Hitting You When You Least Expect It:
A Basic Guide to ERISA Benefits Claims for Non-ERISA Lawyers

By: John J. Conway, Esq.
John J. Conway, P.C.
645 Griswold, Suite 3600
Detroit, Michigan 48226
313.961.6525 (telephone)
313.961.0754 (fax)
john@johnjconway.com

What is ERISA?

"ERISA" is an acronym standing for the Employee Retirement Income Security Act of 1974 which went into effect on January 1, 1975. The statute was designed to protect employee pensions and other employee benefits. 29 U.S.C. §1001 *et seq*.

The statute changed the landscape of employee benefits law by requiring that all benefit plans be regulated by the federal statute versus the laws of the 50 states. ERISA is comprised of four titles: Title I regulates the dissemination of information to the plan participants. Title II covers the tax laws related to employee benefits. Title III covers the administrative and legal enforcement provision of ERISA. Title IV created the Pension Benefit Guaranty Company (PBGC), an insurance program that provides insurance coverage for certain types of pension plans.

Employee benefits are defined as pension benefit plans (defined benefits), 401(k) plans (also known as defined-contribution benefits), healthcare, disability insurance, and other employee benefits paid pursuant to a plan. The adoption of an employee benefit plan is a voluntary act by the employer or sponsor. Therefore, a Plan may typically be amended, altered, or terminated at any time by the employer or sponsor, although vested pension benefits generally may not be reduced.

What Do I Need to Know About the Main Features of ERISA Benefit Claims?

The U.S. Supreme Court has held that ERISA is "a comprehensive and reticulated statute." *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204, 209 (2002). This means that ERISA has broad legislative coverage over the entire area of employee benefits. It also means that any remedies not specifically provided within the statute will generally not be supplied by the courts.

***Preemption*.** Given the reach of the statute, ERISA has broad federal preemption. ERISA §514, 29 U.S.C. 1144. The statute, itself, preempts virtually all state law claims such as breach of contract, fraud, misrepresentation, and other tort claims.

There are limited exceptions to ERISA's preemptive effect which appear in the statute's "savings

clause." Generally, ERISA will not preempt state laws that regulate securities, banking, or insurance. The statute also does not disturb federal securities and employment laws. As for the insurance savings provision, the insurance law has been interpreted narrowly to mean that it must be a law that regulates the risk allocation feature of state insurance law. ERISA, § 514(b)(2).

The Employer Must Be A Private Entity. ERISA does not apply to any employee benefits provided by governmental and public employers or churches. ERISA, §4, 29 U.S.C. 1003.

There Must Be A Plan. ERISA covers only benefits provided pursuant to a Plan sponsored and maintained by an employer or other Plan sponsor. In other words, sometimes an employer will allow a company to sell "group" benefits to employees and the employer may simply collect the payment for those benefits through payroll deductions but does not intend to offer the benefits to the employees. In such cases, the benefits may be exempt from the application of the ERISA statute. This depends on the facts of the case and whether the benefits fall within ERISA's "safe harbor" provisions.

There Must Be An Entitlement to the Benefit or to a Future Benefit. In an ERISA case, the claimant must be a "participant" in the plan. That is, an individual must have standing to demonstrate an entitlement to a promised benefit, or the future entitlement to a benefit in order to request documents and pursue claims against the Plan.

If I am Representing an ERISA Claimant, What Do I Need to Do?

The initial determination is whether the benefit is actually subject to ERISA. That is, does the entitlement to the benefit come from a Plan sponsored and maintained by the employer or other sponsor for the benefit of the employees? If yes, then here is the proper course of action:

Ascertain the Name and Address of the Plan Administrator. The Plan Administrator must be identified. The reason for this is that the Plan Administrator has the duty to provide certain documents to the plan participant. For example, the Plan Administrator must provide the participant or that participant's authorized representative with a summary of all available Plan benefits known as a Summary Plan Description (SPD). The Plan Administrator also must, upon request, produce all contracts that govern the Plan and all other information sufficient to inform participants of the benefits to which they may be entitled and the procedure for acquiring their benefits. The Plan Administrator should be clearly identified in any employee benefits manual, but this is not always so. If the Plan Administrator has not been identified then typically, the "default" administrator is the employer or other entity which sponsored the Plan.

Request the Plan Documents from the Plan Administrator. After the identity and address of the Plan Administrator has been ascertained, you should send the Plan Administrator a request for all Plan documents. The request for documents should outline all categories of documents that relate to the Plan with as much specificity as possible. These documents must be provided by the Plan Administrator under ERISA §104, 29 U.S.C. §1024. The request should be sent by certified mail and should request, at a minimum, the following,

- A copy of the Plan document;
- A copy of any applicable Summary Plan Descriptions;
- Any insurance agreements, policies, or amendments and any third-party service agreements;
- Any brochures, benefits statements, or individual certificates that have been distributed to participants;
- A summary of all benefits paid to the participant and a written breakdown of all benefits that may be due and owing;
- Any benefit formula, calculation, procedure, worksheet, or similar document setting forth the manner in which eligibility or benefits are determined; and
- Any other documents under which the Plan is administered.

Calendar the Dates. By law, the Plan Administrator must provide the requested documents within (30) days of its receipt of the request. The failure to produce the requested documents may expose the Plan Administrator to per diem penalties of $110 per day until the documents are actually produced. 29 U.S.C. § 1132(c); 29 C. F. R. § 2575.502c (2003 DOL Regulation increasing the penalty to $110 per day).

File a Claim for the Benefit. The Plan Documents should contain an outline of the procedures for filing a claim for benefits. Typically, the Plan Administrator, the employer, or a third-party administrator must furnish claims forms for either pension or welfare (*i.e.*, healthcare and disability) benefits. The claim is either approved or denied. There are usually time limitations for the filing of a claim for welfare benefits, but not with filing of a claim for the distribution of normal vested retirement benefits.

Again, Calendar the Dates. The Department of Labor has promulgated time limitations for the resolution of claims and appeals depending on the type of claim that is filed. Under the DOL regulations, claims for health care must be resolved within certain time frames and claims for other types of benefits are to be resolved within certain time frames. There are exceptions for more complicated claims.

What if the Claim Is Denied?

Appeal the Denial If the claim is denied, in whole or in part, the claimant **must** appeal the adverse determination according to the appeal procedures established by the Plan, itself. This is yet another distinguishing feature of the statute which requires that every employee benefit plan inform the claimant of the precise reasons for the claim denial and set forth a procedure for appealing and reviewing a denied benefit claim. This is not optional, rather it is an absolute condition precedent to bringing litigation. The failure to exhaust the administrative remedies may be grounds for a dismissal with prejudice of the claim in subsequent litigation.

Not Only Should the Claimant Exhaust The Administrative Appeal Remedy, The Appeal Should Be Exhaustive. The pre-litigation administrative appeal is perhaps the most important feature of an ERISA claim for benefits. The reason for this is that the appeal is, almost without exception, the

only evidence that will be admitted in any subsequent legal proceeding. The appeal should contain all supporting documentation, citations to relevant plan provisions, and thorough analysis of why the claim was incorrectly denied. ERISA, §503, 29 U.S.C. §1133. In litigation, the content of the appeal typically becomes the basis for the lawsuit and the evidence presented to the Plan Administrator is the evidence considered by the court. The court may admit outside evidence in certain instances, but they are narrow, such as to demonstrate a procedural due process violation such as bias.

Should I File Suit? If the denial of a claim for benefits is eventually upheld, the claimant must decide whether to actually litigate the claim in court. A claim to recover benefits or enforce the right to benefits may be brought in either state or federal court under ERISA §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B). Other statutory claims under ERISA must be brought in federal court which has exclusive jurisdiction over them. ERISA, §502(e), 29 U.S.C. §1132(e).

There are two inquiries that should be made prior to filing suit. First, does the Plan vest the Plan Administrator (or its duly authorized administrator) with "discretionary" authority to decide claims and interpret the Plan's terms? If the Plan vests the Administrator with this authority, then the Plan Administrator's decision to deny benefits may be overturned only if it acted in an "arbitrary and capricious" manner. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The court's review will be constrained by this standard of review which has also been called "the least demanding form of judicial review." *Smith v. Continental Casualty Co.*, 450 F.3d 253, 258-259 (6th Cir. 2006).

If the Plan does not grant the Plan Administrator discretionary authority, then the denial is reviewed *de novo* by a trial court. Here, the trial court will decide whether or not the decision to deny benefits was correct. *Hoover v. Provident Life and Accident Ins. Co.*, 290 F.3d 801,808-809 (6th Cir. 2002).

In recent years, the number of claims that are reviewed *de novo* has greatly diminished since vesting the Plan Administrator with discretionary authority is a relatively simple process. At the same time, courts have grown stricter in scrutinizing the handling of benefits claims in the insurance context. *Rochow v. LINA*, –F.3d–, 2007 U.S. App. LEXIS 7599 (6th Cir. April 3, 2007).

When Do We Try the Case Before a Jury?

There are no jury trials in an ERISA case seeking benefits. *Daniel v. Eaton Corp*., 839 F.3d 263, 267 (6th Cir 1988). Typically, claims for benefits are resolved by cross-motion practice set forth in the concurring opinion in *Wilkins v. Baptist Healthcare System, Inc*., 150 F.3d 609 (6th Cir. 1998) discussed below.

What Happens In Court?

The Case Moves Fast Owing to Relatively Quick Deadlines. Given the fact that an ERISA claim is decided based on an Administrative Record compiled before the litigation commences, a typical scheduling order will set forth the date for a) the production of the Administrative Record, b) a deadline for filing notices for procedural challenge, and c) a briefing schedule requiring the filing of cross-motions for judgment on the Administrative Record, response briefs, and reply briefs.

It is not unheard of for an ERISA case to be resolved completely within a nine (9) month time frame from the date of filing to the date of judgment. In some courts, this deadline can be as short as six (6) months.

There is Limited Discovery. There is limited discovery in ERISA that is available only to make challenges related to procedural due process violations or bias on the part of the Plan Administrator. *Calvert v. Firstar Financial, Inc.*, 409 F.3d 28 (6th Cir. 2005). Typically, written discovery requests requesting evidence of such issues as the amount of fees paid to service providers are discoverable and may be used in the presentation of the cross-motions for judgment. Depositions are rare in ERISA benefits cases, although a court may permit them in certain circumstances.

The Case is Typically Resolved on Cross-Motions for Judgment. ERISA benefits actions are resolved upon the filing of cross-motions for judgment on the Administrative Record. *Wilkins v. Baptist Healthcare System, Inc*., 150 F.3d 609 (6th Cir. 1998). In some cases, oral argument is not permitted. The entire framework for resolving ERISA claims is akin to handling a summary judgment motion. The primary difference is that, in an ERISA case, both sides are moving for judgment on the Administrative Record.

Other Claims May Be Brought. There are other claims available to Plan participants, but the available remedies are typically limited. Claims for breach of fiduciary duty or for equitable relief are available, but in those claims equitable relief means just that – no money damages. *Gore v. El Paso Corp.***,** 477 F.3d 833 (6th Cir. 2007). Generally, the claims to recover benefits or enforce one's right to benefits under a Plan provide the best and most useful relief.

Attorneys Fees, Costs, and Interest. Finally, the prevailing party in an ERISA case may file a motion to recover attorneys fees, costs, and interest under 29 U.S.C. §1132(g). Either prevailing party may apply for an award of attorneys fees which are awarded in the court's discretion.

CHECKLIST FOR HANDLING ERISA BENEFITS CLAIMS

ITEM	DESCRIPTION	DONE
1.	Set up initial meeting with client and inform prospective client to bring all materials related to the employment relationship including, the employee benefits guide, any Summary Plan Descriptions or other documents related to insurance coverage.	
2.	Ascertain the name and address of the Plan Administrator.	
3.	Issue document request to Plan Administrator requesting all documents that relate to the employee benefit plan by certified mail, return receipt requested.	
4.	Calendar dates for 30 days from the receipt of the returned certified mail receipt.	
5.	Issue a follow-up letter to Plan Administrator on the 31st day after the documents are due.	
6.	Ascertain a proper method for filing a claim.	
7.	File a claim for benefits.	
8.	Calendar dates according to the Department of Labor (DOL) regulations for the resolution of the ERISA claim.	
9.	File an appeal of a claim denial providing all supporting documentation and interpretations and send by facsimile and certified mail, return receipt requested.	
10.	If the claim is denied, determine the appropriate Standard of Review.	
11.	If the claim is to be litigated, prepare a lawsuit and determine which claims will be brought. Are there any claims other than a claim for benefits under ERISA Section 502 (a)(1)(B)? Are there procedural violations under ERISA Section 503 or document violations under ERISA Section 502 (c) that should also be brought?	
12.	Request a complete copy of the Administrative Record in the case.	
13.	Draft/serve discovery requests related to procedural due process violations, such as bias.	
14.	Draft cross-motions for judgment on the Administrative Record in accordance with court's scheduling order.	
15.	File post-judgment motions for the imposition of attorney's fees and costs and interest.	