, consider evidence in addition to the administrative record developed in proceedings before the plan administrator in order to conduct the de novo review. *See*, *e.g.*, *Kearney v. Standard Ins. Co.*, 175 F. 3d 1084, 1090–

91 (9th Cir. 1999). This means that the fact finder may only look at the documents submitted to and used by the plan administrator when the decision was made. Finally, even where plan documents confer discretion, "wholesale and flagrant" procedural violations of ERISA may necessitate de novo review and consideration of new evidence. *Abatie*, 458 F.3d at 971. This could also occur if the administrator violated plan terms or procedures in claims handling.

Conflict of Interest

The presence of a conflict of interest may also affect the court's review and the evidence considered. In *Met. Life Ins. Co. v. Glenn*, for example, the Supreme Court concluded that, while a conflict of interest on the part of the plan administrator did not require the application of de novo review, "a conflict should be weighed as a factor in determining whether there is an abuse of discretion." *Met. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

The quintessential conflict is the one identified by the *Glenn* Court: where the plan administrator (an insurer) both evaluated benefits claims and paid them. *See also Abatie*, 458 F.3d at 965 ("an insurer that acts as both the plan administrator and the funding source for benefits operates under what may be termed a structural conflict of interest."). A court may consider evidence beyond the administrative record to determine whether a conflict of interest exists. *Tremain v. Bell Industries, Inc.*, 196 F. 3d 970, 977 (9th Cir. 1999). Under this situation, if a claimant asserts that the plan administrator had a conflict of interest, there may be an evidentiary hearing limited to that issue. This does not mean that there is a full evidentiary hearing, on the actual denial of benefits decision for example.

How Does Arbitrator Determine Standard and Scope of Review?

As noted, the arbitrator has several options of what standard and scope of review to use in determining whether to uphold the action of a plan. There are three issues to be evaluated:

- Did the plan language confer discretion?
- Were proper processes followed?
- Is there a conflict of interest?

Only after evaluating those issues can the arbitrator advise the parties as to the nature of review and whether additional evidence is needed.

Is There Discretionary Language in the Plan?

The case law on the appropriate standards of review demonstrates the critical importance of the arbitrator's initial study of plan documents. If the plan document unambiguously confers discretionary authority on the plan administrator to interpret the plan and make any necessary benefits determinations, the arbitrator must generally use the discretionary standard of review. Although there is no magic language, the following examples have been found sufficient to confer discretion on plan administrators:

- The administrator "reserves the absolute right to interpret" plan provisions and "to make determinations of facts and eligibility for benefits, and to decide any dispute that may arise." *McElroy v. Smithkline Beecham Health & Welfare Benefits Trust Plan for U.S. Employees*, 340 F.3d 139, 141 (3d Cir. 2003).
- "[T]he Administrative Committee shall have such duties and powers as may be necessary to discharge its responsibilities under the Plan, including… decid[ing] all questions of eligibility of any Employee to participate in the Plan or to receive benefits under it, its interpretation thereof in good faith to be final and conclusive." *Twomey v. Delta Airlines Pilots Pension Plan*, 328 F.3d 27, 31 (1st Cir. 2003).
- "The decisions of the Plan Administrator shall be final and conclusive with respect to every question which may arise relating to either the interpretation or administration of this Plan." *Duhon v. Texaco, Inc.*, 15 F.3d 1302, 1305 (5th Cir. 1994).
- The plan grants the administrative committee the "power" and "duty" to "interpret the plan and to resolve ambiguities, inconsistencies and omissions" and to "decide on questions concerning the plan and the eligibility of any Employee[.]" *Bergt v. Ret. Plan for Pilots Employed by MarkAir, Inc.*, 293 F.3d 1139, 1142 (9th Cir. 2002).

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Are There Procedural Irregularities?

The claims review and determination process record should be reviewed by the arbitrator to determine the standard and scope of review. ERISA law requires plan administrators to follow certain practices when processing and deciding plan participants' claims. For example, administrators must follow procedures for giving notice, reporting and claims processing. *See* 29 U.S.C. §1021(a) (disclosure to all plan participants); *id*. §1021(b) (reporting requirements); *id*. §1133 (claims procedures); 29 C.F.R. §2560.503-1 (same). Plan documents may contain deadlines or specify particular processes that have to be followed.

Indeed, if proper procedures are either nonexistent or not followed, the regulations provide that a claimant need not exhaust administrative remedies and may seek relief directly in court (or arbitration if the plan so provides) under a de novo standard of review. 29 C.F.R. §2560.503-1.

Similarly, the plan must act promptly under its procedures, as an administrator's failure to exercise discretion (by failing to act in the time limits of the plan) may determine how a court or arbitrator reviews a claim determination. *See*, *e.g.*, *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98, 109 (2d Cir. 2005) ("deemed denied" claim, in which the administrator did not issue a decision within the time required by the regulations, constituted "inaction," which was not an exercise of discretion entitled to deference). An arbitrator's decision to review the claim

determination under the de novo standard instead of under the abuse of discretion standard usually makes it more difficult for a denial of benefits to be upheld.

Is There a Conflict of Interest?

Finally, the plan administrator must take steps to avoid a conflict of interest. Ideally, the plan will avoid the "structural" conflict arising from the plan administrator both evaluating and paying benefit claims. *See Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993) (noting that "to the extent that [the administrator] has discretion to avoid paying claims, it thereby promotes the potential for its own profit"). For example, in the context of Taft-Hartley plans jointly administered by employer and union representatives, at least one federal circuit court of appeals has concluded that the employer administrators have a "categorical conflict" if the employers both fund the plan and participate in the evaluation of claims. *See Durakovic v. Building Service 32 BJ Pension Fund*, 609 F.3d 133, 138–39 (2d Cir. 2010); *but see Anderson v. Suburban Teamsters North. Ill. Pension*, 588 F.3d 641 (9th Cir. 2009) (no conflict in Taft-Hartley plan because trustees have no personal economic interest).

However, in some multi-employer plans, the workers fund most or some of their benefits programs, reducing the opportunity for a conflict of interest to arise among employer trustees. The Supreme Court in *Glenn* suggests other ways of minimizing potential conflicts: "where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits." *Glenn*, 554 U.S. at 117. Taft Hartley plans usually have procedures whereby trustees who have an interest in the outcome recuse themselves from the decision on the claim.

Conclusion

An employer should give careful consideration to plan drafting and consider whether a mandatory arbitration clause would provide a more efficient resolution mechanism for the employer and its employees for claims denials to be adjudicated. An arbitrator must pay careful attention to plan language and claim processes before making decisions about what standard of review to use and whether there is an evidentiary hearing and the scope of that hearing. Review under the abuse of discretion standard, confined to the plan's administrative record, promotes the relatively quick and inexpensive disposition of claims by summary judgment motions and oral argument during arbitration.

However, if the plan documents do not confer discretion on the decision maker or there are procedural irregularities in the claim-handling process, the arbitrator may have to use the de novo standard of review and hold a full evidentiary hearing. It is critical that the arbitrator have a deep understanding of the intricacies of ERISA law to handle these cases properly.

Plan sponsors, administrators, and trustees can ensure the most efficient and effective claims resolution process by following three guidelines. First, have clear plan language that confers discretion on the administrator, follows plan procedures and ERISA regulations during claims processing, and avoids conflicts of interest. Second, have an arbitration provision in the plan that covers all plan disputes, including claim determinations. Third, select an arbitrator experienced in ERISA law and procedures who will make proper decisions about the standard and scope of review.