Strafford

Presenting a live 90-minute webinar with interactive Q&A

ERISA Compliance: Implementing Effective Claims Procedures Under Section 503 and DOL Regulations

Drafting and Amending Plan Claims Procedures to Minimize Litigation and Ensure Compliance

WEDNESDAY, JUNE 27, 2018

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

Timothy K. Eicher, Principal, **Slevin & Hart**, Washington, D.C.

Roberta Casper Watson, Partner, **The Wagner Law Group**, Boston

The audio portion of the conference may be accessed via the telephone or by using your computer's speakers. Please refer to the instructions emailed to registrants for additional information. If you have any questions, please contact **Customer Service at 1-800-926-7926 ext. 1**.

Tips for Optimal Quality

FOR LIVE EVENT ONLY

Sound Quality

If you are listening via your computer speakers, please note that the quality of your sound will vary depending on the speed and quality of your internet connection.

If the sound quality is not satisfactory, you may listen via the phone: dial **1-866-258-2056** and enter your PIN when prompted. Otherwise, please **send us a chat** or e-mail **sound@straffordpub.com** immediately so we can address the problem.

If you dialed in and have any difficulties during the call, press *0 for assistance.

Viewing Quality

To maximize your screen, press the F11 key on your keyboard. To exit full screen, press the F11 key again.

Continuing Education Credits

FOR LIVE EVENT ONLY

In order for us to process your continuing education credit, you must confirm your participation in this webinar by completing and submitting the Attendance Affirmation/Evaluation after the webinar.

A link to the Attendance Affirmation/Evaluation will be in the thank you email that you will receive immediately following the program.

For additional information about continuing education, call us at 1-800-926-7926 ext. 2.

Program Materials

FOR LIVE EVENT ONLY

If you have not printed the conference materials for this program, please complete the following steps:

- Click on the ^ symbol next to “Conference Materials” in the middle of the left-hand column on your screen.
- Click on the tab labeled “Handouts” that appears, and there you will see a PDF of the slides for today's program.
- Double click on the PDF and a separate page will open.
- Print the slides by clicking on the printer icon.

ERISA Compliance: Implementing Effective Claims Procedures Under Section 503 and DOL Regulations

Timothy K. Eicher – Slevin & Hart, PC
teicher@slevinhart.com

Roberta Casper Watson – The Wagner Law Group
rcwatson@wagnerlawgroup.com

CLAIMS PROCEDURE REQUIREMENTS

- ERISA Section 503
- DOL regulation §2560.503-1
- Case law

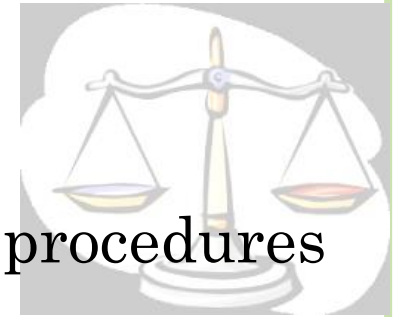
Overview

- ERISA § 503 – employee benefit plans must
  1. notify participants and beneficiaries in writing of any denial of a claim for benefits, and
  2. afford participants and beneficiaries the opportunity for "full and fair review" of adverse claim determinations
- Participants generally are required to exhaust administrative remedies under the plan before they may file suit

Overview (cont)

- Department of Labor (DOL) has rulemaking authority over "full and fair review" requirement
  - Regulations first published in 1977, revised in 2000
  - Apply to all ERISA-covered plans except apprenticeship funds
  - Employee Benefit Security Administration (EBSA) issues FAQs on its website
- Affordable Care Act introduced expanded requirements for non-grandfathered group health plans
- New regulations on disability claims issued in 2016
  - First effective January 18, 2017, but applicability delayed to April 1, 2018

Overview (cont)



- Why require exhaustion of internal claims procedures before suit?
  - *"to help reduce the number of frivolous lawsuits under ERISA" (9th Cir)*
  - *"to promote the consistent treatment of claims for benefits" (9th Cir)*
  - *"to minimize the costs of claims settlement" (9th Cir)*
  - *"permits plan fiduciaries to efficiently manage their funds; correct their errors…and assemble a factual record which will assist a court in reviewing the fiduciaries' actions" (6th Cir.)*
  - *enables plan administrators to apply expertise (DC Cir.)*

Reasonable procedures

- "every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notifications of benefit determinations, and appeal of adverse benefit" - DOL Reg. 2560.503-1(b)
- General reasonableness requirements apply to all covered plans
- Other requirements are specific to certain types of plans or claims (e.g., group health plans, disability claims)

Reasonable procedures (cont)

1) Procedures must meet all requirements in the regs to be "reasonable"
2) Summary plan description (SPD) must describe procedures and time limits
3) May not inhibit or hamper claims
   - No fees may be required for claimant to appeal
   - No denying for lack of prior approval where impossible or dangerous (e.g., participant is unconscious and needs immediate care)
4) Permit an authorized representative to act on participant's behalf
5) Contain safeguards ensuring determinations are made according to plan documents and are applied consistently to similarly situated claimants

Reasonable procedures (cont)

Additional rules for group health plans and disability claims:

- Claimant must not be required to file more than two appeals before bringing civil suit
- If voluntary appeal is available, plan must, e.g., toll statute of limitations, waive right to assert exhaustion, and not charge a fee
- No mandatory arbitration, unless included as part of two-step appeal process, and can be challenged in court

Reasonable procedures (cont)

- Group health plans only:
  - claimant must be notified within certain time periods if proper pre-service claim procedures not followed
  - Notice may be oral, unless written notice is requested
- Disability claims (per new final regulation*):
  - Plans must ensure claim adjudicated in manner designed to ensure independence and impartiality
  - No adverse or beneficial employment action based on decision

*There was concern that prior practices required that these be addressed

Reasonable procedures (cont)

Additional requirements for non-grandfathered group health plans:

- Under the ACA, group health plans were exempted from certain requirements, including covering out-of-network emergency services on an equal basis and implementing external review procedures, as long as they remained "grandfathered"

- Grandfather status could be lost if the plan increased participant cost-sharing or coinsurance by more than the maximum amount or ceased to cover certain conditions

- Many plans initially attempted to maintain grandfather status, but over time found it cost-prohibitive to do so

→ non-grandfathered plans must ensure impartiality and independence of decision makers, and must adopt external review procedures that provide an addition, optional level of appeal and review by an independent review organization

Adequate notification

- Claims regulations contain standards for notifying participants of any benefit determination, but most rules focus on adverse benefit determinations
- Notice must contain sufficient information to permit participant to present argument for reversal as part of full and fair review
- Courts often review whether enough specific info was given, or if not, whether there was substantial compliance by the plan

Adequate notification (cont)

Statement of reasons inadequate

- "no document adequately notified [claimant] of the specific reasons" claim was rejected (1st Cir. 2006)
- denial gave a conclusion rather than specific reasons (4th Cir. 1993)
- denial provided only 2 of 3 reasons plan denied claim (6th Cir. 2005)
- Claim was denied for reasons other than those discussed in denial letter (9th Cir. 2008)

Statement adequate

- plan not required to identify each and very piece of evidence relied on (7th Cir. 2012)
- denial was adequate when viewed together with other communications (7th Cir. 2012)

Adequate notification (cont)

Finding substantial compliance

- initial notice defective, but claimant informed of reasons at later conference (4th Cir. 1997)
- defects in first 2 levels of review cured by participation in 3rd level that complied with requirements (5th Cir. 2007)
- Initial denial contained only conclusory statement, but numerous subsequent communications informed claimant of reasons for determination (6th Cir. 1996)
- EOB provided sufficient explanation to prepare an informed request for further review (8th Cir. 2010)

Finding no substantial compliance

- plan gave oral and written notice of 3 reasons relied on, but had relied on a 4th (DC Cir. 2000)
- letter failed to cite specific plan provisions or provide info needed to perfect claim, provided new reason for denial after appeals were exhausted (D. Kan. 2004)

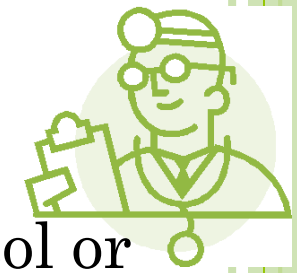
Adequate notification – Timing

- General rule – within 90 days after receipt of a claim; additional 90 days permitted if more time is needed
- Health plans – timing depends on type of claim
  - Urgent care: within 72 hours after receipt of a claim (but sooner if medically needed)
  - Pre-service claims: 15 days
  - Post-service claims: 30 days
  - Concurrent care (reduction or termination of ongoing treatment): before expiration of treatment, sufficient time to appeal before reduction takes effect
  - Additional time if plan needs more information, and time period is generally tolled while waiting on info from participant
- Disability claims – within 45 days after receipt of a claim; additional 45 days permitted if more time is needed

Adequate notification – Manner and Content

- Written in a manner calculated to be understood by the claimant (ERISA § 104(b))
- Set forth specific reasons for denial, reference specific plan provisions, describe additional info needed
- Describe plan's review procedures, time limits, right to sue
  - some circuits hold that any "statute of limitations" established by the plan must be disclosed in denial notice
    - For disability claims, new final regulations require disclosure
  - others have found substantial compliance where the notice included a copy of the benefit booklet and reference to pages describing the time limits for suit
  - Plans also should consider describing any forum selection rules adopted by the plan – see *Rodriguez v. PepsiCo LTD Plan* (N.D. Cal. 2010)

Adequate notification – Manner and Content for Group Health Plans



- Must include any specific "rule, guideline, protocol or other similar criterion" relied on
- If based on medical necessity, must include explanation of scientific or medical judgment
- Urgent care denials must describe expedited review process
- Non-grandfathered plans subject to additional requirements, including
  - culturally and linguistically appropriate communications
  - diagnosis and treatment codes
  - description of external review procedures
  - contact info for consumer assistance agencies

Adequate notification – Manner and Content for Disability Plans – Items Added for Disability Claims by Final Regulations

- Rescissions of Coverage Procedures. Plan administrators must treat rescissions of coverage as adverse benefit determinations.
  - Termination for failure to pay premiums is not a rescission.
- Benefit Denial Notices. Benefit denial notices must provide a more detailed description of the reason for the claim denial and be written in a linguistically and culturally appropriate manner.
- Explanation of Claims Procedures. Plan administrators must either explain the protocols that were used to determine the participant's benefit claim, or note that copies are available on request.
  - Must explain how protocols apply to individual.

Adequate notification – Manner and Content for Disability Plans – Items Added for Disability Claims by Final Regulations

- Explanation of Any Disagreement with or failure to follow:
  - Views of claimant's own treating health care and evaluating vocational professionals
  - Views of medical or vocational experts engaged by plan, whether or not relied upon
  - Social Security Administration determination (but need not address determinations of other payors)
- Access to Claims File. Plan administrators must inform participants, in benefit denial notices, that they are entitled to access, free of charge, all documents relevant to the adverse claim determination.

Items Added for Disability Claims by Final Regulations (cont)

- Access to New Evidence or New Rationale. Plan administrators must provide participants with any new evidence or any new rationale being considered by the plan during the appeal process.
  - Notification must give claimant adequate time to respond
- Conflicts of Interest. Plan administrators must make benefit determinations in a manner that ensures independence and impartiality of the decision-makers involved in the process.
  - Adjudicators cannot be judged or rewarded based on denials

Full and fair review of appeals

- All claims:
  - At least 60 days for participant to appeal
  - Opportunity to submit written comments and documents
  - Reasonable access to relevant documents
  - Plan must consider all comments and documents submitted, even if not relied upon in initial denial
  - Review must not give deference to initial determination
- Additional rules for group health plans:
  - At least 180 days for appeal
  - If medical judgment involved, must consult independent health care professional (not same doctor as initial claim, or a subordinate)
- Additional rules for non-grandfathered group health plans:
  - Opportunity to review claim file, present evidence and testimony
  - Provide any new or additional evidence considered or generated, and time to review
  - Provide continued coverage pending the outcome of an appeal
- Additional rules for disability claims, effective 2018
  - At least 180 days for appeal

Full and fair review of appeals – Access to relevant documents

- Documents are "relevant" if
  - Relied upon in making the benefit determination
  - Submitted, considered, generated during review
  - Demonstrates consistency in plan's decision making
  - For group health plans, statements of policy on denied treatment options, even if not relied upon

Full and fair review of appeals – Access to relevant documents

Relevant

- Internal guidelines on preexisting conditions and training materials on plan interpretation (*Glista*, 1st Cir. 2004)
- Pension plan's 50-year-old plan document, which plan negligently failed to maintain (*James*, D.C. Cir. 2013)

Not relevant (?)

- Plan administrator's internal guidelines (*Weidner*, 8th Cir. 2007)
  - But for disability claims, final regulations require disclosure of applicable internal guidelines
- Claims manual guidelines (evidence of compliance subject to disclosure, not the process itself) (*Palmiotti*, S.D.N.Y. 2006)
- Regulation "does not impose a blanket requirement for pension funds to provide data on all related cases every time it denies benefits." (*Militello* 7th Cir. 2004)

Notice of adverse determination after appeal

- General rule: within a reasonable period, but not more than 60 days after receipt of the appeal
  - May be extended an additional 60 days, with notice, if circumstances require
  - Special rule for boards of trustees or committees that meet quarterly
  - Period tolled if more info requested from claimant
- Group health plans:
  - Urgent care: ASAP, no later than 72 hours after receipt
  - Pre-service: within 30 days (15 if 2 levels of appeal)
  - Post-service: within 60 days (30 if 2 levels of appeal)
- Must describe specific reasons, description of voluntary appeal procedure
- Disability claims: not more than 45 days after receipt of the appeal
  - May be extended an additional 45 days, with notice, if circumstances require

ACA EXTERNAL REVIEW PROCEDURES

- Required for non-grandfathered plans
- Fully insured plans generally must follow state procedures, provided those procedures satisfy the minimum consumer protection requirements
- Self-insured plans (and fully-insured plans whose state's process does not meet minimum standards) generally follow the federal external review process
- Courts have applied ERISA standard of review to state external appeals (where discretionary standard not banned by state law) (*Alexandra H. v. Oxford*, S.D. Fla. 2015)
- Unclear if exhaustion of external appeals required – so far, courts say no (*Bailey v. Chevron*, C.D. Cal. 2014)

ACA EXTERNAL REVIEW PROCEDURES

- State procedures must comply with 16 standards under Nat'l Assoc. of Insurance Commissioners (NAIC) rules to qualify under ACA
- Federal procedures available for determinations that involve medical judgment
  - includes medical necessity and determinations that treatment is experimental, rescissions of coverage
  - but not plan eligibility
  - Claimant may request external review within 4 months of denial; other time limits apply to preliminary review, submission to IRO

ACA EXTERNAL REVIEW PROCEDURES

- Plans must refer qualifying external review requests to an independent review organization (IRO), except for certain insurers not covered by a state process, which may refer claims to HHS
- Process of selecting IROs must be unbiased and independent
- IRO must be selected from a panel of at least 3 IROs
  - No financial incentives
  - Must contract with plan, follow guidelines
  - Must use legal experts when appropriate
- IROs review claims *de novo*, and decisions are binding on the plan

Failure to establish or follow reasonable procedures

- Participant is deemed to have exhausted administrative remedies
- Allowed to bring suit against the plan under Section 502(a)
- May result in loss of deferential standard of review by court

- General standard is <u>substantial compliance</u>
- Largely a facts and circumstances determination by the court
- See *Schorsch v. Reliance Standard* (7th Cir. 2012) (procedural errors by insurer, including loss of admin record, did not excuse exhaustion where the failures did not prevent claimant from seeking review)
- But see *Rasenack v. AIG* (10th Cir. 2009) (applying de novo standard of review where plan administrator failed to issue a timely claim determination)

Remedies for procedural violations

- Courts are split on whether failure to follow procedures entitles a claimant to a substantive remedy or a procedural one
- Courts generally decline to award benefits or damages for failures
  - *DiGregorio v. Hartford* (1st Cir. 2005) (substantive relief not justified where claimant did not show the plan's failure prejudiced right to fair review)
  - *Watson v. Deaconess* (1st Cir. 2002) (substantive remedy not justified except in cases of fraud or concealment, or other extraordinary circumstances)
- Some courts, however, have held that reinstatement of benefits is the appropriate remedy
  - *Sanford v. Harvard* (6th Cir. 2001) (reinstatement appropriate where plan initially approved benefits but later revoked decision and failed to follow its procedure)
  - *Schneider v. Sentry* (7th Cir. 2005) (reinstatement appropriate to restore status quo where administrator terminated benefits under noncompliant procedures)
- Courts also differ on whether penalties are appropriate under ERISA Section 502(c) for procedural violations

Remedies for procedural violations – judicial options

- Excuse exhaustion, permit suit under ERISA 502
  - *Bilyeu v. Morgan Stanley* (9th Cir. 2012)
- Remand to administrator for reconsideration
  - *Harrison v. Wells Fargo* (4th Cir. 2014)
- Tolling statute of limitations
  - *Hahnemann v. All Shore* (3d Cir. 2008)

Remedies for procedural violations – loss of deference

Proper remedy for regular violations…

- *LaAsmar v. Phelps Dodge* (10th Cir. 2010) (claims decision well outside permitted time period)
- *Abatie v. Alta* (9th Cir. 2006) (wholesale and flagrant violations result in de novo review, but even less flagrant transgressions may be weighed by the court in determining to apply deference)

Or only for serious and prejudicial ones?

- *Conkright v. Frommert* (U.S. 2010) (previous arbitrary decision does not nullify administrator's discretion in subsequent review)
- *Barboza* (9th Cir. 2014) (failure to issue timely decision was not "wholesale and flagrant" and did not cause forfeiture of discretionary standard)

EXHAUSTION

- Claimants generally may not bring suit until they exhaust the plan's available administrative remedies
- This requirement is not in the statute, but comes from legislative history and existing federal labor law, including the LMRA's framework for grievances
- "balance between providing meaningful reform and keeping costs within reasonable limits" - House Conference report
- Claimants not required to exhaust every possible issue, and not required to pursue optional appeals before suit
- Courts generally have held statutes of limitation are tolled while the participant engages in the claims review process (see *Fallin*, 6th Cir. 2012)
- Failure to exhaust generally may result in dismissal, with or without prejudice, or remand to the plan, either with a dismissal or staying the court proceedings

EXHAUSTION – WHEN EXCUSED

- Futility
  - See *West* (6th Cir. 2007) (based on cash balance plan administrator's benefit formula, appeal would not have yielded different result)
  - But see *Midgett* (8th Cir. 2009) (exhaustion of short-term disability claim not futile where long-term claim already denied)
  - Bare allegation of futility is not sufficient – *Chorosevic* (8th Cir. 2010) (plaintiff failed to present facts to show futility)
- Denied meaningful access to procedures
  - See *Baptist Mem'l Hosp.* (5th Cir. 2010) (administrator never formally denied claim in writing)
  - But see *Heller* (D.C. Cir. 1998) (denial failed to mention appeal procedure but insurer accepted the appeal, and communications as a whole satisfied ERISA)
- Irreparable harm
  - See *Turner* (1st Cir. 1997) (excusing exhaustion in case of "imminent threat to life or health")

STANDARD OF REVIEW

- ERISA is silent on the standard of review for participant claims
- Many courts adopted the "arbitrary capricious" standard under the LMRA that applies to multiemployer plans – see *Wardle* (7th Cir. 1980)
- In *Firestone* (1989) the Supreme Court adopted a two-level analysis
  - If trust document grants discretion, administrator decisions receive deference, overturned only if arbitrary and capricious
  - Otherwise, *de novo* review
  - Existence of a conflict may be relevant in whether decision if arbitrary and capricious, but it does not necessarily entitle claimant to benefits
- *MetLife v. Glenn* (2008): a conflict exists where the decision maker might benefit financially from a denial of benefits, and such conflict may factor into the finding of abuse of discretion, but not does not by itself warrant a change in the standard of review
  - Conflict more important where there is a "higher likelihood" the conflict affected benefit decisions or where there is a pattern of biased determinations
  - But conflict less important where decisions makers are walled off or subject to penalty for inaccurate decisions

Standard of review – discretionary language

- Because of *Firestone*, discretionary language is included in most plans
- Some states (including CA, NY, TX, NJ) attempt to limit discretionary language in health insurance policies
  - NAIC adopts model act prohibiting such clauses
  - The 6th (*Ross*), 7th (*Fontaine*) and 9th Circuits (*Morrison*) have found these rules are not preempted by ERISA because they fall under the "savings clause"
  - But the 10th Circuit in *Hancock* (2010) found Utah's rule not preempted because it is not related to insurance risk pooling

Plan interpretation

- Under an abuse of discretion standard, a court may not substitute its own judgment for the reasonable judgment of the plan fiduciary
- When reviewing plan language *de novo*, court may apply several canons of interpretation that are not found in ERISA
  - *Contra proferentem* – ambiguities in contracts construed against the drafter
    - Accepted by most circuits (but not the 6th, 10th, and DC) as to insured benefits – see, e.g., *Frommert* (2d Cir. 2008); *Santaella* (7th Cir. 1997)
    - Circuits split on whether this doctrine applies to self-insured and pension plans – compare *West* (6th Cir. 2007) and *Rodriguez-Abreu* (1st Cir. 1993)
    - Almost always rejected where standard is deferential – see *Clemons v. Norton* (6th Cir. 2018) ("Whatever the precise contours of Firestone deference, it must include the ability to choose between two reasonable interpretations of the Plan, and that is precisely the situation in which the traditional *contra proferentum* [sic] rule operates against the drafter.")
  - Reasonable expectations – court reads the plan language for plain meaning, based on the reasonable expectations of the insured
    - See *Santarelli* (9th Cir. 1994) ("Critically important" exclusion unenforceable where it was buried in definitions section, not included in exclusion section of plan document)
    - Circuits split on whether doctrine applies under abuse of discretion standard

EVIDENTIARY ISSUES

- Courts generally agree, the extent to which new evidence may be considered at trial depends largely on the standard of review
- However, courts disagree on what evidence is admissible when
  - See *Orndorf* (1st Cir. 2005) (same rules apply regardless of standard of review)
  - But see *Luby* (3d Cir 1991) (*de novo* review not limited to administrative record)
- After *Glenn*, courts have adopted varied approaches when faced with the allegation of a conflict, but in practice few have completely barred discovery
  - Compare *Stephan* (9th Cir. 2012) (allowing discovery of internal memoranda to show biased decision making) and *Samuel* (D.S.D. 2008) (holding *Glenn* did not alter standard of review and merits determinations must be made on the record)
  - Others permit discovery into a potential conflict only as a tie-breaker on close questions – see *Kellner* (S.D.N.Y. 2008)

Evidentiary issues – the "administrative record"

- Refers to the body of materials considered by the plan in making its determination, including as part of an appeal
- Some courts consider materials submitted after exhaustion outside the record – see *Townsend* (11th Cir. 1008)
- Other courts include all materials submitted up to the start of litigation - see *Pari-Fasano* (1st Cir. 2000)
- Some courts have considered information that was available to the administrator, even if not submitted by the claimant – see *Mirsky* (3d Cir. 2014)

EVIDENTIARY ISSUES ON *ABUSE OF DISCRETION* REVIEW

- Presumption that extra-record evidence is not admissible
- However, several courts have permitted extra-record evidence in certain cases
  - Discovery into fairness of plan's process – see *Moore* (6th Cir. 2006)
  - Evidence of customary plan interpretation – see *Glista* (1st Cir. 2004)
  - Determining whether the admin record was complete – see *Burke* (9th Cir. 2008)
- Courts have denied discovery in other cases
  - Data on rate of denial for similar claims - *Doe v. MAMSI* (D.D.C. 2006)
  - Evidence on training and qualifications of decision makers – *Perlman* (7th Cir. 1999)

EVIDENTIARY ISSUES ON *DE NOVO* REVIEW

- Some courts limit discovery to the administrative record even in cases of de novo review, based on ERISA's goal of an expeditious review process – see *Orndorf* (1st Cir. 2005)
- The 11th Circuit has held excluding extra-record evidence is antithetical to the concept of *de novo* review - *Moon* (1989)
- Other circuits avoid bright line rules, permitting extra-record discovery if special circumstances warrant but avoiding it otherwise, preferring to leave the issue to the district court's discretion

¯_(ツ)_/¯

Plan document vs. other documents

- Claims have been brought under ERISA 502(a)(1)(B) based on conflicts between plan and SPD, either as estoppel claims or fiduciary breach claims
- In *Cigna v. Amara* (2011), the Supreme Court held that an SPD is not a plan document that may give rise to a claim under 502(a)(1)(B)
- Post-*Amara*, however, courts have found SPDs enforceable as plan documents where they are incorporated by reference
- Courts continue to review whether a single document may serve as both the SPD and plan document
- *Amara* left open the possibility that an estoppel claim might be brought based on more generous language in an SPD

Trial proceedings and disposition

- Benefit claims typically decided on pleadings or summary judgment, since admin record usually contains the relevant facts
- In *Wilkins* (1998) the 6th Circuit found bench trials and summary judgment inappropriate, and instructed district court to make finding of fact and law based on its review of the admin record and the parties' arguments
- Other circuits have settled on similar approaches
  - 9th Circuit- "trial on the administrative record" – *Kearney* (1999)
  - 2nd Circuit- "bench trial on the papers" – *Muller* (2003)
  - 7th Circuit- in de novo review, conflicting evidence demands a full trial, but in abuse of discretion cases, a stipulation of facts is acceptable (compare *Krolnik* (2009) and *Hess* (2001))

Trial proceedings and disposition - remand

- Courts regularly remand cases to the plan administrator for further review
- Remand is not provided for in the statute, but courts have found a basis for it implicit in the principle of exhaustion
- Courts have held remand is appropriate, rather than awarding benefits, to correct procedural errors – see *Tate* (7th Cir. 2008)
- But in cases where entitlement to benefits is so "clear cut that it would be unreasonable" to deny the application on any grounds, reinstatement of benefits may be warranted
  - See *Schane* (7th Cir. 2014)

Practical Tips

- Consider what you want to provide in a plan's claims procedure.
  - Do you want *Firestone* discretion? (Presumably yes.)
  - Do you want a short "statute of limitation"?
- Draft denial notices to be both compliant and communicative.
- Claims procedure requirements are minimums. They can be expanded, where appropriate (with consideration being given to the setting of precedent).
  - If a dispute can be "solved" during the administrative process, the parties can save the costs and burdens of litigation.
  - Also, ERISA attorney fee awards generally are only for work done during the litigation phase of the dispute and not the administrative phase.