Consistency Under the Claims Process: ERISA Duty or Regulatory Hobgoblin?

The final claims procedure regulations dramatically change the benefits claims process. (See "Employer Compliance with the New Claims Procedures" by Tara E. Silver-Malyska, Spring 2001.) While attention has tended to focus on the compressed timetables contained in the regulations, the regulations go well beyond shortened time limits. Call it the institutionalization of the claims process. Much more information has to be available to plan participants. This includes such things as medical plan guidelines, protocols, and other treatment guidelines. Much more information also has to be collected by the plan administrator. An easily overlooked provision in the final regulations requires plan administrators to keep careful histories of their claims decisions.

The requirement to keep a claims history was one of the more controversial aspects of the 1998 proposed regulation. Under the original proposal, plans would have been required to disclose whether a particular claims decision was consistent with prior decisions on similar issues. This disclosure obligation would have been limited to cases where the claimant commenced litigation and to claims involving the same plan or insurance contract language.

The final regulation abandoned this disclosure requirement, although an important remnant survived. Instead of requiring disclosure of similar prior cases, the final regulation mandates administrative safeguards to ensure that plan claims are made in accordance with plan documents and, "where appropriate," that the plan provisions "have been applied consistently with respect to similarly situated claimants." (DOL Reg. §2560.503-1(b)(5).) The plan does not have to disclose the history of prior claims to a participant, but the plan should keep a record of prior claims to ensure consistency of treatment.

The new regulation will make claims reviewing a full-time business for most plan administrators. From where we sit, even the best companies fall far short of meeting these new recordkeeping standards. Many outfits keep detailed minutes of their claim reviews and occasionally a plan committee member will ask, "Isn't this the same as the case we dealt with five years ago?," but beyond that, there is

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little in the way of an organized history of past decisions. To the extent the new rule requires plans to keep a searchable database of plan decisions, it will have to be done prospectively; few administrators will have the wherewithal to catalog prior decisions.

The focus in the claims regulation on interpretative consistency raises basic questions. Is there a duty of a plan administrator to be consistent? The claims regulation suggests that consistency might be required in "appropriate" cases. When is consistency "appropriate"? If there is a duty of consistency, does it come from ERISA itself, or is it something that looms from plan provisions? Finally, is there anything that can be done to protect plan administrators from charges of inconsistent treatment of participants?

Consistency of Interpretation

The likely touchstone for the Labor Department's focus on procedural safeguards to ensure consistent plan interpretation is found in the case law which applies the "arbitrary and capricious" test articulated by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Under the typical *Firestone* clause in an ERISA plan, the plan administrator is vested with the discretion to interpret and construe the plan and determine plan eligibility. As described in a recent *Benefits Law Journal* article, there are scores of cases analyzing grants of interpretative power to a plan administrator and whether the grants of authority satisfy the Supreme Court's *Firestone* test. ("Discretion, and Why it Matters," Marilyn M. Cochran, Summer 2000.) The recent *Firestone*-type cases differ on a number of key points, such as whether the administrator's interpretative "discretion" applies to factual determinations and whether a tougher standard of review applies to administrators of self-funded plans. Often overlooked in the analysis of these cases is the fact that the courts have arrived at a fairly uniform test for judging whether a particular decision was "arbitrary." There is a long line of cases adopting variations of a five-part test on the question of "arbitrariness." Based on the Eighth Circuit's articulation of the test in *Buttram v. Central States, S.E. & S.W. Areas Health*, 76 F.3d 896 (8th Cir. 1996), these factors are:

1. whether the interpretation is contrary to the clear language of the plan,
2. whether it might render some plan language meaningless,
3. whether the interpretation is at odds with the procedural requirements of ERISA,

4. whether the interpretation is consistent with the goals of the plan, and
5. whether the plan provision at issue has been applied consistently.

While the consistency of plan interpretation is one of the factors to be examined to determine the correctness of an administrator's decision, there is little law describing the relative importance of the various factors and what inconsistencies are, and are not, fatal to the plan administrator's case. Indeed, in the majority of cases, the courts have noted that they could not assess the consistency test because no evidence had been put forward as to prior plan interpretations. (*Watermann v. Murphy Oil USA*, 1997 U.S. Dist. LEXIS 20568 (E.DL. 1997); *Webb v. Cytec Indus.*, 1999 U.S. Dist. LEXIS 1035 (E.DL. 1999).) There are a couple of reasons why evidence of prior plan interpretations tends not to be introduced. First, it is probably true that few employers have a systematic approach to keeping track of prior plan interpretations. Second, many claims that get to court tend to involve unique questions that may not have surfaced previously. There simply is no track record to review in these cases.

Duty To Treat Consistently

The *Firestone* line of cases deal with consistency of plan interpretation as possible evidence of bad faith by a plan administrator. These cases involve actions for benefits under ERISA Section 502, and do not involve the more fundamental question whether plan administrators have an ERISA duty to be consistent in their treatment of plan participants.

If plan administrators are subject to a duty to be consistent in applying a plan to plan participants, the duty might come from a couple of sources. Clearly, one source might be the plan itself. Many plans include some kind of a "uniformity" or "nondiscrimination" requirement in the provisions detailing the fiduciary duties. An example of this is found in *Frary v. Shorr Paper Products, Inc.* 494 F. Supp. 565 (N.D. Ill. 1980). The issue in *Frary* involved a plan administrator's failure to pay a lump sum to a departing employee where the plan (prior to the appearance of the anti-cutback rule of Code Section 411(d)(6) in the law) gave the employer the discretion to pay a lump sum distribution prior to normal retirement date. The court cited a plan provision requiring that the plan administrators exercise their payout discretion "in accordance with a uniform and

nondiscriminatory policy." On the basis of this plan wording, the court held that the administrator violated Section 404 of ERISA when it denied an early lump sum distribution to a participant even though these distributions had been made in the past. The clear lesson from cases like *Frary* is that plan sponsors should terminate these kinds of "uniformity" clauses from plans if the sponsor wants to retain flexibility under the plan.

The second place that a duty of consistency might be found is in the ERISA Section 404 requirement that a plan be administered solely on behalf of plan participants. The first case to focus on ERISA "equal protection" was *Winpisinger v. Aurora Corp.*, 456 F. Supp. 559 (N.D. Oh. 1978). The case involved an amendment to a pension plan canceling past service credits for one group of plan participants. *Winpisinger* can be read to stand for the proposition that every plan participant must be treated identically and that the ERISA exclusive benefit rule does not allow a plan fiduciary to distinguish between participants for any reason. More recently, the Supreme Court's decision in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), holds that plan fiduciaries have a duty to be impartial to all plan participants. In *Varity*, the Supreme Court noted that "the common law of trusts (made applicable to ERISA §§ 404, 409) recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries." Other recent cases also have found that plan fiduciaries have a duty to be impartial to all plan participants and that the interest of one plan participant cannot be sacrificed to benefit other plan participants. (*Jackson v. Truck Drivers' Union Local 42*, 933 F. Supp. 1124 (D. Mass 1996); *Morse v. Stanley*, 732 F. 2d 1139 (2d Cir. 1984).)

While it is clear that the duty of impartiality found in the common law of trusts has been imported into ERISA, the prevailing view is that the *Winpisinger* holding was too broad. ERISA does not mean that plan fiduciaries must treat participants exactly the same. Rather, participants can be treated differently as long as there is a rational basis for doing so. For the most part, the courts have gotten to this conclusion by applying the same "arbitrary and capricious" standards to fiduciary decision that the *Firestone* case applied to benefit claims decisions, at least where the fiduciary is not in a clear-cut conflict of interest. (*Mahoney v. Board of Trustees*, 973 F.2d 968 (1st Cir. 1992); *Moench v. Robertson*, 62 F.3d 553 (3d Cir. 1995).)

Against this backdrop the requirement in the claims regulation that administrators must have procedural safeguards to ensure consistent interpretation of a plan makes some sense. This information is

needed to prove or disprove an "arbitrary and capricious" benefit denial and it also may be needed to assess whether a fiduciary has violated any ERISA duty of impartiality.

So, plan administrators had better get ready to catalog their own "cumulative bulletins" of claims decisions in order to implement the January 1, 2002 effective date of the claims regulation. Time to hire a new in-house lawyer? Well, perhaps not. The final claims regulation states that the plan consistency procedures must be put in place "where appropriate." Whether consistency is or is not "appropriate" goes back to the question of discretion and how much may be built into an ERISA plan.

Discretionary Plans and Benefits

As we all know the question of discretion is taboo for qualified plans; these plans must meet a requirement of definitiveness and are subject to the "anti-cut back" rule. The same is not the case for ERISA welfare plans and nonqualified ERISA pension plans, however. Based on the seminal decision of *Hamilton v. Air Jamaica, Ltd.*, 945 F.2d 74 (3d Cir. 1991), there is legal support for concluding that ERISA welfare plans and nonqualified pension plans can be drafted to be completely discretionary. The plan in *Air Jamaica* involved severance benefits. The plan explicitly provided that the company could decide on a case-by-case basis who was entitled to severance benefits. The Third Circuit held that the arrangement qualified as an ERISA plan despite its deliberate ad hoc nature. The court held that ERISA does not require an employer to provide any set of benefits, so that it is free to design a plan however it wants. Although ERISA includes certain procedural safeguards to protect benefits, the employees in *Air Jamaica* were on notice that they had no guaranteed benefits.

The *Air Jamaica* case is not some ERISA outlier. Since *Air Jamaica* was decided in 1991, it has been reaffirmed in the Third Circuit, and it has been applied in other circuits as well. (*In Unisys Corp. Retiree Medical Benefits ERISA Litigation,* 18 E.B.C. 1257 (E.D. Pa. 1994); *Ryan by Capria-Ryan v. Federal Express Corp,*, 78 F.3d 123 (3d Cir. 1996); *Bell v. Allstate Ins. Co.* 822 F. Supp. 1222, 1225 (D.S.C. 1992) ("ERISA permits an employer to reserve the right to determine welfare benefit levels on a case-by-case basis, provided the limitation is explicitly stated as part of the plan"); *In Re Frontier Airlines,* 137 B.R. 811 (D. Col 1992) (citing *Air Jamaica* for the proposition that an employer has the right to decrease severance benefits based on language in employee handbook permitting unilateral change in policy).)

Applying the holding of *Air Jamaica*, it appears that every ERISA plan could get around any ERISA duty of consistency by adding a broadly worded discretion clause to the plan. For example, a medical plan might include a list of possible benefits under the plan, but note that the plan administrator has full discretion to pay these benefits or pay nothing at all. Adding such a provisions to a medical plan should not jeopardize the tax treatment of plan benefits. The regulation under Code Section 105 explicitly provides that a medical plan does not have to be enforceable to qualify for tax-free treatment. (Treas. Reg. §1.105-5.) If the plan is not enforceable, however, the plan participants must be on notice that the plan was in effect on the date the employee becomes sick or injured. (Treas. Reg. §1.105-5; *American Family Mut. Ins. Co. v. U.S.*, 815 F. Supp. 1206 (W.D. Wis. 1993).)

We would also note that Congress legislatively reenacted this particular provision of the Section 105 regulations. Some of our readers may recall that old quagmire, Code Section 89, which would have required that welfare-type plans intended to qualify for tax-free treatment must be enforceable and preclude employer discretion under the plans. This requirement was repealed when Section 89 itself was repealed.

Conclusion

There is one statutory duty of consistency in the administration of our ERISA welfare benefit plan. But case law has tended to find that the ERISA plan administrator has a fiduciary duty to interpret some plan provisions consistently among different plan participants. By imposing recordkeeping requirements for the documentation of such consistency, Labor Department regulations too would seem to imply the existence of a duty that Congress itself did not see fit to enact. But we have also seen that, under the *Air Jamaica* line of cases, permitted plan provisions include a broad grant of discretionary authority to provide benefits on a case-by-case basis. The administrator who consistently interprets a plan provision that expressly states that benefits under the plan are totally discretionary, will properly provide benefits on a basis that is—discretionary. The emerging ERISA duty of consistent plan interpretation and administration may in the end be no more than an issue of estute plan drafting.

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