ERIC BUCHANAN & ASSOCIATES
DISABILITY INSURANCE ATTORNEYS

ERISA & DISABILITY BENEFITS NEWSLETTER

VOLUME 14, ISSUE 4, MAY 2022

ABOUT OUR FIRM

The Disability Insurance Team at Eric Buchanan & Associates helps individuals nationwide who have been denied disability insurance benefits and employee benefits. Our insurance and employee benefits team helps people apply for, or fight denials of, disability insurance benefits, life insurance, health insurance, and similar insurance benefits.

For more information, visit our website at buchanandisability.com.

Contact our intake team at intaketeam@buchanandisability.com.

Hudson T. Ellis, Eric L. Buchanan, R. Chandler Wilson, Noah A. Breazeale, Audrey C. Dolmovich, & Kaci Garrabrant

SPECIAL RULES ON WHAT EVIDENCE THE ERISA RECORD SHOULD CONTAIN IN THE SIXTH CIRCUIT - BY AUDREY C. DOLMOVICH

I. INTRODUCTION

In a previous article, I generally discussed what an ERISA record is and what it includes.[1] This article will focus more on the particular rules created by the Sixth Circuit as to what the ERISA record should contain.

An ERISA benefits claim is unlike most other cases. ERISA claimants do not have a right to a jury trial, they get limited damages, and often, the standard of review is a deferential standard of review in favor of the ERISA decision-maker.

Another big difference between ERISA cases and most other cases is that the collection of documents the judge will review is limited. The general rule is that the ERISA record[2] closes when the ERISA decision-maker issues its final decision and the courts can only consider what was in the record at that time. The problem is that neither the ERISA statute nor the regulations limit the court's review to just a record, much less define what would be in such a record.[3] Thus, the courts set out the rules on what belongs in the ERISA record.

That said, the Court of Appeals for the Sixth Circuit, like many circuits, has not fully explained what goes into the record. The lack of specificity by the courts is especially problematic when the insurance company is the one compiling the ERISA record and essentially choosing what the ERISA record contains. Should the ERISA record have the insurance company's internal notes about the claim? Its emails about the claim? Its messages about the claim?

Because there are no rules from the Court of Appeals, what goes in and stays out will remain contested.

II. THE SIXTH CIRCUIT HAS NOT CLARIFIED WHAT AN ERISA RECORD SHOULD CONTAIN.

A. In the Sixth Circuit, the ERISA record is the same whether the standard of review is arbitrary and capricious or *de novo*.

The Court of Appeals for the Sixth Circuit has established that in ERISA benefits cases, district courts can only consider evidence from "the record before the administrator" under either a *de novo* or arbitrary and capricious standard of review. *Perry v. Simplicity Engi-*

neering, 900 F.2d 963, 966-67 (6th Cir. 1990). In *Perry*, the court recognized there could be two options for *de novo* review: One based only on the record below and one based on the record below plus any additional evidence received by the court. 900 F.2d 963, 966-67 (6th Cir. 1990). The court decided to limit its review to exclude new evidence because "[i]f district courts heard evidence not presented to plan administrators, employees and their beneficiaries would receive less protection than Congress intended" when they enacted ERISA. *Id*. at *967.

Subsequently, in *Wilkins v. Baptist Healthcare Sys., Inc.*, the court reaffirmed that a court's review is limited to the record no matter the standard of review, with limited exceptions for due process or bias concerns. 150 F.3d 609, *615-616 (6th Cir. 1998). Sixth Circuit case law continues to rely on these cases.

B. While the Sixth Circuit Court of Appeals limited its review to a "record," the Court has not provided specific guidance as to what goes into the record other than differing general descriptions.

The Sixth Circuit has not been clear in its opinions as to what the ERISA record should contain. The Sixth Circuit has variously described the ERISA record as information "presented to the administrator," "available to the administrator," or "before the administrator." The Sixth Circuit has never explained whether it intended any difference in these terms. Do those different terms provide any guidance? Should they be interpreted differently?

For example, in *Wilkins v. Baptist Healthcare Sys., Inc*., the Sixth Circuit Court of Appeals found that the district court's review was "confined to the record that was *before the Plan Administrator*" and "the district court must take a 'fresh look' at the administrative record but may not consider new evidence or look beyond the record that was *before the plan administrator*." 150 F.3d 609, *615-616 (6th Cir. 1998)(emphasis added). Wilkins sought to have an affidavit considered by the court, and the court rejected this request because it was not "included in the record upon which LINA based its decision." *Id.* at 614–15.

In *Perry*, the Sixth Circuit again explained that the ERISA record is "based on the record *before the administrator*." 900 F.2d 963, 966-67 (6th Cir. 1990) (emphasis added). However, the *Perry* court later limited the record to exclude "evidence *not presented to the plan administrator in connection with a claim*." *Perry,* 900 F.2d at 966 (emphasis added). The court did not explain any further differences between the two phrases.

Another example is, *Miller v. Metropolitan Life Ins. Co.,* in which the Court of Appeals described the ERISA record as "only the evidence *available to the administrator* at the time the final decision was made." 925 F.2d at 986 (emphasis added). Again, the court did not expand on what "available to the administrator" includes.

It is unknown whether the Sixth Circuit meant to assign any meaning to those different terms leaving the question of whether they intended for there to be any guidance about what goes into the record.

The Sixth Circuit's three different ways to describe the ERISA record could be interpreted differently. For example, "presented to" could only mean anything that was given to the administrator. This would include anything that the claimant sent to the administrator, such as medical records, opinions from treating providers, or any other information the claimant sent to the administrator to consider during its review. It could also include anything that any other person presented to the administrator during their review. This could consist of medical reviews, vocational reviews, or documents from the claimant's employer. This description of the ERISA record is problematic in that it does not include important documents such as the policy, the administrator's internal notes, recordings of phone calls where the claim was discussed, or any other document or recording that might be important to the claim but was not presented to the administrator.

"Before the administrator" could have a broader interpretation to include anything in the administrator's computer system, anything in the administrator's building, the administrator's emails and phone call recordings, and anything else that the administrator maintains. This can be problematic because it is so broad that it could include the insurance company's entire records not related to the case (i.e. lunch schedule, Christmas party invite, etc.), and it doesn't have specific guidance on what is relevant to the claim.

"Available to" sounds broader than "before" and "presented to." "Available to" could be interpreted to include anything the administrator would have had available to it while deciding the claim. This would include all of the items listed above and anything that the administrator was not presented or had before it, but had access to. Suppose the claimant did not present a social security file to the administrator but the administrator had an authorization or access to the social security file, and knew that the claimant won his social security case. In that case, it is reasonable that information falls into the category of being "available to" the administrator.[4]

The Sixth Circuit has not used the same terminology in its opinions, nor has the court been presented with a case where it has analyzed the terminology. Therefore, it is not clear that the court meant those terms to have different meanings. Without some clarification from the Sixth Circuit, it is difficult to determine what goes in and what stays out of the record.

C. The ERISA record should include the information listed as relevant in the ERISA regulations.

Neither the ERISA statute nor the regulations define what should be in the ERISA record because nothing in either the statute or regulations limits ERISA cases to a closed record in the first place. As explained above, the courts have created rules limiting ERISA cases to a review of a closed record. *See e.g., Perry* and *Wilkins*, *supra*. The closest that the ERISA regulations get to describing the ERISA record is by defining "relevant" information that the administrator is required to turn over to the claimant when asked. Since the ERISA regulations define what is "relevant" information, that should be the minimum information that the ERISA record contains.

ERISA subsection 29 C.F.R. § 2560.503-1(m)(8) states that information is "relevant" if it:

> (i) Was relied upon in making the benefit determination;
> (ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
> (iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or
> (iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

29 C.F.R. § 2560.503-1(m)(8). Since ERISA states that this information is relevant, it should be at least the baseline of what is included in the ERISA record. This information includes internal and external claim emails, internal messaging, meeting notes, documents, recordings, requests to third party vendors for reviews, draft reports of those reviews, the plan documents, claim notes, call logs, letters to and from the claimant, medical reviews, vocational reviews, medical records, opinion letters and forms from treating providers, claims manuals or other internal guidance, vocational reports and opinions, claim meeting notes, independent medical reviews, anything submitted by the claimant in support of his/her claim, and any other information that was generated or considered during the claim.

III. THE SIXTH CIRCUIT HAS CREATED RULES TO CONSIDER EVIDENCE THAT MIGHT BE OR SHOULD HAVE BEEN ADDED TO THE ERISA RECORD.

A. There are exceptions that allow courts in the Sixth Circuit to consider evidence not already in the ERISA record when the administrator's decision-making conduct contributes to an incomplete record.

In *VanderKlok v. Provident Life & Accident Ins. Co.*, the court found that the district court could consider the evidence not in front of the administrator at the time of its decision because the administrator failed to follow the statutory notice requirement. 956 F.2d 610, 616 (6th Cir. 1992). The court found that the defendant violated the provisions of ERISA § 1133 by denying the claim without giving proper timely notice, not setting forth the specific reasons for denial in the notice, and not giving "explicit information as to the steps to be taken if the employee wishes to submit his claim for review." *Id.* VanderKlok requested that the case be remanded to the district court for review based on the entire record—including the evidence in front of Provident at the time of its decision and any other evidence VanderKlok wished to submit. *Id.* at 617. The court held that the district court, upon remand, consider the entire record rather than solely the record that Provident considered in coming to its determination. *Id.* In explaining this distinction from the facts in *Perry*, the court noted:

> [P]laintiff was not given the opportunity to present additional evidence to defendant Provident in an administrative appeal because Provident failed to follow the statutory

> notice requirement. The failure to follow administrative review procedures was Provident's, not plaintiff's. Therefore, we do not believe it is necessary to require that plaintiff first submit additional evidence to Provident before bringing an appeal before the district court.

Id.

Likewise, in *Killian v. Healthsource Provident Administrators, Inc.*, the Sixth Circuit remanded the case because Healthsource improperly did not consider evidence submitted by the claimant while still considering evidence that it was generating. 152 F.3d 514 (6th Cir. 1998). Killian appealed Healthsource's denial, and he submitted approximately 50 affidavits from oncologists supporting his appeal. *Id*. at *517. Healthsource said they would not consider the new evidence as the deadline to submit evidence had already passed. However, after Killian submitted this evidence, Healthsource received a report from a file reviewing physician it hired, and Healthsource had Killian attend an appointment to get a second opinion on her condition. The court explained, "though Healthsource was telling Matkin that the record was closed, it was still gathering information about her condition." *Id*. at *519. The court reasoned, "it is not open to a plan administrator to curtail consideration of the information propounded by the plan beneficiary, while continuing to accumulate information that bolsters a denial decision already made." *Id*. at *521. Since Healthsource did not review the information submitted by Killian, the court remanded the case for Healthsource to review and consider the evidence submitted by Killian.

Since *Vanderklok* and *Killian*, the Sixth Circuit has affirmed that a procedural challenge is necessary to add documents to the ERISA record. For example, in *Buchanan v. Aetna Life Ins. Co.*, the plaintiff wanted to supplement the ERISA record with an MRI film and report and argued in support of his supplementation that "the record is flawed and not developed properly" since Aetna would not accept the MRI film and report. 2006 WL 1208069, *308 (6th Cir. 2006). The court explained that the MRI film and report are not a part of the ERISA record since he did not raise a procedural challenge to Aetna's decision. *Id*.

In *Storms v. Aetna Life Ins. Co.*, the Sixth Circuit once again reaffirmed that a court "may only consider evidence outside of the administrative record when considering claims of lack of due process of bias." 2005 WL 2175997, *759 (6th Cir. 2005). The plaintiff sought to include social security documents in the ERISA record. *Id.* at *759. The court denied the request to have the social security documents included in the ERISA record since it did not fall under the procedural challenge and bias exception. *Id.*

District courts in the Sixth Circuit have also explained that the court may consider evidence outside of the ERISA record. In *Walsh v. Metropolitan Life Ins. Co.*, the Middle District of Tennessee concluded that *Wilkins* suggests that lack of due process or bias "are circumstances under which a district court should examine new evidence and resolve ERISA disputes without remand to the plan administrator." 2009 WL 603003, *9 (M.D. Tenn. March 9, 2009). In *Walsh* the plaintiff alleged three procedural errors: "(1) Metlife instructed Plaintiff that an appeal of his benefits termination was to be filed within 60 days, rather than 180, as ERISA requires; (2) Metlife failed to notify Plaintiff of the reasons his benefits were terminated; and (3) Metlife failed to notify Plaintiff of the materials that would be necessary to perfect his claim." *Id*. at *4. Metlife argued that the doctrine of substantial compliance applies and its "procedural requirements must be excused if, upon review of all communications between a claimant and the fiduciary, it is clear that the purposes of §1133 were satisfied." *Id*. at *5. Metlife further argued that the purposes of §1133 were met since Plaintiff appealed within the 60 day deadline and "MetLife would have considered any materials submitted by Plaintiff within the 180-day period." *Id*. The court found that "MetLife's substantial compliance argument is without merit" because "the purpose of ERISA §503 is to insure that the ERISA claimant is notified to the specific reasons for termination of benefits and provide an opportunity for a full and fair review." *Id*. at *6.

The court in *Walsh* explained that the proper remedy is to remand the case to the plan administrator and that the "Plaintiff must therefore be afforded a new opportunity to appeal MetLife's termination of Plaintiff's LTD benefits." *Id.* at *7-8. The court looked to *Vanderklok* when deciding whether the remand should be to the district court or the plan administrator and noted that *Vanderklok* "lists no particular set of facts as supporting the decision to remand to the district court rather than the plan administrator." *Id.* The court then looked to *Perry* and *Wilkins* and noted that the Sixth Circuit has conflicting opinions on whether the case should be remanded to the district court or the administrator. *Id*. The court reasoned that "'lack of due process' would seem to refer to some procedural error apart from the underlying violation of § 1133 – something on par with bias, which would suggest to a district court that the ERISA claimant might not receive impar-

tial adjudication of his claim on remand to the administrator." *Id*. at *9. The court determined that the "district courts clearly must intervene where remand would not protect the procedural rights of the claimant." *Id*. at *10. The court adopted the rule that "a district court should review new evidence and determine an ERISA plaintiff's claim only where a plan administrator has violated § 1133 and shown itself incapable of protecting the plaintiff's procedural rights." *Id*. The court explained that in this case "the Court cannot say that Plaintiff would be unlikely to receive due process upon remand to the plan administrator", thus the court remanded the case to the plan administrator. *Id*.

Without a specific procedural violation, the Sixth Circuit does not allow new evidence into the record. An allegation of bias is generally not enough, either. Although the Sixth Circuit has reaffirmed that new evidence may be allowed in the ERISA record when a procedural violation has been made, it is unclear whether the appropriate remedy is a remand to the insurance company or the district court. As we saw above in *Vanderklok* and *Killian*, the Sixth Circuit remanded the case to the district court in one case and the insurance company in another.

B. Plan documents will be considered part of the ERISA record even if it is not included in the ERISA record.

In *Campbell v. Hartford Life & Accident Insurance Company*, the Sixth Circuit found that the district court improperly applied a *de novo* standard of review by finding that the ERISA record did not include the certificate containing discretionary language. 2022 WL 620151 (6th Cir. 2022). The district court "applied *de novo* review, reasoning that it could not treat the certificate as part of the plan because Hartford failed to make the amendment part of the administrative record." *Id*. at *3. The Sixth Circuit reversed, stating the "'rule preventing a reviewing court from considering evidence outside of the administrative record does not preclude consideration of the plan documents.'" *Id*., quoting *Brooking v. Hartford Life & Acc. Ins. Co.*, 167 F.Appx'x 544, 547 n.4 (6th Cir. 2006). The Sixth Circuit explained that "the certificate is incorporated into the policy (and therefore the plan) through a separate amendment to the policy" and "thus gives Hartford discretionary authority, so arbitrary-and-capricious review applies when reviewing Hartford's decision . . ." *Id*. at *3. The Sixth Circuit also explained that the certificate contained substantive terms of the plan, so the plaintiff cannot argue that she meets the terms of the plan and is entitled to benefits and "on the other hand, claim that the certificate is not a plan document for purposes of obtaining a favorable standard of review." *Id*. at *4. The Sixth Circuit further relied on the "time-honored rule that a district court must enforce a benefit plan's unambiguous plain language." *Id*.

The Sixth Circuit has held that if a certificate of coverage is incorporated into the policy, it is part of the plan documents and will be considered a part of the ERISA record even if it was not included in the record by the administrator. Thus, another exception to the closed record rule is that rule "does not preclude consideration of the plan documents." *Id*. at *3.

C. In the Sixth Circuit, courts can also consider additional evidence beyond the record that is offered in support of a procedural challenge to the administrator's decision, such as an alleged bias on its part.

In *Wilkins*, the majority explained, "[t]he only exception to the above principle of not receiving new evidence at the district court level arises when consideration of that evidence is necessary to resolve an ERISA claimant's procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part." *Id.* at *618. Thus, the Sixth Circuit allows the court to consider evidence to support a procedural challenge such as a plan administrator's bias.

If a claimant alleges bias on behalf of the administrator, the court may allow discovery into how the bias or conflict affected the decision. However, if such discovery is permitted, it does not go into the ERISA record, rather, the judge considers the evidence when determining how much deference to give to the administrator's decision. *See*, *generally Metlife v. Glenn*, 554 U.S. 105 (2008).

When and what discovery is permitted and whether such discovery is always allowed is the subject of a future article.

IV. CONCLUSION

The Sixth Circuit decided that under both the *de novo* and the arbitrary and capricious standards of review, the court is limited to considering the record before the administrator. However, the Sixth Circuit has not specifically addressed the scope of the record. The court has allowed several exceptions, such as always including plan documents or allowing documents to be considered when the administrator made a procedural error that resulted in documents unfairly not being considered.

End Notes:

[1]*What Should be Included in the ERISA Record?*, EBA Newsletter Article, April 2020. https://www.buchanandisability.com/helpful-resourcesandarticles/attorney-newsletters/what-should-be-included-in-the-erisa-record/

[2]Courts borrowed concepts from administrative law and historically referred to this limited collection of documents as an "administrative record," while the modern trend is to call it an "ERISA administrative record," or simply, an "ERISA record."

[3]As will be discussed below, the ERISA regulations do, however, provide guidance on what documents are "relevant" to a claim and must be provided to a claimant during the claims process. See, 29 CFR § 2560.503-1(m)(8). Arguably, these should provide guidance on a minimum of what documents should be in the record.

[4]See, *Melech v. Life Ins. Co. of North America*, 739 F.3d 663 (11th Cir. 2014) ("Because LINA's disclosure authorization form allows it to obtain information directly from the SSA, and because LINA's policies allow it to deduct "assumed" SSDI if a claimant does not cooperate with LINA's requests for information, any documentation LINA needs regarding its claimants' SSDI applicants is available upon request. Yet, once LINA decided at first blush that Melech had not provided enough medical evidence to support her claim, it treated the SSA process and the evidence generated by it as irrelevant and unavailable. This treatment is internally inconsistent with LINA's mode of evaluating claims.").

Eric Buchanan & Associates, PLLC is a boutique plaintiffs' firm located in Chattanooga, Tennessee. We help individuals nationwide obtain disability insurance benefits and other ERISA employee welfare benefits (such as life, health or disability benefits offered through work). Attorneys are our number one source of cases. If you have a client who could use our help, we would appreciate your referral.

Eric Buchanan & Associates, PLLC
414 McCallie Avenue • Chattanooga, Tennessee 37402
PO Box 11208 • Chattanooga, Tennessee 37401
telephone (423) 634-2506 • fax (423) 634-2505 • toll free (877) 634-2506
intaketeam@buchanandisability.com • buchanandisability.com