

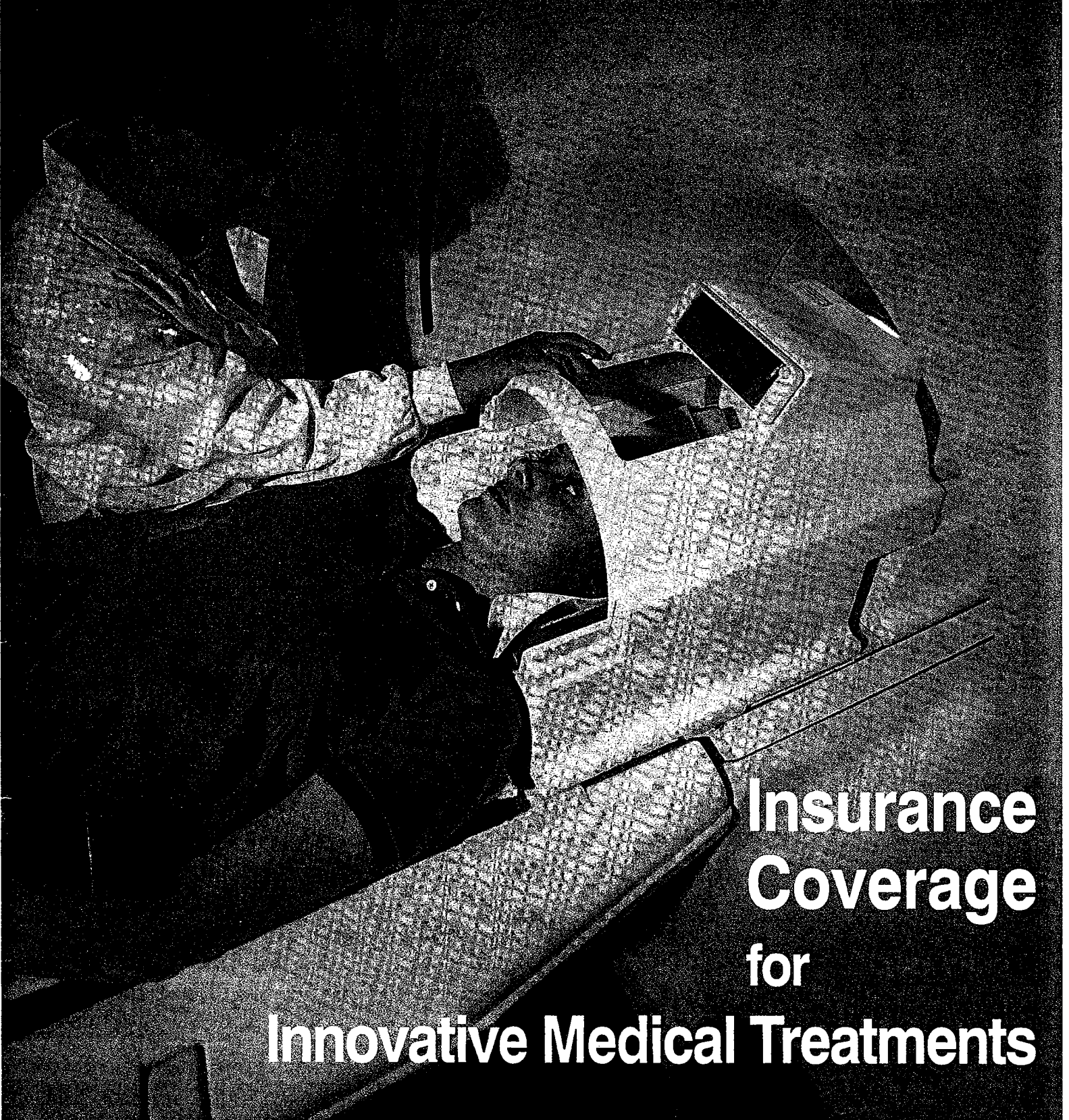
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The Scope of Evidentiary Review in ERISA Litigation

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INTRODUCTION

In 1989, the Supreme Court of the United States issued a watershed opinion having significant impact upon the manner in which reviewing courts examine benefit determinations in ERISA cases. Prior to *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the vast majority of courts reviewing claim decisions made by administrators or fiduciaries of ERISA-governed employee benefit plans extended a high degree of deference to such benefit determinations. In general, courts would overturn benefit determinations only if they were found to be "arbitrary and capricious." See, e.g., *LeFebvre v. Westinghouse Electric Corp.*, 747 F.2d 197 (4th Cir. 1984); *Wardle v. Central States, Southeast & Southwest Areas Pension Fund*, 627 F.2d 820 (7th Cir. 1980); *Jung v. FMC Corp.*, 755 F.2d 708 (9th Cir. 1985).

In *Firestone*, the Supreme Court rejected the "wholesale importation of the arbitrary and capricious standard into ERISA . . ." (489 U.S. at 109), a concept borrowed from labor law, and instead adopted a *de novo* standard for the review of benefit denials challenged under ERISA's civil enforcement provision (U.S.C. §1132(a)(1)(B)). Following *Firestone*, courts are instructed to apply a *de novo* review standard in all instances except those in which the plan documents expressly vest in the plan administrator or fiduciary "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115.

As might be expected, given a ruling which constituted such a dramatic departure from traditional notions of judicial review in ERISA cases, the Supreme Court's decision in *Firestone* left unanswered several important questions concerning ERISA litigation which have given rise to conflicting opinions and diverse interpretations among the various federal appellate circuits.

At least three major controversies have divided

the courts of appeal in the three years following the *Firestone* decision. The first of these is whether the *de novo* review standard, when mandated by *Firestone*, applies with equal force to cases involving benefit decisions based upon plan term interpretations as well as those based upon factual determinations. Secondly, what plan language will be deemed to vest a plan administrator or fiduciary with a sufficient degree of discretion in determining benefit eligibility or in construing plan terms to allow the retention of a deferential review standard when their decisions are challenged in court? Lastly, in reviewing a benefit determination, is it proper (or even permissible) for a court to consider evidence which was not before the plan administrator or fiduciary at the time the benefit determination was made, or must the court confine its consideration to such evidence as was present before, or available to, the decision-maker at the time the benefit claim was decided?

This article will address only the last of these three questions left unanswered by *Firestone*, and will review the responses handed down thus far by reviewing courts which have considered the issue of the proper scope of evidentiary review in ERISA cases.

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TRADITIONAL STANDARD OF EVIDENTIARY REVIEW

Prior to *Firestone v. Bruch*, the vast majority of federal appellate courts adhered to the traditional notion that in passing upon a benefit determination made by a plan administration or fiduciary, the reviewing court should restrict its consideration to such evidence as was actually before the decision-maker, or that which was available, at the time that the claim determination was made. *Wardle*, supra; *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1007 (4th Cir. 1985); *Crews v. Central States, Southeast & Southwest Areas Pension Fund*, 788 F.2d 332, 336 (6th Cir. 1986); *Short v. Central States, Southeast & Southwest Areas Pension Fund*, 729 F.2d 567, 571-72 (8th Cir. 1984); and *Carter v. Central States, Southeast & Southwest Areas Pension Plan*, 656 F.2d 575, 576 (10th Cir. 1981).

In addition to abundant case law, proponents of a restricted scope of review also found support in the language of ERISA itself. In describing the "prudent man standard of care," 29 U.S.C. §1104(a)(1)(B) states that:

a fiduciary shall discharge his duties with respect to a plan . . . with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims . . . (emphasis added).

Thus, the statute could be read to suggest that a judicial review of a fiduciary's decision regarding a claim for benefits under an ERISA-governed plan should be limited to an examination of the evidence that was before the fiduciary, or was available to the fiduciary, at the time of the decision, i.e. such evidence as was considered "under the circumstances then prevailing."

Such a limitation could also be said to be consistent with ERISA's statutory scheme of enforcing a uniform standard of conduct on the part of plan administrators and fiduciaries, and is likewise supported by the statutory requirement that any administrative remedies existing under the plan must first be exhausted before suit is filed. 29 U.S.C. §1133.

Allowing a court to consider new evidence not brought before the plan administrator or fiduciary during the course of the administrative review pro-

cess, it was claimed, would frustrate the purpose of such an internal review procedure in attempting the proper and orderly resolution of claims, and could transform the role of the court into that of a claims administrator. *Perry v. Simplicity Engineering*, 900 F.2d 963, 966-67 (6th Cir. 1990).

Indeed, in the vast majority of pre-*Firestone* benefit cases, any attempt to supplement the trial court's record with information not previously brought before the claims administrator or fiduciary resulted in the remand of the case to the trustee for a new determination of the claim in light of the additional evidence. See, e.g., *Phillips v. Kennedy*, 542 F.2d 52, 55 n.10 (8th Cir. 1976); *Sturgill v. Lewis*, 372 F.2d 400 (D.C.Cir. 1966); *Pickett v. United Mine Workers of America Health & Retirement Funds*, 467 F.Supp. 2 (E.D.Tenn. 1978); *Ruth v. Lewis*, 166 F.Supp. 346, 349 (D.D.C. 1958).

The traditional practice of restricting the court's consideration to such evidence as was before the trustee at the time of the final decision was premised upon the principle that in reviewing a benefit determination under the "arbitrary and capricious" standard, the court "is not to hold a *de novo* factual hearing on the question of the applicant's eligibility." *Wardle*, supra, 627 F.2d at 824.

Following *Firestone*, however, the question arises as to what evidence can prop-

erly be considered by a court under the *de novo* review standard in situations in which the plan documents fail to vest a sufficient degree of discretion on the part of the plan administrator or fiduciary to warrant a retention of the deferential review standard. In other words, does the application of the *de novo* review standard, when required by *Firestone*, equate with the trial *de novo*, in which the consideration of all competent evidence is deemed appropriate, regardless of whether or not such evidence was actually before the plan administrator or fiduciary? Or, is the court still to limit its consideration to the evidence which was before the decision-maker at the time of the claim determination?

The answer to these questions may lie, in part, in an examination of the nature of *de novo* review, about which significant differences in interpretation can be found among courts which have considered this issue.

Prior to *Firestone* [a reviewing court would] restrict its consideration to such evidence as was actually before the decision-maker, or that which was available, at the time that the claim determination was made. ██████████

DE NOVO REVIEW AFTER FIRESTONE

The term "*de novo* review" is not defined or described in the *Firestone* opinion, and decisions of federal courts in the wake of *Firestone* differ greatly as to its meaning and application on the issue of the proper scope of evidentiary review.

In an ERISA case decided under the *de novo* review standard, the court contrasted that "*de novo* review" with "trial *de novo*," stating that "[d]espite its name, '*de novo*' review does not imply that the judge throws the plan's calculations into the trash and makes its own. The court is still 'reviewing' the plan's decision, which ought to stand unless mistaken." *Ziaee v. Vest*, 916 F.2d 1204, 1208 (7th Cir. 1990).

In stark contrast is a decision from a Virginia federal district court which discusses the differences of opinion among various courts as to what *de novo* review actually encompasses, and which goes on to hold that *de novo* review equates with trial *de novo*. In *Quesinberry v. Individual Banking Group Accident Insurance Plan*, 737 F.Supp. 38, 39 (W.D.Va. 1990), the trial court discussed the varying interpretations which the contesting parties in that case had placed upon the term *de novo* review:

Plaintiff contends that *de novo* review means, in effect a new trial at which he would be permitted to put on evidence, including evidence that was not presented to the plan fiduciary. Defendants, in contrast, argue that *de novo* review simply means that the Court would examine the evidence presented the fiduciary and makes its decision based solely on that evidence, giving no deference to the decision of the fiduciary.

The court resolved the conflict by holding that "the *de novo* standard of review requires that plaintiff be permitted to put on all its admissible evidence, including evidence that was not presented to the plan fiduciary." *Id.*

The court in *Quesinberry* based its reasoning, in part, on the public policy underlying ERISA, which was "enacted to promote the interests of employees and their beneficiaries in employee health benefit plans . . . and to protect contractually defined benefits." *Id.*, quoting from *Firestone v. Bruch*, 489 U.S. at 113.

The court opined that a narrow scope of review would frustrate the objectives of ERISA and might result in less protection being provided to employees and their beneficiaries than that which existed prior to the enactment of the statute. From this reasoning, the court concluded (737 F.Supp. at 39):

. . . it follows that ERISA's objectives will best be furthered by permitting plaintiff to introduce evidence beyond that which was submitted to the fiduciary. Such a standard will best promote the interests of employees and their beneficiaries in employee benefit plans by providing them with as much pro-

tection as they enjoyed before the enactment of ERISA. Such a standard will also ensure that the Court has as full a record as possible before it when it makes its decision.

The court disagreed with the contention that *de novo* review and trial *de novo* are distinct concepts (the former being a non-deferential review of an existing record, and the latter being an entirely new proceeding). It concluded that "the concepts of *de novo* review and trial *de novo* are identical . . . no distinction can be made between the two concepts." *Id.* at 40.

As the following cases illustrate, there is as much conflict among the courts as to the nature of *de novo* review as exists concerning the scope of the evidence to be considered when undertaking such a review.

SCOPE OF EVIDENTIARY REVIEW AFTER FIRESTONE

The majority of post-*Firestone* decisions discussing the proper scope of evidence that a court may consider in reviewing a benefit determination retain the pre-*Firestone* restriction to such evidence as was before the plan administrator or fiduciary at the time of the benefit decision. See, e.g., *Oldenburger v. Central States Southeast & Southwest Areas Teamster Pension Fund*, 934 F.2d 171 (8th Cir. 1991); *Miller v. Metropolitan Life Insurance Co.*, 925 F.2d 979 (6th Cir. 1991); *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480 (9th Cir. 1990). Two cases from the Eleventh Circuit Court of Appeals, however, decided less than three months apart, have reached opposite conclusions about the scope of the evidence to be considered in benefit denial cases, typifying the split of opinion on this issue which exists among, and even within, federal appellate circuits.

Jett v. Blue Cross & Blue Shield of Alabama, Inc., 890 F.2d 1137 (11th Cir. 1989), is a post-*Firestone* case in which the plan language granted the administrator sufficient discretionary authority to justify retention of the arbitrary and capricious review standard. The Eleventh Circuit described the function of a trial court in reviewing a denial of health plan benefits as determining "whether there was a reasonable basis for the decision, based upon the facts as known to the administrator at the time the decision was made." 890 F.2d at 1139 (emphasis added).

The court of appeals in *Jett* reversed the district court because it had considered the testimony of a physician given subsequent to the claim denial. The testimony contained new information which had not been presented to the insurer who had declined the claim. *Id.* The appellate court instructed the trial court that, on remand, it should "limit its review to consideration of the material available to [the insurer] at the time it made its decision." *Id.* at 1140.

Less than three months earlier, two of the three judges who had decided the *Jett* case rendered an opinion in *Moon v. American Home Assurance Co.*, 888 F.2d 86 (11th Cir. 1989), a case decided under the *de novo* review standard. There, the Eleventh Circuit rejected an insurer's contention that a court conducting a *de novo* review must examine only such facts as were available to the plan administrator at the time of the benefit denial, stating that such a limitation upon the reviewing court is "contrary to the concept of a *de novo* review." 888 F.2d at 89.

Borrowing a concept from *Firestone*, the *Moon* court reasoned that ERISA should not be interpreted or applied in such a way as would give employees and their beneficiaries less protection than they had prior to ERISA's enactment. It adopted in part the Supreme Court's rationale for rejecting the wholesale application of deferential review in ERISA cases. Restricting a reviewing court's consideration to the record before the claims administrator, according to the *Moon* decision, would compromise ERISA's protective purposes.

The fact that *Jett v. Blue Cross* was decided under the arbitrary and capricious standard, while *Moon* was decided under the *de novo* review standard, does not fully explain the split in the opinions as to the proper scope of the evidence to be considered by trial courts undertaking benefit reviews. A number of authorities state that the scope of review should not vary depending upon whether an "arbitrary and capricious" or a *de novo* review standard is employed. See, e.g., *Miller v. Metropolitan Life Insurance Co.*, supra; 925 F.2d at 986; *Gramling v. Grit Publishing Co.*, 767 F.Supp. 97, 100 (M.D.Pa. 1991); and *Henderson v. UNUM Life Insurance Co. of America*, 736 F.Supp. 100 (D.S.C. 1989).

In direct contrast to the rationale employed by the court in *Moon v. American Home* to support a wider scope of evidentiary review is *Perry v. Simplicity Engineering*, 900 F.2d 963 (6th Cir. 1990), decided six months later. *Perry* is particularly instructive because it discusses in some detail the concept of *de novo* review, which it contrasts with the notion of a *de novo* hearing. The *Perry* opinion also explains how a review of a benefit decision, in which the trial court limits its consideration to the evidence before the decision-maker, is not only in line with ERISA's protective purposes, but is consistent with the proper role of the federal courts in applying the statute.

As to the nature of *de novo* review, after first noting that the Supreme Court did not discuss the meaning of *de novo* review in its opinion in *Firestone*, Judge Gibbons stated in *Perry* that under the standard announced in *Firestone*, the district court will review an administrator's decision *de novo*, which she inter-

preted as meaning "without deference to the decision or any presumption of correctness, based on the record before the administrator." 900 F.2d at 966. In describing the scope of the review, Judge Gibbons pointed out that *Firestone* "does not require district courts to hear and consider evidence not presented to the plan administrator in connection with a claim," and that the type of *de novo* review which is contemplated by *Firestone* is "a *de novo* review of the record before the administrator or fiduciary." *Id.*

In so deciding, the Sixth Circuit adhered to *Firestone* precedent which limited the evidence considered by the federal court to that which had been presented to the trustee at the time of the final claim decision. This narrow scope of review was said by the court to be consistent with the proper function of the federal courts in reviewing claim determinations made under ERISA-governed plans (*id.*):

In the ERISA context, the role of the reviewing federal court is to determine whether the administrator or fiduciary made a correct decision, applying a *de novo* standard. Nothing in the legislative history suggests that Congress intended that federal district courts would function as substitute plan administrators, a role they would inevitably assume if they received and considered evidence not presented to administrators concerning an employee's entitlement to benefits. Such a procedure would frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme.

At least one federal court has held that the concepts of *de novo* review and *de novo* hearing are synonymous. *Quesinberry*, supra, 737 F.Supp. at 40. Nevertheless, Judge Gibbons, in *Perry*, contrasted *de novo* review with a *de novo* hearing in terms of the scope of evidence which is properly reviewable by the trial court. She then addressed the contention of the Eleventh Circuit in *Moon v. American Home* that a broader scope of review affords employees a greater safeguard and promotes the protective purposes of ERISA. The *Perry* court held that the reasoning applied in *Moon* overlooks the conflict between the promotion of a broader scope of review and the overall ERISA scheme (900 F.2d at 967):

A primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously . . . Permitting or requiring district courts to consider evidence from both parties that was not presented to the plan administrator would seriously impair the achievement of that goal.

The court concluded its opinion by stating that the adverse effect of a wider scope of review upon the efficiency and economy of ERISA's operation would result in employees and their beneficiaries receiving less protection than Congress had intended, a conclu-

sion diametrically opposite of that reached by the Eleventh Circuit in *Moon*.

DEALING WITH CONFLICTING INTERPRETATIONS

Noting the split in authority among, and even within, federal circuits as to the proper evidentiary scope of a district court's *de novo* review of an administrator's benefit decision, some courts have considered a middle ground; their attempts at a resolution of this question have taken various forms.

In *McMahan v. New England Mutual Life Insurance Co.*, 888 F.2d 426 (6th Cir. 1989), the appellate court determined that the record before the district court was not sufficiently developed for it to make a proper review of a benefit denial which had been predicated upon a issue of fact. The Sixth Circuit therefore remanded, directing the district court to supplement the record and then make a *de novo* determination. The enhanced record, however, was to be limited to additional information before the plan administrator which was not part of the district court's record during its initial review. *Id.* at 431.

One court has based its decision on the proper scope of review upon an analysis of the purpose for which the evidence is received. It drew a distinction between evidence used to assist in the interpretation of plan terms, as opposed to additional information which helps to determine a particular factual issue. *Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*, 936 F.2d 98 (2d Cir. 1991). The district court, in reviewing the denial of benefits for treatment of temporomandibular joint dysfunction (TMJ) on the grounds that the condition was "dental" rather than "medical," and thus excluded from coverage under the group health plan in question, admitted into evidence over the insurer's objection the testimony of expert witnesses as to the medical nature of TMJ disorders. Such testimony had not been before the claims administrator at the time of the denial.

The Second Circuit expressly avoided the conflict between the *Moon* and the *Perry* decisions, both of which involved reviews of benefit denials based upon factual determinations. The *Masella* court ruled that even under a narrow scope of review, "evidence regarding the proper interpretation of the terms of the plan, like the expert testimony here, would be treated differently from evidence intended to establish a particular historical fact regarding the claimant,

like the evidence of the date of total disability at issue in *Perry*." 936 F.2d at 104.

The court held that consideration of evidence relative to the interpretation of plan terms, as opposed to the resolution of factual issues, did not pose a threat of transforming the federal trial courts into "substitute plan administrators" as the Sixth Circuit had suggested (*Perry*, 900 F.2d at 966), particularly since *de novo* review under the *Firestone* standard presupposes that the administrator's role does not include discretion to interpret the terms of the plan.

Other courts have resolved the conflict between the circuits as to the proper scope of evidentiary review by permitting, but not requiring, district courts to consider evidence not before the plan administrator, especially in situations where the reviewing court deems the record insufficiently developed to conduct a proper determination. *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991). If, on the

other hand, the record on review is found to be satisfactory, the district court may, in its discretion, merely conduct a *de novo* review of the record of the administrator's decision, making its own independent benefit determination. *Id.*

CONCLUSION

The responses of various courts to the question of what evidence can be properly considered in reviewing a benefit denial vary widely. One court, for instance, has stated that "federal law clearly holds that review is limited to the record before the administrator at the time the benefits were denied . . . [I]t is error to admit new evidence when reviewing an administrator's decision." *Siska v. The Travelers*, 161 Wis.2d 14, 467 N.W.2d 174, 178 (Wis.App. 1991). At the other end of the range of opinions is a holding which concludes that such a limitation in the consideration of evidence "makes little sense." *Luby*, supra, 944 F.2d at 1184.

Still other courts, noting the conflict among the cases, have declined to address the issue, leaving for another day a determination of the proper scope of evidentiary review. *Petrilli v. Drechsel*, 910 F.2d 1441, 1448 (7th Cir. 1990). Perhaps the ultimate resolution of this issue will have to come from the United States Supreme Court itself, whose ruling in *Firestone* requiring a *de novo* review standard in ERISA litigation left this question, and others, as yet unanswered. Δ

[Currently, there is a] split in authority among, and even within, federal circuits as to the proper evidentiary scope of a district court's *de novo* review of an administrator's benefit decision . . .