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The Best Defense Is a Good Offense: Handling Benefit Plan Claims in a Fair and Efficient Manner

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Successful management of benefit plan claims begins long before the first claim is filed and continues through the claims and appeals process. In the wake of the Supreme Court's holding in Metropolitan Life Insurance Co. v. Glenn*, close attention to compliance with plan and regulatory requirements is more important, and carries more potential rewards for plan fiduciaries, than ever before. Plan sponsors and claims fiduciaries should structure the plan's governing documents and administrative operations in a way that will enable the plan to demonstrate to claimants and courts alike that it provides a fair and comprehensive claims process administered by competent personnel.*

The process of preventing and defending against benefit plan litigation begins with understanding the roots of those lawsuits. Section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) allows plan participants[1] to bring suit to claim or clarify benefits allegedly due to them under the terms of the plan's governing documents. Section 502(a)(2) of ERISA permits a participant or fiduciary to bring suit with respect to alleged violations of ERISA's fiduciary duty provisions. Section 502(a)(3) provides a general cause of action for a participant or fiduciary seeking to enforce

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the terms of the plan or the requirements of ERISA, or to obtain other equitable relief. The U.S. Department of Labor has similar rights to take action on behalf of participants and plans.[2] Section 510 of ERISA prohibits adverse action against an individual seeking to exercise rights under ERISA or participating in an ERISA-related investigation, and also prohibits interfering with attainment of ERISA rights.

In *Metropolitan Life Insurance Co. v. Glenn*,[3] the Supreme Court reaffirmed its 1989 case, *Firestone Tire & Rubber Co. v. Bruch,*[4] regarding the standard for judicial review under ERISA. *Firestone* held that if the terms of the plan grant the plan fiduciary the discretion to interpret the plan, a court should show deference to the fiduciary's interpretation when reviewing a plaintiff's claim.[5] The *Glenn* Court clarified that this same standard applies even if the plan fiduciary who made the claims decision was operating under a conflict of interest.[6] However, the Court added, a court should consider the existence and likely impact of the conflict as a factor in deciding whether the fiduciary's decision, viewed deferentially, was reasonable. The Court also confirmed that if a fiduciary both pays benefits and decides claims, the fiduciary is operating under a conflict of interest.[7]

The Court's decision in *Glenn* resolved a long-standing split among the federal courts of appeals regarding the existence and impact of conflicts of interest.[8] However, important as the resolution of these points is, the decision has much broader ramifications. Writing for the majority, Justice Breyer explained that:

> When judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one. . . . In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. The conflict of interest at issue here, for example, [when the claims fiduciary was also the insurer of the disputed benefits] should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. It should prove less important (perhaps to the vanishing point) 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 decisionmaking irrespective of whom the inaccuracy benefits.[9]

Practitioners have not yet reached a consensus on whether lower courts' efforts to implement the *Glenn* decision's claims review

standards are likely to favor plaintiffs or defendants.[10] However, the case has sparked a flurry of activity among plan fiduciaries eager to turn the decision to their advantage. Fiduciaries want to position themselves in such a way that, in the event of litigation, they will be able to convince the court that any conflict has faded "to the vanishing point" and that the court, accordingly, should not weigh the conflict against the fiduciary when judging the reasonableness of the fiduciary's decision.

Glenn gives fiduciaries increased guidance regarding what to do, what to avoid, and what protective measures courts are likely to consider, guidance that lower court decisions issued in the wake of *Glenn* have already enhanced. A fiduciary thus has a clear path to follow when seeking to create a paper trail that will enable it to prove that its decision was unbiased.

Naturally, fiduciaries hope that enhancing the demonstrated fairness of a plan's claims process will maximize the likelihood of favorable resolution of a claim that proceeds to litigation. In addition, a fair claims process fosters prompt resolution of legitimate claims without recourse to the courts. This offers a significant advantage since, like any litigation, ERISA litigation can be a time-consuming, stressful, and expensive experience. Cases range in size from claims for modest amounts of life insurance, disability, or medical benefits to class actions involving millions or even billions of dollars. Under Section 502(g) of ERISA, the cost of the other party's attorney's fees may also be added to expenses.[11] Even leaving litigation costs aside, however, improvements to the claims process generally make good fiscal sense. Litigation undercuts the employer's goal of enhancing workforce satisfaction and productivity by establishing benefit plans. If employees perceive that their plans are reluctant to pay benefits when due, or that their plans are being mismanaged, the plans will not achieve the desired results.

The advantages of a proactive response to *Glenn*'s directives are not one-sided, however. While plaintiffs might bemoan *Glenn*'s affirmation of a court's obligation to defer to a fiduciary's reasonable decision even when the plaintiff's position also is reasonable, fiduciaries' post-*Glenn* emphasis on demonstrating an unbiased approach to benefit plan decision-making should have the salutary effect of focusing fiduciaries' and employers' attention on the fairness and overall quality of the claims process. Even if improvements are motivated by the fiduciary's self-interested desire to position itself well in the event of litigation, claimants still benefit from a fair, well-documented claims process. After all, under such a process, valid claims are more likely to be granted without the need to resort to litigation, and the claimant is more likely to receive the information necessary to understand legitimate claim denials. The *Glenn* holding may prove to be the rising tide that lifts all boats.

LAYING THE FOUNDATION

Consistent and accurate plan administration by well-informed fiduciaries is the essential first step in successful benefit plan operation. Such a strategy also lays the groundwork for an effective defense if a dispute arises. There are several concrete steps that plan sponsors and fiduciaries should take to facilitate proper plan administration.

Creating the Plan Documents

Section 402(a)(1) of ERISA requires each plan to be maintained pursuant to a written plan document. Plan sponsors should invest the time and money to ensure that every ERISA-governed benefit plan has a document that complies with all legal requirements and that reflects the employer's intended plan benefits in appropriate detail. The employer and its employees or vendors who will serve as fiduciaries or plan service providers must read the document carefully and be familiar with its provisions.

If benefits are insured, the insurance policy should form part of the document, but insurance companies design their policies to comply with state law requirements and to meet the insurer's needs. An employer will often benefit from having a supplemental document that addresses ERISA-specific considerations, administrative issues, claims procedures for claims not handled by the insurer, and the employer's rights and duties as plan sponsor. Many employers utilize a "wraparound" plan document containing general provisions addressing these issues, and attach that document to the employer's welfare plan insurance policies and self-insured benefit program descriptions. This allows the employer to create a uniform administrative structure.[12]

Specific documentation requirements apply to tax-favored retirement plans, such as 401(k) plans, 403(b) plans, and defined benefit plans. Many employers utilize a document that has been pre-approved by the IRS. These "prototype" or "volume submitter" documents consist of two parts, an adoption agreement and a basic plan document. The employer uses the adoption agreement to select among various plan design options. For example, the employer can decide how the plan will calculate benefits, and when distributions will be available. The basic plan document contains additional detail regarding the optional provisions selected through the adoption agreement, as well as the text of basic rules that all plans must satisfy in order to remain in compliance with the Internal Revenue Code. It is important for the employer and plan fiduciary to read and understand both documents.

In addition to ensuring that plan documents adequately describe plan benefits, plan sponsors should consider including administrative

provisions that maximize the protection available to the sponsor and to the fiduciaries who will administer the plan. The sponsor should:

- Select the plan fiduciaries carefully. It may be desirable for an individual or committee to serve as plan administrator and/or claims fiduciary, rather than for the employer as an entity to do so. In any event, it is essential that the people who actually decide claims are the people assigned this task under the plan document or pursuant to a delegation permitted by the plan document. Section 2560.503-1(h) of the Labor Regulations requires that appealed claims be decided by a "named fiduciary";

- Consider drafting the plan to require all claims to pass through the claims process, as discussed at more length later in this article;

- Consider imposing a deadline for filing claims and, in the event a claim is denied on appeal, for filing lawsuits, rather than relying on potentially lengthy statutes of limitations;[13]

- Consider the advantages and disadvantages of an arbitration clause;[14] and

- Ensure that the claims fiduciary has the discretion to interpret the plan, in accordance with the *Firestone* standard discussed earlier in this article.

Preparing the Ancillary Documents

After the plan document itself, the most important plan-related document is the summary plan description (SPD).[15] Section 102 of ERISA requires that each participant receive an SPD, which must be

> written in a manner calculated to be understood by the average plan participant and . . . sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

Section 104(b) of ERISA requires that the SPD be furnished within 90 days of the date the participant becomes a participant.[16] The SPD is supposed to serve as the participant's primary source of information about the plan.[17] Thus, although an SPD typically contains a statement that the plan document will control in the event of any conflict between the terms of the plan document and the terms of the SPD, courts routinely defer to the SPD when a conflict occurs.[18]

Therefore, it is important for plan fiduciaries to read the SPD carefully before distributing it to participants, to ensure that it accurately reflects the plan. Likewise, whenever the employer updates the plan document, timely issuance of a summary of material modifications to amend the SPD is essential. When benefits are insured or covered by stop-loss insurance, the fiduciary should have benefit descriptions approved or prepared by the insurer. Often, an insurer will provide an SPD, or an insurance certificate that can be used as an SPD when accompanied by a supplemental document containing additional regulatory information. However, plan fiduciaries should review insurer-provided documents carefully. These documents often misstate plan administrative information, such as the plan name and number or the name of the plan administrator, and sometimes omit important information as well.

In addition to the SPD, every retirement plan must maintain written procedures for reviewing and approving qualified domestic relations orders (QDROs), and every group health plan must maintain written procedures for reviewing and approving qualified medical child support orders (QMCSOs). Plan fiduciaries should do more than ensure that these procedures meet the minimal legal requirements. They should regard these documents as a valuable opportunity to assist plan staff and the parties to QDRO/QMCSO proceedings in making the review and approval of these orders as efficient and amicable as possible. Written procedures that detail the rules for preparing and submitting orders, the plan's rules regarding administration of a participant's benefits while an order is under review, and the timeframes for review, approval, and implementation of orders prevent confusion and enable the plan to present a professional, detached image that will help it avoid getting embroiled in potentially emotional disputes between the parties about the proper terms of the order.

Qualified retirement plans also often maintain separate documents governing plan loans and hardship distributions, if these features are available. In addition, these plans generally utilize standard forms for beneficiary designations, distribution requests, investment directions, rollover contributions, and other purposes. All of these documents should be readily understandable by plan participants, and consistent with the terms of the plan document. If the participant should take further action after submitting the form, the form should provide the necessary instructions.

Welfare plans likewise often utilize a battery of administrative procedures and administrative forms. If benefits are insured, most of these documents will be prepared by the insurer. However, the employer's staff responsible for the plan should request copies of communications distributed to participants and be familiar with important administrative information. It is often surprisingly difficult

to obtain documents from insurers, so plan fiduciaries should discuss their expectations about disclosure with the insurer before entering into a contract. That way, any obstacles imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), state insurance law, or an insurer's internal policies can be identified and addressed in advance.

Fiduciary Training

Plan fiduciaries should undergo periodic training to ensure they are familiar with the terms of the plans they operate, their responsibilities under the law, and established administrative practices and procedures. Fiduciaries also are responsible for ensuring that employees and third-party vendors who assist with the various aspects of plan operations understand the plans for which they are responsible, the plans' administrative practices, and the overlay of legal duties, and are performing their duties appropriately. Regular training for fiduciaries and staff assists in the proper fulfillment of these responsibilities and prevents situations from arising that can lead to lawsuits. Furthermore, if litigation arises, such demonstrated commitment to proper fiduciary conduct should assist in convincing a court that the plan has established appropriate safeguards against conflicts of interest.

PARTICIPANT OUTREACH

Accurate plan administration is only one component of an effective claim-prevention strategy. Ensuring that participants understand their benefits is just as essential. To achieve this, SPDs should be drafted carefully, provided on time, and kept updated. Plan fiduciaries should ensure that the plan's SPD contains all legally required information,[19] and that a participant who reads the SPD will be able to understand the benefits available, the process for claiming those benefits, and potential limitations on benefits. In light of the judicial tendency to follow the SPD when a plan document conflicts or is silent, plan fiduciaries should err on the side of being inclusive in the SPD. However, fiduciaries must balance the desire to ensure that the SPD adequately addresses all issues of significance against ERISA's requirement that the average participant be able to understand the SPD.

Despite fiduciaries' best efforts, SPDs are often complex, detailed documents. Fiduciaries therefore may utilize additional, less formal methods of communication, such as participant meetings, memos, or newsletters regarding specific plan features or developments. Some communications are required, such as notices regarding a health plan participant's right to continued medical coverage or a "safe harbor" 401(k) plan's annual notice of safe harbor status. Others are optional, such as investment education seminars for retirement plan

participants. The fiduciary should vet all communications carefully to ensure they are consistent with plan documents and legal requirements, and retain copies of all written materials.

In addition, any personnel assigned to answer questions about the plan must be thoroughly familiar with the plan terms. Staff members who do not have the necessary familiarity should refer all questions to the proper contact person. That way, it is less likely that misinformation will spread. Obviously, it is much harder to ensure proper training for staff at an insurer or third-party vendor, particularly for a small employer. Fiduciaries should make the best efforts reasonable under the circumstances, and should address any problems that come to their attention as promptly as possible to prevent recurrences.

Plan fiduciaries increasingly are taking advantage of electronic media to make disclosure cheaper and easier. The Labor Regulations place limits on electronic distribution of required disclosure materials,[20] but within those limits, electronic media can make required communication much more efficient. Fiduciaries also can use electronic media to provide enhanced outreach on a cost-effective basis. For example, fiduciaries may provide access to an investment education Web site.

Ultimately, the goal of a participant communication program is to ensure that participants understand what their plans do and do not offer, and what the fiduciaries are and are not obligated to do. For instance, if participants in a retirement plan are responsible for selecting their own investments, the plan's fiduciary must inform them that they have sole responsibility for the consequences of their decisions.[21] If a health plan does not cover stomach stapling procedures, even when medically necessary rather than cosmetic in nature, the SPD must say so clearly. Ensuring that participants have easy access to the SPD and know how to use it, and that they know whom to contact for accurate answers to questions, helps prevent participants from forming false expectations about their benefits. In turn, this makes it less likely that they will suffer the sort of losses that can lead to litigation.

THE CLAIMS PROCESS

Despite a fiduciary's best efforts, benefit plan disputes will arise from time to time. Sometimes, the dispute is based on the underlying facts, as in the case of a dispute over whether a participant in a long-term disability plan is disabled. Other cases involve disputes over the legal implications of agreed-upon facts, as when a claim asserts that fiduciaries violated ERISA by not divesting a plan of employer stock prior to a decline in value or, conversely, by divesting a plan of employer stock that subsequently rose in value.

Acknowledging the inevitability of benefit plan claims, Section 503 of ERISA requires the plan to establish an internal claims review and appeal process.

Applicability of the Claims Process

By requiring each plan to maintain a claims procedure, Congress sought to ensure that participants would have an opportunity to obtain either the benefits claimed to be due or a satisfactory explanation of why benefits were not in fact due, without the need to resort to the courts. The federal courts agree that before a claimant can file an action under Section 502(a)(1)(B) of ERISA, the claimant must exhaust his or her remedies under the plan's claims procedure,[22] although plans should be sure to buttress this requirement by stating it clearly in their documents, SPDs, and claims communications.[23] The courts disagree as to whether this exhaustion requirement also applies to other types of claims, such as claims alleging a breach of fiduciary duty.[24]

In recent years, more plans have added language requiring all claims to go through the claims and appeals process. Strategically, such a requirement can reduce the likelihood of lawsuits by adding to the expenditure of time and money required in order to get a claim into court at all. Significantly, courts have held that attorney's fee awards under Section 502(g) of ERISA cannot cover costs attributable to the administrative claims process.[25] Since a claimant generally must present his or her entire case to the administrator during the claims process,[26] a great deal of attorney time can be excluded in this fashion. Furthermore, a well-developed administrative record may assist with a prompt dismissal of a lawsuit if one is brought, particularly if a court is willing to extend *Firestone* deference beyond the context of Section 502(a)(1)(B) claims.[27] However, the claims process, properly administered, provides practical benefits to both sides of a dispute.

If a participant's claim is valid, the claims process gives the fiduciary an opportunity to realize as much and grant benefits without the need for expensive and time-consuming litigation. If the participant's claim is not valid, the claims process gives the fiduciary the opportunity to explain that to the participant. A participant who has received a clear explanation of the reasons his or her claim has been denied and been provided with proof that the fiduciary's decision is justified is much less likely to sue. For those cases in which the facts or the proper interpretation of the plan or the law are open to debate, the claims process gives both parties the chance to develop their positions, to familiarize themselves with the strengths and weaknesses of the opposing side, and make a considered decision as to whether taking the dispute to court is likely to be worthwhile.

The Regulatory Requirements

Section 2560.503-1 of the Labor Regulations sets forth detailed requirements that a plan's claims procedure must satisfy. The claims procedures, which must be part of or provided together with the plan's SPD,[28] must provide for a "full and fair" review of the claimant's claim, must provide for an appeals process for denied claims, and must permit a claimant to proceed via an authorized representative. The procedures cannot contain undue impediments to a claimant's pursuit of his or her claim. This means that, for example, claim filing fees generally are prohibited. Group health and disability benefit claims cannot be subjected to mandatory arbitration, or to more than two levels of mandatory appeal. If a plan requires a participant to seek prior approval before taking action that will result in a benefit claim, the requirement must be enforced in a reasonable manner and enhanced disclosure requirements apply.

If the plan denies a claimant's claim on initial review or if the plan reduces or suspends previously approved benefits, the plan must give the claimant a detailed explanation of the reasons for the denial or reduction, with citations to relevant provisions of the plan. The notice of denial also must include an explanation of additional information necessary to perfect the claim, an explanation of the plan's appeal procedures and associated deadlines, and an explanation of the claimant's right to file suit under Section 502(a) of ERISA if the claim is denied on appeal. If the benefits at issue are group health or disability benefits, the plan also must disclose any internal protocols, rules, or guidelines used in connection with the review or disclose that such a protocol, rule, or guideline was relied upon and will be made available upon request. Group health and disability plans also must inform the claimant if the denial is based on grounds of medical necessity or experimental treatment or similar issues, and offer a supporting explanation. The plan must provide the claim denial notice within 90 days for claims other than group health or disability benefits, with a 90-day extension permitted upon prior notice. Group health plan and disability benefits are subject to accelerated deadlines.[29] The notice must be in writing,[30] or in an electronic format that satisfies Department of Labor guidelines for electronic communication.

If the plan denies a claim, in whole or part, it must permit the claimant to appeal. The claimant must appeal claims other than group health and disability benefit claims within 60 days of notice of the claim denial, unless the plan permits a longer period. The claimant must appeal group health or disability benefit claims within 180 days of notice of the claim denial, unless the plan permits a longer period.[31] During the relevant interval, the plan must permit the claimant access to all relevant documents and other materials[32] and must provide copies (free of charge) of those materials upon request. In

the case of urgent care group health benefits, the plan must conduct the appeal process and transmit communications in an expeditious manner.

For group health and disability claims, the regulations specifically require that the appeal be conducted by a named fiduciary independent of the original decision-maker. That fiduciary must submit decisions based in whole or in part on a medical determination to the review of a medical professional who has appropriate training and experience and who is independent of the medical professional(s) involved in the initial determination. *Glenn*'s ruling regarding conflicts of interest means that all plans should consider utilizing an independent decision-maker for all appeals. Likewise, fiduciary prudence requires that a fiduciary consult an appropriate expert when an expert's advice is necessary to the fact-finding process, and *Glenn* again weighs in favor of utilizing an independent expert not involved in the original denial.

For example, to ensure an independent decision-making process on appeal, an initial claim might be reviewed by a benefits representative or an outside claims administrator, with a committee of senior employees of the plan sponsor overseeing the appeal. Alternatively, a plan's administrative committee may form subcommittees for the purpose of hearing initial claims and appeals separately, or the plan may refer appeals to a separate committee or a senior manager independent of the committee. Insurers and third-party administrators often have the resources to establish entirely separate departments to hear claims and appeals, and insurers' decisions may be subject to additional review by state agencies and review boards as well.

In any event, once a decision is made, the fiduciary must communicate the decision to the claimant in writing, or in a permissible electronic format. For claims other than group health and disability claims, the plan must communicate the decision on appeal within 60 days of the claim denial, with a 60-day extension available upon proper notice. Special rules apply to multiemployer plans that meet certain requirements. In addition, accelerated timeframes once again apply for group health and disability benefits.[33]

The notice of denial on appeal must include a detailed explanation of the reasons for the denial, with citations to relevant provisions of the plan, a statement of the claimant's right to access and obtain copies (free of charge) of relevant documents and other materials, and an explanation of the claimant's right to file suit under Section 502(a) of ERISA now that the claim has been denied on appeal.[34] If the benefits at issue are group health or disability benefits, the plan must disclose any internal protocols, rules, or guidelines used in connection with the review or disclose that the plan relied upon such a protocol, rule, or guideline and will make the protocol, rule, or guideline available

upon request. Group health and disability plans also must inform the claimant if the plan based its denial on grounds of medical necessity or experimental treatment or similar issues, and offer a supporting explanation.

Failure to meet these requirements can result in loss of the deferential standard of review.[35] In fact, it is even possible that a court could award benefits to a plaintiff as a method of penalizing a non-compliant plan fiduciary.[36] Accordingly, it is important for plan fiduciaries to ensure satisfaction of the procedural requirements, and to maintain documentation to this effect.

In light of the regulatory deadlines, it is essential for a claims fiduciary to identify when the claims process begins. Claims procedures should provide specific instructions for filing formal claims, so that the plan knows when the initial claim review period begins. Sometimes, a participant may contact the fiduciary with a question rather than with an express claim. In such cases, the fiduciary may want to advise the participant that the contact is being treated as a request for information, and to outline the steps for filing a formal claim.

Communicating the Claims Process

As noted above, a plan's SPD must explain the claims and appeal process, and a denial letter must explain the appeal process. In addition, it is to the fiduciary's benefit to ensure that the claims and appeal process is readily available, and to remind participants of where to find the procedure and that they are required to follow the procedure. A plan may issue an SPD in complete form only once every five to ten years, and participants may lose track of the claims and appeal procedure in the meantime if fiduciaries do not provide reminders. Since participants cannot be held to the claims and appeal process if they are not aware of its rules,[37] it is to the fiduciary's advantage to avoid the possibility of debate regarding adequacy of disclosure.

Creating the Record

In the first place, it is essential that the claims fiduciary engage in a thorough, well-documented review of all of the information presented by the claimant and all information otherwise available to the fiduciary. The claim file should contain all relevant evidentiary materials, and should document the fiduciary's review process and analysis. The fiduciary will not be able to prove it conducted its duties properly unless it has kept the evidence demonstrating the thoroughness and fairness of its review process.

In addition, as explained above, the Labor regulations require that denied claimants receive an explanation of the reasons for the denial, complete with citations to the relevant provisions of the plan

documents. The claims fiduciary generally need not provide the complete claim file unless requested, but should provide quotations from or copies of material documents as necessary to ensure that the claimant receives a full explanation of the reasons for the denial. Denial letters should detail all the possible grounds for denial. A fiduciary may be foreclosed from relying on justifications for denial not explained in its correspondence, especially if the claimant had no chance to address the fiduciary's reasoning on appeal.[38]

Obviously, it is in the claims fiduciary's interest to provide the participant with documents that support the fiduciary's decision. However, the fiduciary needs to resist the temptation not to provide less favorable evidence as well. Concealment would violate the fiduciary's duty under ERISA, raise a definite inference of bias, and possibly result in significant financial penalties. Instead, the fiduciary should address the unfavorable evidence by including in the claims denial letter an explanation of why the evidence did not sway the fiduciary's decision. If a fiduciary fails to discuss evidence favorable to the claimant, a court may take that as an indication that the fiduciary overlooked or misunderstood the evidence, and even as an indication that the fiduciary deliberately disregarded the evidence out of bias.[39] In contrast, a thorough and well-reasoned claim denial will reduce the likelihood of a lawsuit and increase the chance of success if a lawsuit is filed.

Conflicts of Interest

In addition, fiduciaries should consider ways to demonstrate that claims fiduciaries are insulated against conflicts of interest, in keeping with Justice Breyer's comments in the *Glenn* decision.[40] Obviously, policies that provide incentives for improper claim denials, such as those alleged to have been used by UnumProvident,[41] should be avoided. Such policies not only constitute grounds for a reversal of the claim denial, they are a violation of ERISA, which requires plan fiduciaries to act in the best interest of plan participants.[42] However, plans should not provide incentives for improper grants of benefit claims, either. Such claims are a waste of plan resources, and hence also constitute a breach of fiduciary duty. Even if the plan in question does not have its own assets, and instead pays benefits from the employer's general assets, imprudent expenditure is likely to harm the plan and participants in general by causing the employer to amend the plan to eliminate or reduce benefits, increasing stop-loss insurance premiums (and hence, in all probability, participant premiums), and in some cases creating a risk that the employer's assets will be insufficient to pay legitimate claims. Accordingly, plan fiduciaries should design their procedures to allow for fair decisions, not to favor the plan over any particular participant or vice versa.

Entities serving as or employing claims fiduciaries should document the safeguards that they have implemented to ensure that claims fiduciaries are insulated from potential sources of a conflict of interest. For example, an employer might document that it does not inform claims fiduciaries of a claim's financial effect on the employer except on a need-to-know basis, instructs them not to take financial effect into account when making decisions, trains them to understand their fiduciary duties, and informs them that as required by federal law, employment evaluations will favor proper performance of fiduciary duties and penalize improper conduct, regardless of the cost of claims decisions to the company.[43] Fiduciaries should also consider communicating administrative safeguards built into the claims process to participants, to build participant confidence that the plan handles claims fairly.

For a claim alleging that a fiduciary has violated ERISA, the affected fiduciary should recuse himself or herself if possible. If all of the individuals holding fiduciary positions, and/or the employer, are affected, and it is not feasible or desirable to appoint a special fiduciary, the fiduciaries should proceed with caution and should document anti-conflict safeguards incorporated into the review process. Consultation with counsel is essential at this point, but must be handled carefully to maximize the applicability of the attorney-client privilege and the work product doctrine to communications intended to be confidential.

DISCLOSURE

Any participant, regardless of whether he or she has initiated a claim, is entitled to the disclosure of certain documents, including the plan document, SPD, and annual Form 5500. Under Section 502(c) of ERISA, plan administrators can be assessed up to $110 a day in penalties if they fail to provide the documents within 30 days of a proper request. Plan administrators are permitted to charge a requesting participant for the cost of providing some of these documents, in accordance with the rules set forth in Section 2520.104b-30 of the Labor Regulations.[44] Upon receipt of a request for documents, the plan administrator should review the request with counsel to determine which documents must be provided, which documents (if any) should be provided voluntarily in the interests of promoting an amicable resolution of the claim, and to what extent the plan administrator can charge the requesting participant for copies. If the plan imposes a charge, the plan administrator should notify the participant in writing that documents will be provided upon payment of the appropriate charge, and provide detailed instructions for submitting payment.

If the plan sponsor and administrator have followed the steps discussed in the Laying the Foundation section of this article, responding

to document requests should be fairly simple. The plan administrator will have up-to-date copies of all plan documents and SPDs, and will feel comfortable disclosing them.

The plan administrator should inform participants of the process for filing document requests and of any charges that may apply. The contact information must be included in the SPD, and there are also advantages to making detailed document request instructions available on the employer's internal Web site, on bulletin boards, or in other places where employees will have ready access to it even if they lose track of their SPDs. Many cases end up in court because document requests were misdirected, and even unsuccessful lawsuits cost time and money and can damage employee relations. In addition, the plan administrator must ensure that procedures are in place to permit every request to receive a timely response.

Along with requiring a written and detailed explanation for any claim denial, the Labor regulations require that a claimant be provided with all documents "relevant" to his or her claim if the claimant so requests. The regulations define "relevant" materials as including any materials considered, submitted, or generated in the course of the claim, whether or not the plan relied on those materials in the end, as well as internal protocols and administrative rules intended to ensure compliance with regulatory requirements.[45] During the pendency of an appeal, and after a decision on appeal, the claimant has the right to access these documents free of charge. The claims fiduciary should bear this in mind and waive the normal document charges when necessary to ensure compliance.

In addition, the plan administrator should be aware that courts have held that a failure to respond to a document request under the plan's claims procedures is subject to the $110 per day non-disclosure penalty, and that this can apply even if a document is in the custody of a third-party vendor rather than the plan administrator itself.[46] Therefore, it is important for the plan administrator to take steps to ensure it has the documents necessary to satisfy its disclosure duties, and that disclosure occurs on a timely basis.

PRIVILEGE

When determining what materials must be disclosed, fiduciaries should take precautions to protect documents covered by attorney-client privilege and/or the work product doctrine. The protection of these rules is limited in the benefit claims context, particularly in the context of claims for benefits rather than claims alleging a breach of fiduciary duty, and it is important that fiduciaries maximize the odds that protection will be available. Conversely, it is important that fiduciaries be aware of the limits of these protections.

Attorney-Client Privilege

In order to protect a communication using the attorney-client privilege, the person asserting the privilege must show that

1. An attorney-client relationship existed or was sought between the attorney and the party claiming the privilege;
2. The communication was to obtain legal advice; and
3. The communication was confidential.[47]

However, even if these conditions are met, plan participants (or the government acting on their behalf) can defeat the privilege in certain circumstances, on the grounds of the "fiduciary exception"[48] to the privilege. The exception holds that plan participants are entitled to disclosure of otherwise privileged communications between plan fiduciaries and their attorneys.[49]

In connection with claims for benefits, some courts have indicated that the fiduciary exception always defeats the privilege with respect to materials associated with the claims process.[50] Other courts have disagreed, holding that each case must be reviewed on its own merits.[51] Accordingly, the extent to which the privilege will apply is likely to vary in different areas of the country. In addition, it is worth noting that the Labor regulations require disclosure of all "relevant" materials and do not address the extent to which a claims fiduciary could argue that a "relevant" item is privileged. Finally, fiduciaries should bear in mind that if a claims fiduciary seeks to rely on legal advice as evidence that a decision was reasonable, that advice may need to be disclosed.[52] A party cannot put information in controversy and then seek to withhold it.

However, if a claim involves a controversy between a fiduciary and a participant that alleges that the fiduciary itself is liable to the participant, it is more likely that the privilege will apply. Courts have long recognized that fiduciaries seeking advice with respect to their own liability, rather than with respect to the administration of the plan, are entitled to the protection of the privilege.[53] Fiduciaries seeking such advice should be alert to ways in which they can distinguish this activity from routine plan administration, since they will need to prove their entitlement to the privilege if a claimant eventually seeks discovery.

Work Product Doctrine

The work product doctrine protects materials prepared in anticipation of litigation.[54] The federal courts of appeals have divided over when to view an item as having been prepared in anticipation of

litigation. Some courts insist that materials be prepared "primarily or exclusively to assist in litigation" and others permit the doctrine to apply so long as materials are prepared "because of" litigation.[55] The latter formulation is broader and may enable fiduciaries' attorneys to protect materials prepared against the prospect of litigation, despite the absence of any pending or specifically anticipated matter.[56] Generally, the fiduciary exception does not apply to the work product doctrine, so protection may be available even if the fiduciary exception prevents the fiduciary from relying on the attorney-client privilege.[57] This doctrine protects factual investigations in the absence of a showing of the opposing party's "substantial need" for the information and inability to obtain it otherwise without undue hardship and shields the attorney's trial strategy and other mental impressions from disclosure in all circumstances.[58]

Impact of the Privilege Analysis

Fiduciaries should not delay or avoid seeking legal advice out of concern that the attorney-client privilege and/or the work product doctrine will not be available to shield the communication from disclosure. In the first instance, obtaining proper legal advice should reduce the odds that the fiduciary will make a wrong decision, inadequately communicate the decision, or otherwise miss an opportunity to avoid litigation. In addition, while the fiduciary should be wary of putting the contents of legal advice in controversy, the fiduciary may want to use the fact of its consultation with legal counsel as evidence of a full and fair investigation of the merits of the claimant's claim. Finally, when a fiduciary involves counsel promptly, counsel can assist the fiduciary to prepare a solid administrative record to support the fiduciary's position at trial. Fiduciaries should, however, discuss privilege concerns with counsel at the time an issue arises and maintain careful documentation to support application of the attorney-client privilege and work product doctrine to materials they desire to protect.

GENERAL SUGGESTIONS

In short, fiduciaries should bear the following in mind:

- Be sure plan information is disclosed properly and that participants know whom to contact with questions;
- Consider defensive measures, such as requiring all claims to go through the claims process, contractual statutes of limitations, and arbitration clauses;
- Be courteous and prompt in responding to requests for information and documents, and throughout the claims

process. Monitor all regulatory deadlines closely. If an extension is necessary, be sure a timely extension notice is provided;

- Provide thorough written explanations of all benefit denials and all decisions on appeal. Be sure that staff who deal with routine claims and inquiries are well-trained and that appropriate personnel consult with counsel promptly when a claim or inquiry arises that requires expert assistance; and

- Document and follow administrative practices that ensure a fair and consistent claims process, and consider ways to enhance participant confidence in the existence of such a process.

Ultimately, a fiduciary who understands that his or her job is to approve legitimate claims, deny invalid claims, and make the best decision possible after review of all the evidence on questionable claims; who understands the plan documents and his or her fiduciary duties; who adheres to consistent and well-documented practices when administering the plan in general and claims in particular; and who communicates effectively with plan participants has positioned the plan well to minimize litigation and to prevail if litigation occurs.

NOTES

1. References to participants in this article include references to beneficiaries, dependents, and any other person claiming through or on account of a participant.

2. *See* ERISA §§ 502(a)(2), 502(a)(4), and 502(a)(5).

3. 128 S. Ct. 2343 (2008).

4. 109 S. Ct. 948 (1989).

5. *See Glenn*, *supra* n.3, 128 S. Ct. at 2348 (describing *Firestone*).

6. *Id.* at 2350–2351.

7. *Id.* at 2348–2349.

8. *See, e.g.*, Stup v. UNUM Life Ins. Co., 390 F.3d 301 (4th Cir. 2004) (conflict of interest when fiduciary also pays claims requires "sliding scale" review with degree of deference adjusted based on conflict of interest); Pulvers v. First UNUM Life Ins. Co., 210 F.3d 89 (2d Cir. 2000) (plaintiff must show that administrator was actually influenced by conflict, not merely that there was potential for conflict, in order to claim *de novo* review); Pinto v. Reliance Std. Life Ins. Co., 214 F.3d 377 (3d Cir. 2000) (insurer acting as claims fiduciary generally acting under a conflict warranting heightened review using a "sliding scale" depending on the degree of the conflict); Chojnacki v. Georgia-Pacific Corp., 108 F.3d 810, 815 (7th Cir. 1997) (mere fact that claims fiduciary also paid benefits not automatic conflict of interest; when conflict of

interest exists, arbitrary and capricious standard is applied "with more bite"). *See generally* Jo-El J. Meyer, "*Glenn* Decision Will Require Several Courts to Revisit Standards, Official Says," 35 *Pens. & Benefits Rep.* (BNA), 1666–1667 (2008) (discussing attorney comments on pre-*Glenn* case law in various circuits).

9. *Glenn*, *supra* at n.3, 128 S. Ct at 2351 (internal citations omitted).

10. *See* Jo-El J. Meyer, "*Glenn* Decision Changed ERISA 'Landscape' for Plaintiffs and Defendants, Attorneys Say," 35 *Pens. & Benefits Rep.* (BNA), 2748–2749 (2008).

11. Courts disagree on whether a party must prevail in order to obtain an award of attorney's fees. *Compare* Freeman v. Cont'l Ins. Co., 996 F.2d 1116, 1119 (11th Cir. 1993) (rejecting requirement that party prevail) *with* Martin v. Blue Cross & Blue Shield of Va., Inc., 115 F.3d 1201, 1210 (4th Cir. 1997), *cert. denied*, 522 U.S. 1029 (1997) *and* Chambers v. Family Health Plan Corp., 100 F.3d 818, 828 (10th Cir. 1996) (requiring that party prevail to obtain award).

12. This approach also has the advantage of simplifying the annual reporting obligations, since the plan administrator only needs to file one Form 5500 for all of the welfare plans "wrapped" into the master document.

13. Section 413 of ERISA establishes the statute of limitations for breach of fiduciary duty claims. The statute of limitations for claims for benefits is governed by state law. *See generally* Sal L. Tripodi, *The ERISA Outline Book*, 13B.353-59. A contractual statute of limitations set forth in the plan document is enforceable if it is reasonable. *See* Northlake Regional Med. Ctr. v. Waffle House System Employee Benefit Plan, 160 F.3d 1301 (11th Cir. 1998).

14. Under Sections 2560.503-1(c)(4) and (d) of the Labor Regulations, claims for group health and disability benefits cannot be subjected to binding arbitration. Conversely, some claims associated with collectively bargained plans may be subject to mandatory arbitration, a consideration accommodated by Section 2560.503-1(b)(6)(i)(B) of the Labor Regulations. *See, e.g.*, E.I. DuPont de Nemours & Co. v. Ampthill Rayon Workers, Inc., 290 Fed. Appx. 607 (4th Cir. 2008) (union's objection to plan amendments was arbitrable); *c.f. USW,* AFL-CIO-CLC v. Rohm & Haas Co., 522 F.3d 324, 336 (3d Cir. 2008) (ruling against arbitration in particular case, but discussing applicable rules and contrasting cases).

15. Some welfare plans prefer to use a single document as both the summary plan description (SPD) and the plan document. This has the advantage of preventing conflicts between the SPD and the plan document, and gives plan personnel and participants a single source on which to rely. However, some of the more complicated concepts that must or should be included in a plan document may be difficult to accommodate in an SPD. Plan sponsors should discuss their options with their attorneys in order to select the right approach for their situations. If a plan sponsor elects to use a single document as both the plan document and the SPD or considers the SPD to be part of the plan document, the document should state expressly that it fulfills both functions. In particular, a plan sponsor using a vendor's "form" document must be sure to delete any references to a separate plan document if such a document will not exist.

16. A beneficiary of a deceased participant must receive the SPD within 90 days of the date he or she first receives benefits.

17. *See, e.g.*, Joyce v. Curtiss-Wright Corp., 171 F.3d 130, 135–136 (2d Cir. 1999).

18. *See, e.g.,* Burstein v. Retirement Account Plan for Employees of Allegheny Health Educ. and Research Found., 334 F.3d 365, 378 (3d Cir. 2003) (citing cases

from nine other circuits); Heidgerd v. Olin Corp., 906 F.2d 903, 907 (2d Cir. 1990); McNight v. Southern Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985).

19. *See* Labor Reg. § 2520.102–3.

20. Labor Reg. § 2520.104b-1(c).

21. *See* Labor Reg. § 2550.404c-1. Although compliance with the regulatory requirements under Section 404(c) of ERISA is not required, it is advisable for a fiduciary seeking to maximize protection against liability for participant decisions.

22. *See, e.g.*, Chappel v. Laboratory Corp. of America, 232 F.3d 719, 724 (9th Cir. 2000); Miller v. Metro. Life Ins. Co., 925 F.2d 979, 986 (6th Cir. 1991).

23. *See* Burke v. Kodak Retirement Income Plan, 336 F.3d 103 (2d Cir. 2003) (failure to include notice of deadline for appeal in denial letter coupled with language in SPD that claimant "should" file an appeal insufficient to require claimant to exhaust appeal remedies prior to filing suit).

24. *Compare, e.g.*, Radford v. General Dynamics Corp., 151 F.3d 396 (5th Cir. 1998), *cert. denied*, 525 U.S. 1105 (1999) (exhaustion required for breach of fiduciary duty claim) *and* Ames v. American Nat. Can Co., 170 F.3d 751 (7th Cir. 1999) (exhaustion required for ERISA Section 510 claim) *with* Zipf v. American Telephone and Telegraph Co., 799 F.2d 889 (3d Cir. 1986) (not requiring exhaustion for ERISA Section 510 claim) *and* Horan v. Kaiser Steel Retirement Plan, 947 F.2d 1412 (9th Cir. 1991) (exhaustion applies only to claim for benefits, not to breach of fiduciary duty).

25. *See, e.g.,* Peterson v. Continental Casualty Co., 282 F.3d 112, 121 (2d Cir. 2002).

26. *See, e.g.*, DeFelice v. American Int'l Life Assur. Co., 112 F.3d 61, 65 (2d Cir. 1997) (information beyond the administrative record ought not to be allowed without good cause).

27. The scope of *Firestone* deference has not been the subject of a definitive Supreme Court ruling. However, Chief Justice Roberts' concurring opinion in LaRue v. DeWolff, Boberg & Assocs., 128 S. Ct. 1020, 1027 (2008), associated *Firestone* deference with Section 502(a)(1)(B) claims. *See also Burke*, *supra* at n.23 (noting that question of standard of review applicable to SPD's compliance with ERISA's disclosure standards might be *de novo* even when administrator's decision was reviewed with deference). However, if the plan document grants the fiduciary discretionary authority, and particularly if the claim relates to the terms of the document rather than strictly to the law, a fiduciary can argue for deferential review. For example, *Firestone*'s rationale suggests that a court should defer to a fiduciary as to whether the plan document mandates investment in employer stock.

28. *See* Labor Reg. § 2520.102-3(s); Labor Reg. § 2560.503-1(b)(2).

29. A plan must provide notice of a denial of disability benefits within 45 days of the claim, with two permissible 30-day extensions available upon provision of a notice explaining the plan's need for an extension, the standards to be used in making the disability determination, and any necessary information that has not been provided. A plan must render its decision regarding urgent care group health benefits as soon as possible and in any case within 72 hours, or notify the claimant within 24 hours that additional information is necessary to approve the claim (in which case a decision is required within 48 hours after the information is supplied or expiration of the 48-hour period that must be granted to the claimant to supply the information, whichever is earlier). Decisions regarding requested extensions of concurrent care

benefits (*i.e.*, an ongoing course of treatment) must be made within 24 hours after the request if the benefits qualify as urgent care benefits and the request is made at least 24 hours before the previously approved concurrent care benefits expire. For group health benefits that require pre-approval, a plan must make a decision within a reasonable period of time and in any case within 15 days, with a permissible 15-day extension upon notice of circumstances requiring an extension. For group health plan benefits that do not require pre-approval, a decision is required within a reasonable period of time and in any event within 30 days, with a permissible 30-day extension upon notice of circumstances requiring an extension. In any case, a plan can claim an extension only if circumstances beyond its control require the extension. Except as otherwise provided under the special rules applicable to urgent care claims, if the plan needs the claimant to provide additional information, the claimant must be so informed in writing, and must be given at least 45 days to provide the information. The plan can delay its decision while waiting for requested information.

30. Under Section 2560.503-1(g)(1)(vi) of the Labor Regulations, urgent care benefit notices can be provided orally, subject to confirmation in writing within three days.

31. The Labor regulations do not specify a minimum appeal period if a plan provides for a second level of appeal. Courts have held 60 days to be a reasonable period for this purpose, notwithstanding that a claim may have been entitled to a 180-day window prior to the initial appeal. *See* Price v. Xerox Corp., 445 F.3d 1054 (8th Cir. 2006).

32. Under Section 2560.503-1(m)(8) of the Labor Regulations, an item is "relevant" if the item "(i) Was relied upon in making the benefit determination; (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) Demonstrates compliance with the administrative processes and safeguards required [under the regulations] in making the benefit determination; or (iv) In the case of a group health plan or a plan providing 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 such advice or statement was relied upon in making the benefit determination."

33. Group health benefit urgent care appeals must be resolved as soon as possible, and in any case within 72 hours. Group health benefit claims requiring pre-approval must be decided within a reasonable period of time, and in any case within 30 days (15 days for a first appeal and 15 days for a second appeal, if the plan allows two levels of appeal). Other group health benefits must be resolved within a reasonable period of time, but in any case within 60 days (30 days for a first appeal and 30 days for a second appeal, if the plan allows two levels of appeal). Disability claims must be resolved within 45 days, with one permissible 45-day extension available on proper notice.

34. If the plan imposes a contractual statute of limitations, it is advisable for the plan to include this information in its denial letter as well, in order to maximize its assertion that its contractual deadline is "reasonable." *See Northlake*, *supra* n.13 (noting that it would be preferable for the plan to include notice of the deadline).

35. *See, e.g.*, Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 970–972 (9th Cir. 2006) (flagrant violations require *de novo* review); Nichols v. Prudential Ins. Co. of Am., 406 F.3d 98, 108–109 (2d Cir. 2005) (failure to take timely action to deny claim meant that plan administrator had declined to exercise its discretion and hence was

not entitled to deference; collecting cases on this issue); *but see Burke*, *supra* n.23 (excusing failure to exhaust in light of deficient denial notice but proceeding to merits of the case under the "arbitrary and capricious" standard); Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 100 (5th Cir. 1993). *See also* 2560. 503-1(l) of the Labor Regulations, stating that a plan's failure to follow the claims procedure means that the claimant is deemed to have exhausted his administrative remedies and can proceed with taking legal action to pursue claimed benefits, on the grounds that the plan has failed to provide a reasonable claims procedure as required by law.

36. *See, e.g.*, Wenner v. Sun Life Assur. Co., 482 F.3d 878 (6th Cir. 2007), *cert denied*, 128 S. Ct. 1086 (2008) (awarding benefits due to insurer's failure to follow claims procedure notice requirements); Glista v. Unum Life Ins. Co. of America, 378 F.3d 113, 130–132 (1st Cir. 2004) (medical exigency demanded award of benefits rather than remand as remedy for flawed claims procedure; collecting cases discussing remedies for procedural violations); *but c.f., e.g.*, Tate v. Long Term Disability Plan For Salaried Emples. of Champion Int'l Corp. #506, 545 F.3d 555 (7th Cir. 2008) (remand proper remedy for failure to provide adequate reasons for decision); Moore v. Lafayette Life Ins. Co., 458 F.3d 416, 435 (6th Cir. 2006) (remand normal remedy for flawed claims procedure; substantial compliance by administrator sufficient to avoid need to remand for further proceedings and enable court to decide case).

37. *See* Spectrum Health v. Valley Truck Parts, 44 Employee Benefits Cas. (BNA) 1715 (W.D. Mich. 2008) (plan's failure to explain appeal procedure in denial letter excused claimant from exhausting administrative remedies); Bechtol v. Marsh & McLennan Cos., Case No. C07-1246MJP, 2008 U.S. Dist. LEXIS 9154 (W.D. Wash. Jan. 28, 2008) (ruling that failure to include appeal instructions in claim denial letter constituted violation of claims procedure requirements and excused failure to appeal, and citing Department of Labor informal comments supporting decision to excuse compliance with appeal procedures not described in denial letter).

38. *See* Kellogg v. Metro. Life Ins. Co., 549 F.3d 818, 829 (10th Cir. Utah 2008) (court will only consider rationale articulated by the administrator in claim denial); *c.f.* Juliano v. HMO of N.J., Inc., 221 F.3d 279, 288 (2d Cir. 2000) (allowing administrator to raise new ground for denial, but holding that plaintiffs could present new evidence at trial since they were not on notice of the issue during the claims process).

39. *See Glenn*, *supra* n.3, at 2352 (noting that MetLife's failure to consider the Social Security Administration's finding of disability after MetLife urged participant to apply for Social Security benefits was evidence of bias); Helm v. Sun Life Assurance Co. of Canada,45 Employee Benefits Cas. (BNA) 2032 (W.D. Ark. 2008) (decision to ignore unfavorable opinions and rely on favorable opinion was arbitrary and evidence of bias); Klein v. Central States, Southeast & Southwest Areas Health & Welfare Plan, Case No. 3:08CV02268, 2009 U.S. Dist. LEXIS 14032 (N.D. Ohio Feb. 20, 2009) (cherry-picked medical file was evidence of bias; noting that in contrast to the standard of review used by a court, the standard for ERISA fiduciary's initial decision was not whether a given decision would be arbitrary and capricious but whether a decision is in accordance with the plan document, and use of any other standard is erroneous).

40. *See* n.9, *supra*. Lower courts have indicated that plaintiffs may be entitled to discovery on the existence and scope of conflicts of interest. *See* O'Bryan v. Consol Energy, Inc., CIVIL ACTION NO. 08-11, 2009 U.S. Dist. LEXIS 10851 (E.D. Ky. Feb. 11, 2009) (allowing limited discovery); Winterbauer v. Life Ins. Co. of N. Am., 45 Employee

Benefits Cas. (BNA) 1820 (E.D. Mo. 2008) (allowing limited discovery; surveying post-*Glenn* caselaw); *c.f.* Strope v. Unum Provident Corp., 06-CV-628C(SR), 2009 U.S. Dist. LEXIS 19383 (D. N.Y. 2009) (finding that discovery granted pursuant to pre-*Glenn* conflict of interest rules provided adequate information).

41. *See* UnumProvident's press release regarding the settlement of state and Department of Labor investigations into its claims practices at *http://www.investors.unum.com/phoenix.zhtml?c=112190&p=irol-newsArticle&ID=645732&highlight* (last visited April 11, 2009).

42. ERISA § 404(a).

43. Adverse employment action as a result of a valid claims decision would be illegal, since it would require a fiduciary to breach his fiduciary duty to avoid negative consequences.

44. As a cost-effective supplement to on-request disclosure, a plan administrator for a plan whose participants frequently inquire about the plan document may want to consider making documents available online, with a hard copy available (upon payment of costs, if the plan administrator so requires) upon request. So long as the plan administrator meets the legal requirements, it is free to provide additional disclosure. Ready access to plan documents may enable potential claimants and their counsel to resolve questions and objections on their own, without needing to file a claim. On the other hand, given the complexity of plan documents, making the document available automatically to all participants rather than upon request by individual participants may generate more confusion than it prevents. Plan fiduciaries will have to decide which approach is most efficient for their plans.

45. Labor Reg. § 2560.503-1(m)(8).

46. *See* Mondry v. Am. Family Mut. Ins. Co., No. 07-1109, 2009 U.S. App. LEXIS 5076 (7th Cir. Mar. 5, 2009) (failure to disclose claims administrator's internal protocol rendered plan administrator liable); LeRoux v. Woodgrain Millwork Inc., 44 Employee Benefits Cas. (BNA) 1344 (D. Idaho 2008) (failure to provide adequate claim denial notice rendered plan administrator liable for penalties).

47. *See, e.g.*, United States v. Tedder, 801 F.2d 1437, 1441 (4th Cir. 1986).

48. *See, e.g.,* Washington-Baltimore Newspaper Guild, Local 35 v. The Washington Star Company, 543 F. Supp. 906, 909 (D.D.C. 1982); Tatum v. R.J. Reynolds Tobacco Co., 247 F.R.D. 488 (M.D.N.C. 2008).

49. *See Id*.

50. *See* Coffman v. Metropolitan Life Ins. Co., 204 F.R.D. 296 (S.D. W. Va. 2001) (citing Geissal v. Moore Medical Corp., 192 F.R.D. 620 (D. Mo. 2000) and noting that attorney's advice seems to have related to the claim and not to defense in eventual litigation).

51. *See, e.g.*, *Tatum*, *supra* n.48.

52. *See* Estate of Cornwell v. AFL-CIO, 197 F.R.D. 3 (D.D.C. 2000).

53. *See, e.g.*, U.S. v. Mett, 178 F.3d 1058, 1065 (9th Cir. 1999); *Tatum*, *supra* n.48.

54. *See* F.R.C.P. 26(b)(3).

55. *See* U.S. v. Adlman, 134 F.3d 1194, 1198–1204 (2d Cir. 1998) (collecting cases; ruling in favor of the "because of" doctrine).

56. *See* Byrnes v. Empire Blue Cross Blue Shield, 98 Civ. 8520 (BSJ) (MHD), 1999 U.S. Dist. LEXIS 17281, *15-*16 (S.D.N.Y. 1999).

57. *See, e.g.*, Donovan v. Fitzsimmons, 90 F.R.D. 583, 587–588 (N.D. Ill. 1981); *Tatum*, *supra* n.48; *but see* Everett v. USAir Group, Inc., 165 F.R.D. 1 (D.D.C. 1995); Martin v. Valley National Bank, 140 F.R.D. 291 (S.D.N.Y. 1991).
58. *See, e.g.*, *Tatum*, *supra* n.48.

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