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**DAILY**

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## ERISA Claims Review: A Tale of Two Cases



By HISHAM M. AMIN AND ANDY BANDUCCI

The United States Supreme Court's April 21, 2010, decision in *Conkright v. Frommert*<sup>1</sup> upholds the continuing vitality of deference owed to an ERISA plan administrator as established in *Firestone v. Bruch*.<sup>2</sup> The *Conkright* decision is welcome relief in light of *MetLife v. Glenn*,<sup>3</sup> a decision handed down by the court on the same issue only two years before. The controversial *Glenn* decision has reduced deference to plan administrators, caused deeper examination of "conflicts of interest," and increased discovery activity

in many cases and courts. *Conkright* may offer a course correction away from the trends established in the wake of *MetLife v. Glenn*. This article contrasts these two cases to develop practical solutions for dealing with the current litigation climate in ERISA claims review.

### **Glenn and Its Fallout: An Open Door for ERISA Claimants?**

The Supreme Court in 2008 addressed deferential review in *MetLife v. Glenn*. In *Glenn*, a plan participant submitted an application for long-term disability benefits to a "dual-role" administrator, i.e., one with responsibility for both evaluating and paying claims. The plan conferred upon the administrator discretionary authority to construe and apply its terms. Acting with such authority, the administrator denied the participant's claim for benefits.

The participant appealed the denial to the district court, which affirmed. The plaintiff then appealed the decision to the Court of Appeals for the Sixth Circuit. That court treated the administrator's "conflict of interest" arising from its dual role as a "relevant factor" in ultimately overturning MetLife's denial of benefits. The

<sup>1</sup> 130 S. Ct. 1640, 48 EBC 2569 (2010) (76 PBD, 4/22/10; 37 BPR 994, 4/27/10).

<sup>2</sup> 489 U.S. 101, 10 EBC 1873 (1989).

<sup>3</sup> *Met. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 43 EBC 2921 (2008) (119 PBD, 6/20/08; 35 BPR 1501, 6/24/08).

*Hisham Amin and Andy Banducci are associates at Groom Law Group, Chartered, in Washington, D.C., where their practices focus on employee benefits litigation.*

Sixth Circuit emphasized that MetLife failed to credit quality evidence supporting the claimant while operating under this conflict.

The Supreme Court accepted certiorari to consider the question of whether a dual-role administrator has a conflict of interest that must be a factor on judicial review of a discretionary benefits decision. The court held that when the entity that is responsible for paying claims also determines whether the benefits should be paid, it operates under a financial conflict of interest that courts *must* consider as a factor in determining whether the administrator abused its discretion.<sup>4</sup> The court noted that such a factor may act as a “tie breaker” when the other factors are closely balanced.<sup>5</sup> Specifically, the conflict of interest will be more important where “circumstances suggest a higher likelihood that it affected the benefits decision,” such as where the administrator has a history of biased claims administration.<sup>6</sup> The conflict is less important “where the administrator has taken active steps to reduce potential bias and to promote accuracy.”<sup>7</sup>

Although the explicit language of the case arguably suggests a deference-favorable opinion, claimants’ attorneys routinely rely upon the case. By mandating that judicial review include a consideration of whether the plan administrator had a conflict of interest, many claimants contend that *Glenn* opened the door to discovery in ERISA claims cases.<sup>8</sup> After all, they argue, how can a reviewing court determine whether the decision-maker was biased based solely on the record created by the administrator? According to such claimant-side advocates, common sense alone suggests that evidence of a conflict is generally unavailable in the administrative record. Consequently, benefits claimants have seized upon *Glenn* to argue that traditional limitations on discovery in ERISA cases should be inapplicable where the claims administrator had a conflict of interest.

Courts have interpreted *Glenn* in a variety of nuanced ways. One general rule that can be distilled is that evidence of a conflict of interest must at least appear in the administrative record prior to opening the door to discovery.<sup>9</sup> But once that conflict is established, courts may allow the plaintiff an opportunity to explore the contours of alleged bias.<sup>10</sup> Courts have permitted lim-

ited discovery, for instance, to delve into various related topics, including procedural defects, the relationship between outside experts and administrators, compensation arrangements with employment consultants, and statistical records pertaining to claims handling.<sup>11</sup>

An excellent overview of this post-*Glenn* type of ERISA discovery is contained in *Dandridge v. Raytheon Co.*<sup>12</sup> In *Dandridge*, the U.S. District Court for the District of New Jersey identified three goals of the plaintiff’s discovery requests. First, the plaintiff wanted to investigate the defendant’s structural conflict of interest, and the court approved:

*Glenn* supports limited discovery directed to the issue of a structural conflict of interest. . . . Thus, discovery beyond the administrative record is permissible if such discovery is directed toward uncovering the extent to which a structural conflict record has morphed into an actual conflict that could have influenced the administrator’s discretionary decision.<sup>13</sup>

Second, plaintiff sought evidence of perceived bias and irregularity in the claims review process. Noting that *Glenn* did not impact discovery targeted toward procedural irregularities, fraud, mistake, or bias, the court retained its pre-*Glenn* standard for discovery:

[C]ourts in this district have rejected the implication that *Glenn* supports broad discovery into issues of bias and mistake. . . . [S]ome discovery into alleged procedural irregularities is permitted in ERISA cases, but only when the party seeking discovery has made at least some minimal showing of bias or irregularity that could have impacted the administration of the claim.<sup>14</sup>

Third, the plaintiff sought discovery relating to the merits of defendant’s claim determination. The court quickly dispensed with the possibility of allowing discovery into the actual merits of the claims decision. Indeed, the court noted that no Third Circuit cases either before or after *Glenn* permitted such broad discovery.<sup>15</sup>

This limited approach described in *Dandridge* appears to be gaining traction. Courts acknowledge that there is a disconnect between the traditional restrictive discovery rules and *Glenn*’s admonition that a conflict

mination. The courts are not unanimous as to whether there must be a threshold showing of bias to obtain discovery on the issue of whether the bias influences the claim denial. Compare *McGahey v. Harvard Univ. Flexible Benefits Plan*, No. 08-10435-RGS, 2009 WL 799464, at \*2 (D. Mass. March 25, 2009) (“a court should permit discovery only where a plaintiff makes a threshold showing that the denial of benefits was improperly influenced by the administrator’s conflict of interest”), with *Kinsler v. Lincoln Nat. Life Ins. Co.*, 660 F. Supp.2d 830, 835-36 (M.D. Tenn. 2009) (where plaintiff alleges an inherent conflict of interest in dual role administration, “discovery into this alleged conflict of interest is proper, even if the plaintiff has not made an initial threshold showing of bias beyond alleging the existence of this type of conflict of interest.”).

<sup>11</sup> *Blankenship v. Met. Life Ins. Co.*, 686 F. Supp. 2d 1227, 1233 (N.D. Ala. 2009) (listing cases; “The Eleventh Circuit appears, then, to understand *Glenn* to allow discovery beyond the bare existence of the conflict and to explore the level of that conflict and the degree to which it may have influenced the denial decision.”); *Hogan-Cross v. Met. Life Ins. Co.*, 568 F. Supp.2d 410, 415 (S.D.N.Y. 2008) (discovery of compensation of an outside consultant permitted).

<sup>12</sup> 48 EBC 2809 (D.N.J. 2010).

<sup>13</sup> *Id.* at \*5.

<sup>14</sup> *Id.* at \*5-6.

<sup>15</sup> *Id.* at \*3.

<sup>4</sup> *Id.* at 2350.

<sup>5</sup> *Id.* at 2351.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> Some of the early post-*Glenn* cases rejected this view. See, e.g., *Achorn v. Prudential Ins. Co., of Am.*, No. 1:08-cv-125-JAW, 2008 WL 4427159, at \*3 (D. Me. Sept. 25, 2008) (“. . . *Glenn* is not a case about discovery. . .”).

<sup>9</sup> See, e.g., *Kendel v. Zurich American Ins. Co.*, No. 4:09CV00040 SWW, 2009 WL 3063363, at \*2 (E.D. Ark. Sept. 21, 2009) (denying discovery where administrative record does not indicate a conflict of interest; record contained no evidence that the administrator did not follow established claims procedures); *Winkler v. Aetna Life Ins. Co.*, No. CV 08-8269 AHM (CWx), 2009 WL 2913568, at \*2 (C.D. Cal. Sept. 10, 2009) (evidence establishing that a conflict of interest exists is a predicate to seeking discovery outside the administrative record).

<sup>10</sup> See *Kruk v. Metro. Life Ins. Co., Inc.*, 46 EBC 2777 (D. Conn. 2009) (permitting interrogatories and depositions because plaintiff demonstrated that this evidence might provide “good cause” for the court to look to extrinsic evidence). Showing the existence of a conflict is, of course, easier than demonstrating that the conflict influenced the benefits deter-

of interest be weighed as a factor on review. To this effect, one district court asked rhetorically, “[h]ow else could a court determine whether a *per se* conflict of interest gave rise to an actual abuse of discretion, than by permitting at least a modicum of discovery?”<sup>16</sup> But even permissive courts appear to be trending toward fairly concrete standards, generally allowing discovery into three broad areas of inquiry: (1) history of biased claims denials; (2) steps taken by the employer to reduce bias and promote accuracy; and (3) whether the administrator incentivizes claim denials.<sup>17</sup>

In short, after *Glenn*, the role of discovery outside the administrative record is to aid the judge in deciding whether a conflict of interest gave rise to an actual abuse of discretion.<sup>18</sup> The trend is to permit discovery related to the impact of those conflicts, and courts have generally rejected discovery aimed at relitigating the claims decision itself.

The *Glenn* decision and its resulting impact on conflicts of interest and discovery were not the only factors that chipped away at discretionary review and that may ultimately forever change the way claims cases are handled. In fact, the *Glenn* case unfolded during the course of a separate attack on discretionary clauses in ERISA plans. For the last several years, the National Association of Insurance Commissioners has driven a movement to abolish discretionary review in claims cases. Broadly speaking, NAIC argues that discretionary clauses promote unfair claims practices. In 2002, NAIC proposed a model state regulation that would prohibit discretionary clauses altogether.<sup>19</sup> Since then, the effort to discourage discretionary clauses has seen considerable success, as more and more states adopt regulations banning the inclusion of such clauses in policy forms. One such regulation was at issue in a case that the Supreme Court had an opportunity to hear very recently, but it declined to do so.<sup>20</sup>

<sup>16</sup> *Thornton v. W. and S. Life Ins. Co. Flexible Benefits Plan*, No. 3:08CV-00648-M, 2010 WL 411119, at \*2-3 (W.D. Ky. Jan. 28, 2010) (“[W]hen courts have permitted discovery post-*Glenn*, the discovery permitted has not been unfettered. In keeping with the pre-*Glenn* precedent, the discovery allowed has been restricted in scope, and generally limited to a search for evidence of whether an inherent conflict of interested affected a benefits decision”).

<sup>17</sup> *Id.* at \*3; see also *Kinsler v. Lincoln Nat. Life Ins. Co.*, 660 F. Supp.2d 830, 836 n. 3 (M.D. Tenn. 2009) (noting that discovery into personnel files and pay records is impermissible, but allowable for bonuses or reward incentives for claims reviewers and information relating to the “temporal and financial depth” of any relationship between a third party reviewer and the defendant.”)

<sup>18</sup> *Thornton*, 2010 WL 411119, at \*2.

<sup>19</sup> 1 NAIC Model Laws, Regulations and Guidelines, “Prohibition on the Use of Discretionary Clauses Model Act,” NAIC 42-1 (2006).

<sup>20</sup> The first appellate case to consider the viability of state prohibition of discretionary review clauses was *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 46 EBC 1385 (6th Cir. 2009) (51 PBD, 3/19/09; 36 BPR 704, 3/24/09). In *Ross*, the Sixth Circuit considered a rule promulgated by the Michigan Office of Financial and Insurance Services forbidding insurers from marketing policies containing discretionary clauses. The American Council of Life Insurers sought to undercut the rule on preemption grounds. The rule withstood judicial scrutiny and was upheld.

The second case to reach the federal appellate bench was *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 47 EBC 2697 (9th Cir. 2009) (206 PBD, 10/28/09; 36 BPR 2492, 11/3/09), cert. de-

## Back to Basics

In April, the Supreme Court provided good news for plan administrators in a case that significantly supports discretionary review. Some would argue that the case offers a course correction away from the trend being set by *Glenn*, and back towards the higher degree of deference espoused in *Firestone*.

In *Conkright v. Frommert*,<sup>21</sup> a plan administrator sought to calculate current benefits of rehired employees who had previously retired and received lump-sum distributions of their retirement benefits. The administrator chose to replicate the market return of those lump-sum distributions, a procedure to which the rehired employees objected. The participants argued that the administrator’s methodology was unreasonable, and that they did not receive adequate notice. The district court upheld the determination, but the Second Circuit remanded the matter.

The participants were dissatisfied with the administrator’s new interpretation on remand. Rather than deferring to the administrator, the district court adopted its own calculation method. The Second Circuit affirmed the district court’s calculation methodology.

In explaining its decision, the appeals court created an exception to the fundamental ERISA rule that a plan administrator is entitled to deference if the plan confers upon the administrator discretion to interpret plan terms. According to this exception, an administrator that errs in interpreting the plan in the first instance is no longer entitled to deference upon reinterpreting those same plan terms.<sup>22</sup>

The Supreme Court rejected the Second Circuit’s exception and held that the district court should have deferred to the plan administrator’s interpretation of the plan on remand. In reversing the Second Circuit, the court reviewed the seminal cases of *Firestone* and *Glenn*. According to the court, *Firestone* left no room for the creation of ad hoc exceptions to the deferential standard of review.<sup>23</sup> The *Conkright* court further rea-

nied sub nom. *Standard Ins. Co. v. Lindeen*, No. 09-885, 2010 WL 285696 (May 17, 2010) (94 PBD, 5/18/10; 37 BPR 1214, 5/25/10)). It was in this case that the court recently denied a petition for certiorari. *Morrison* involved a Montana statute calling for disapproval of any insurance form containing language that could “deceptively affect the risk purported to be assumed” by the insurer. Montana’s insurance commissioner announced that the statute required him to disapprove of any insurance form containing a discretionary clause. The Ninth Circuit found that the practice of denying approval to forms containing discretionary clauses narrows the “scope of permissible bargains between insurers and insureds.” Noting the Sixth Circuit’s *Ross* decision, the court upheld the decision to forbid such clauses.

In *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 48 EBC 1741 (10th Cir. 2009) (246 PBD, 12/30/09; 37 BPR 16, 1/5/10), the third of these cases, Utah’s insurance commissioner effected a general ban on reservation of discretion clauses in insurance policy forms. The rule contained an exemption for employee benefit plans that included discretionary language. The exemption would apply so long as the plan satisfied certain formatting requirements. The Tenth Circuit held that ERISA preempted the rule as it relates to employee benefit plans.

<sup>21</sup> 130 S. Ct. 1640, 48 EBC 2569 (2010) (rev’g *Fommert v. Conkright*, 535 F.3d 111, 44 EBC 1461 (2d Cir. 2008)).

<sup>22</sup> *Fommert v. Conkright*, 535 F.3d 111, 119 (2d Cir. 2008).

<sup>23</sup> *Conkright v. Frommert*, 130 S.Ct. 1640, 1646-47 (2010) (“Indeed, we refused to create such an exception to *Firestone*

soned that if the standard of review remains intact even when the administrator operates under a conflict of interest (the holding in *Glenn*), then an administrator should not be denied deference after simply making a mistake.<sup>24</sup> An administrative decision may not be entitled to deference if the administrator exercises discretion unfairly, incompetently, or in bad faith; but a good-faith error should not result in a similar loss of deference.<sup>25</sup> An honest mistake is simply insufficient to strip a plan administrator of deference otherwise owed.

The holding and language of *Conkright* provide substantial support for the vitality of discretionary review in claims cases. Indeed, the court arguably invites practitioners to offset attacks on discretionary review by simply reviving the original teachings of *Firestone*, rather than *Glenn*, albeit with more explicit attention to the themes of efficiency, predictability, and uniformity:

[B]y permitting an employer to grant primary interpretive authority over an ERISA plan to the plan administrator, [*Firestone* deference] preserves the “careful balancing” on which ERISA is based. Deference promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from *de novo* judicial review. Moreover, *Firestone* deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions[.]<sup>26</sup>

Stated differently, the court appears eager to caution that *Glenn* and its progeny did not undermine the traditional trust principles crucial to the regime of deferential review. Viewed in this light, *Conkright*'s emphasis on the necessity and importance of deference is a shift away from aggressive interpretations of *Glenn*.

Indeed, a fundamentally “back to basics” interpretation of *Conkright* might view the opinion as a call to remember those ERISA precepts critical to useful defenses for plans and plan sponsors. In the context of a claim for plan benefits, for instance, procedural violations by plan fiduciaries and administrators generally do not create a substantive remedy for benefit claimants. Case law for this proposition is abundant even in traditionally more consumer-protective jurisdictions such as the Ninth Circuit.<sup>27</sup>

deference in *Glenn*, recognizing that ERISA law was already complicated enough without adding ‘special procedural or evidentiary rules’ to the mix.”)

<sup>24</sup> *Id.* at 1646-47. (“If, as we held in *Glenn*, a systemic conflict of interest does not strip a plan administrator of deference, it is difficult to see why a single honest mistake would require a different result.”)

<sup>25</sup> *Id.* at 1651. The Court did entertain the possibility that “[m]ultiple erroneous interpretations, even if issued in good faith, might well support a finding that a plan administrator is too incompetent to exercise his discretion fairly.”

<sup>26</sup> *Id.* at 1649.

<sup>27</sup> See, e.g., *Pisciotta v. Teledyne Indus. Inc.*, 91 F.3d 1326, 1330 (9th Cir. 1996) (“Any ERISA claimant who suffers because of a fiduciary’s failure to comply with ERISA’s procedural requirements is ordinarily not entitled to a substantive remedy such as the retroactive reinstatement of benefits.”); *Parker v. BankAmerica Corp.*, 50 F.3d 757, 768-69, 19 EBC 1044 (9th Cir. 1995) (rejecting argument that employees should recover benefits based on fiduciary’s failure to provide document describing benefits program in part because a fail-

Similarly, although some claimants allege that procedural violations amount to a “breach of fiduciary duty,” in large part these claims are mutually exclusive with traditional benefits claims under ERISA.<sup>28</sup> In short, a benefits claimant generally is not entitled to relief for a breach of fiduciary duty if a claim for plan benefits is available.<sup>29</sup> Likewise, ERISA does not normally permit a benefits claimant to recast a claim for plan benefits as a claim for breach of fiduciary duty.<sup>30</sup>

## ERISA Fundamentals as a Guide to Claims Review

In *Conkright*, we see that ERISA’s fundamental principles have not changed, yet plan administrators can

ure to comply with ERISA’s procedural requirements does not ordinarily entitle a claimant to a substantive remedy).

<sup>28</sup> The principal fiduciary duty provision of ERISA is set forth in ERISA § 404, 29 U.S.C. § 1104. ERISA fiduciaries who breach their statutory duties may be subject to liability under ERISA’s civil enforcement scheme set forth in ERISA §§ 502(a)(2) and (a)(3), 29 U.S.C. §§ 1132(a)(2) and (a)(3). Specifically, the relevant provisions state that an action may be filed:

(a)(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under [ERISA § 409, 29 U.S.C. § 1109]; [or]

(a)(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]

<sup>29</sup> See *Mahoney v. Nw. Airlines Pension Plan for Contract Employees*, No. 02-4339 (MJD/JGL), 2004 WL 114946, at \*5-6 (D. Minn. Jan. 8, 2004) (noting claimants may not state claim for past or future benefits under § 502(a)(2) because claims for benefits are adequately addressed under § 502(a)(1)(B)) (17 PBD, 1/28/04; 31 BPR 309, 2/3/04).

<sup>30</sup> See *Zhu v. Fujitsu Group 401K Plan*, No. C-03-1148RMW, 2003 WL 24030329, at \*2 (N.D. Cal. Sept. 9, 2003) (opining that courts should be wary of § 502(a)(1)(B) claims that are recast as § 502(a)(3) claims); *Kopicki v. Fitzgerald Auto. Family Employee Benefits Plan*, 121 F. Supp. 2d 467, 483 (D. Md. 2000) (“[A] plan beneficiary cannot merely recast a claim predicated upon the fiduciary’s alleged mishandling of an isolated claim for coverage in the form of a breach of duty. Rather, the allegations, if proven true, must establish a breach of fiduciary duty independent of the contested denial of benefits.”).

As a caveat, the Supreme Court has recognized that a § 502(a)(2) action may lie in the defined contribution plan context “for fiduciary breaches that impair the value of plan assets in a participant’s individual account.” *LaRue v. Dewolff, Boberg & Assocs.*, 552 U.S. 248, 42 EBC 2857 (2008) (35 BPR 467, 2/26/08; 35 BPR 467, 2/26/08).

Also, some courts, like the Ninth Circuit, permit remedial relief under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), when an alleged miscommunication or failure to communicate involves fraud, bad faith, trickery, active concealment, or other such pernicious conduct on the part of the plan administrator or fiduciary. See, e.g., *Peralta v. Hispanic Bus., Inc.*, 419 F.3d 1064, 35 EBC 1810 (9th Cir. 2005) (161 PBD, 8/22/05; 32 BPR 1828, 8/23/05); *Patel-Puri v. Metro. Life Ins. Co.*, No. C-05-0455 MMC, 2008 WL 2609711, at \*5 (N.D. Cal. June 27, 2008) (where “the breach consists of a procedural violation of ERISA requirements, equitable relief [under ERISA § 502(a)(3)] . . . has been afforded only where the procedural violation involves bad faith, active concealment, or fraud on the part of the fiduciary”). “[N]egligently inadequate communications,” on the other hand, would not constitute the type of conduct for which appropriate equitable relief is available under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). *Peralta*, 419 F.3d at 1076.

nevertheless be quickly besieged when best practices are not followed. While there is no guarantee, a carefully structured review process will maximize the likelihood that a claims decision will survive judicial review. A solid grounding in foundational precepts of ERISA is essential to the design and structure of a legally sound, efficiently run claims review process.

A plan should carefully examine its claims procedure, its protocol for selecting and consulting with outside personnel, and its methodology for compiling and assembling the administrative record of its decisions. Above all, plans should ensure that the review process seeks to achieve accuracy. A plan might consider taking action in the above areas as follows:

**1. Ensure the structural soundness of the claims procedure.**

- Compensation of claims administrators should not be tied to the outcome of claims decisions. Instead, pay parameters should emphasize quality of work. If pay and claims decisions are to be tied, then reward and incentivize correct decisions, not claim denials. There should be no incentive for claims handlers to deny meritorious claims.

- Compensation and performance evaluations should be totally independent of the financial impact of the claims they decide. The size of a claim should be irrelevant to claims personnel. Performance reviews should focus on the timeliness, thoroughness, and quality of claims review.

- Claims personnel should be separate from business personnel. Plan administrators should not have a direct monetary interest in the sponsor's finances. For instance, the plan sponsor's chief financial officer should not also sit on the plan's claims review committee.

- The initial claims unit should be separate from the appeals unit. The appeals unit should give independent consideration to the claim.

**2. Ensure that outside personnel are qualified and unbiased.**

- Conduct due diligence in selecting third-party administrators and independent medical reviewers. How have courts treated their decisions? Are they under attack from the plaintiffs' bar?

- Rely upon an independent third-party administrator to make the final decision.

- For health and disability claims, rely upon independent, impartial, experienced, and highly credentialed medical personnel.

- Confirm that medical or vocational professionals are sufficiently qualified and experienced to credibly opine on the particular disability at issue.

- If independent medical reviewers are utilized, either rely on their determinations or be able to explain with utmost thoroughness the grounds for rejecting such reliance. Where necessary, ensure that the medical opinions are based on actual physical examinations of the claimant. The reviewer should consider and credit the claimant's reasonable evidence.

**3. Value consistency highly.**

- The administrative record should reflect a sound, consistent process. Handle like claims in like fashion.

- If you urge a claimant to apply for Social Security disability benefits, do not subsequently disregard the Social Security Administration's decision.

- Contemporaneously document, in detail, the procedure used to reach the benefits decision.

- The administrator should adopt and comply with written procedures designed to minimize the risk of error in reviewing claims. Checklists and template letters can help standardize the decision-making process. Claims procedures manuals, training guidelines, and instructive memoranda should all present the consistent message that accuracy is the most important value.

**4. Most importantly, be certain that the claims decision is correct.**

In making this determination, ask the following questions:

- Would the decision withstand *de novo* review?

- Was all the evidence considered?

- Were all of claimant's disabilities/disputes addressed?

- Does the decision make sense from a common-sense perspective?

- Does the decision rely upon evidence taken out of context?

- Did the administrator weigh the evidence reasonably?

- Did the administrator thoroughly and coherently explain the claim denial?

Taking these steps will increase the likelihood that a claims decision will survive judicial review, even if the reviewing court does not give deference to the administrator's decision. Similarly, if the claims decision is unassailable on the merits, then the defense attorney may simply stipulate to limited discovery and in that way control one entire category of fallout from attacks on discretionary review.

In sum, in today's increasingly uncertain legal and regulatory landscape, well-documented and carefully chosen practices will both enhance service and minimize potential litigation costs and problems. ERISA's fundamental precepts should provide the guideposts to such success.