ERISA Litigation Tactics and Best Practices: 
*The Strategy of Litigating the ERISA Claim*

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I. Introduction

The regulations governing employee benefits are changing and benefits litigation is on the rise. Ever resourceful, the ERISA claimants bar continues to develop new tactics and employ old strategies designed to maximize recoveries in litigation. Plan sponsors, administrators, and fiduciaries continue to confront challenges to discretionary review clauses, the aggressive use of discovery, and efforts to increase recoveries against plan assets. This article examines some of the recurring issues our clients commonly confront in employee welfare benefits litigation, and offers practical tips to assist our clients meet these growing challenges.

II. Contours of “the Plan” Post-Amara

In the wake of Cigna Corp. v. Amara, 131 S. Ct. 1866 (2011), the ERISA claimants bar continues to mount opposition to the delegation of discretionary authority in an effort to defeat deferential review of administrative decision-making. Amara concerned an employer’s conversion of its traditional pension plan into a cash balance plan. 131 S.Ct. at 1870. The district court found the employer’s initial descriptions of its post-conversion plan had been significantly incomplete and misleading, and therefore ordered the plan reformed to give the employees their pre-conversion plan benefits augmented by post-conversion plan benefits. Id. at 1875. The Second Circuit affirmed this equitable remedy. Amara v. CIGNA Corp., 348 Fed. Appx. 627 (2d Cir.2009).

The U.S. Supreme Court vacated the district court’s remedy after concluding that reformation amounted to an unauthorized alteration of the plan’s governing documents. 131 S.Ct. at 1876–77. The Court held that although ERISA §502(a)(1)(B) allows a civil action to be brought by a plan beneficiary “to recover benefits due to him under the terms of his plan,” the civil enforcement provision only allows enforcement of existing plan terms, not modification of them. Id. In defending the district court’s reformation, the Solicitor General had argued that the court was simply enforcing the plan’s terms as provided in the summary plan description (SPD), urging that “the terms of the summaries [were] terms of the plan.” Id. at 1877. Rejecting this thesis, the Supreme Court held that “the summary documents, important as they are, provide communication with beneficiaries about the plan, but their statements do not themselves constitute the terms of the plan.” Id. at 1878. This, in turn, has led to a rise in the incidence of litigation challenging the enforcement of discretionary review provisions in plan summaries.

For the most part, courts have been reluctant to completely disregard discretion-granting clauses in plan summaries post-Amara. The federal circuits generally agree that in assessing the grant of discretion, district courts may look to the SPD to determine the appropriate standard of review as long as the summary does not conflict with the master plan document, such as when the SPD is the only formal plan document describing the benefits afforded to employees. E.g., Foster v. Sedgwick Claims Management Services, Inc., 842 F. 3d 721, 731 (D.C. Cir. 2016) (“Although the Summary is not itself legally binding . . ., it provides important information for beneficiaries about the plan.”); Board of Trustees v. Moore, 800 F. 3d 214 (6th Cir. 2015) (summary plan description was the governing plan document for ERISA health benefit plan, and its terms were enforceable since it was the only plan document that explained participant rights to health benefits); Board of Trustees of Nat. Elevator Industry Health Benefit Plan v. Montanile, 593 Fed. Appx. 903 (11th Cir. 2014) (terms of SPD are enforceable where foundational plan document refers to separate SPD in which benefit rights and obligations are described), rev’d on other grounds, 136 S. Ct. 651 (2016); Tetreault v. Reliance Standard Life Ins. Co., 769 F. 3d 49 (1st Cir. 2014) (“Amara poses no automatic bar to a written instrument’s express incorporation of
terms contained in the [SPD].”); Eugene S. v. Horizon Blue Cross Blue Shield of New Jersey, 663 F. 3d 1124, 1131 (10th Cir. 2011) (“We interpret Amara as presenting either of two fairly simple propositions, given the factual context of that case: (1) the terms of the SPD are not enforceable when they conflict with governing plan documents, or (2) the SPD cannot create terms that are not also authorized by, or reflected in, governing plan documents. We need not determine which is the case here, though, because the SPD does not conflict with the Plan or present terms unsupported by the Plan; rather it is the Plan.”).

The Ninth Circuit chooses to follow a different path. Adhering to Amara’s view that the summary is “extraneous” to the plan, the court has refused to enforce “discretion-granting” language in the SPD when the master plan document is silent as to administrative discretion. Prichard v. Metropolitan Life Ins. Co., 783 F. 3d 1166, 1171 (9th Cir. 2015) (because the insurance certificate distributed to participants contained no discretion-granting terms, the court refused to integrate the SPD’s grant of discretion as an additional plan term); Oldoerp v. Wells Fargo & Co. Long Term Disability Plan, 500 Fed. Appx. 575 (9th Cir. 2012) (court isolated SPD from remainder of group policy and certificate of insurance to find that discretionary review clause did not constitute part of the plan); but see, Masuda-Cleveland v. Life Ins. Co. of North Am., 2017 WL 427497 (D. Hawai’i Jan. 31, 2017) (where SPD and the Plan are the “same document,” and the SPD provides for discretionary review, discretion is afforded).

The defense practitioner must watch for efforts to marginalize discretionary review clauses found in summary plan descriptions. If the SPD is a separate document, look to see if the master plan document incorporates its terms. If the only governing plan document is the group policy, consider an affidavit of the plan sponsor to establish the policy is the plan, at least for purposes of the insured benefit in question. Courts are accustomed to reviewing benefit decisions in the context of group insurance. When you encounter Amara-based arguments to divorce the SPD section from the remainder of an integrated group policy, remind the court that ignoring one part of the written whole – that which recognizes administrative discretion – is analogous to the reformatory measure that Amara found offended the statute.

III. ERISA and Voluntary Benefit Plans

Another frequently litigated battle is whether ERISA attaches to insurance coverage purchased voluntarily by employees through their employers, very often to supplement basic employer-provided benefits. Because ERISA preempts extra-contractual claims and can reduce litigation costs, the benefit of having ERISA supply the governing law is apparent. The ERISA inquiry is fact-intensive, but with a well-developed record the defense practitioner may find the courts amenable to its application to optional benefit arrangements.

A. Congressional Goal of Uniform Regulation

Congress enacted ERISA to “promote the interests of employees” and provide federal standards for establishing and maintaining employee benefit plans. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113, 109 S.Ct. 948 (1989); Williams v. Wright, 927 F. 2d 1540, 1543 (11th Cir. 1991). It found that employee benefit plans “affect[] the stability of employment and the successful development of industrial relations . . . [and are] an important factor in commerce because of the interstate character of their activities.” 29 U.S.C. §1001(a). ERISA represents a “careful balancing” between ensuring fair and prompt enforcement of rights under a plan and encouraging the creation of such plans. Foster v. Sedgwick Claims Management Services, Inc., 842 F. 3d 721, 725 (D.C. Cir. 2016) (quoting Conkright v. Frommert, 559 U.S. 506, 517, 130 S.Ct. 1640 (2010)).

The statute defines an “employee welfare benefit plan” as “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by
both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability ….” 29 U.S.C. §1002(1). In the leading case of Donovan v. Dillingham, 688 F. 2d 1367, 1371 (11th Cir. 1982) (en banc), the Eleventh Circuit identified five elements that must be shown for an employee benefit plan to exist. A plan qualifies as an employee benefit plan if there is: (1) a plan or program (2) established or maintained (3) by an employer or employer organization (4) for the purpose of providing enumerated benefits (5) to participants or their beneficiaries through the purchase of insurance or otherwise. “[I]f from the surrounding circumstances a reasonable person could ascertain the intended benefits, a class of beneficiaries, the source of financing, and the procedures for receiving benefits, an ERISA plan is established.” Donovan, 688 F. 2d at 1373.

B. The Safe Harbor Plan Exemption

In cases where the coverage in part of a voluntary benefit program, claimants typically lean on the safe harbor regulations promulgated by the Department of Labor to remove themselves from ERISA’s reach. 29 C.F.R. §2510.3-1(j) states that an “employee welfare benefit plan” shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which:

1. Is There Indicia of Employer Endorsement?

When the facts indicate that the claimant pays his or her own premium for the optional coverage, commonly through payroll deduction, it is important to develop a record that establishes employer involvement in facilitating the acquisition, or demonstrates an ongoing administrative scheme with respect to the program. See Anderson v. Unum Provident Corp., 369 F. 3d 1257, 1263 (11th Cir. 2004) (“[The Court] determine[s] whether the plan is part of an employment relationship by looking at the degree of participation by the employer in the establishment or maintenance of the plan.”); Okun v. Montefiore Medical Center, 793 F. 3d 277, 280 (2d Cir. 2015) (employer’s longstanding severance policy constituted an ERISA plan because it “represents a multi-decade commitment to provide severance benefits to a broad class of employees under a wide variety of circumstances and requires an individualized review whenever certain covered employees are terminated.”) (citing Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 12, 107 S. Ct. 2211 (1987)).

In determining employer involvement, some courts have found persuasive evidence that the employer solicited bids from multiple insurers, selected the insurer who enrolled employees, negotiated key coverage terms, or decided which employees were eligible to participate. Butero v. Royal Maccabees Life Ins.
Co., 174 F. 3d 1207, 1210-11 (11th Cir. 1999) (an ERISA plan was found when the employer relied on the insurance agent’s recommendation of insurer, selected terms of coverage, represented to employees that insurance coverage was available, collected premiums through payroll deductions, and remitted payment to the insurer); Anderson, 369 F. 3d at 1259-60 (ERISA plan was found when the employer contracted with the insurer to provide disability insurance, published a “Benefits Portfolio” that included optional disability coverage for employees, determined eligibility criteria, answered employees’ coverage questions, and provided a summary plan description that invoked ERISA); Wilson v. Greater Georgia Life Ins. Co., 2015 WL 11549074 (N.D. Ga. May 21, 2015) (voluntary coverage falls within ERISA plan where applicants were required to apply through employer, and employer selected one of the coverage terms). The Fifth Circuit, by contrast, has looked to whether insurance is made available to all or most of the employees rather than to only a limited class. Martin v. Trend Personal Services, 656 Fed. Appx. 34, 38 (5th Cir. 2016) (employer’s purchase of six life insurance policies for a “small number of key employees” did not demonstrate intent to establish or maintain an ERISA benefits plan).

2. Is Supplemental Coverage Linked to Employer-Provided Coverage?

Several courts look to whether the supplemental or optional coverage is tied to a group insurance program funded by the employer. Courts are often reluctant to “unbundle” optional coverage from the employer-funded benefits program, especially where eligibility for the voluntary optional coverage is rooted in participation in the employer-funded program. E.g., Menkes v. Prudential Ins. Co. of America, 762 F. 3d 285, 292 (3rd Cir. 2014) (treating employer-provided basic coverage and employee-paid supplemental coverage as two parts of a broader whole in keeping with the goal of uniform regulation and consistent administration); Gross v. Sun Life Assur. Co. of Canada, 734 F. 3d 1, 8 (1st Cir. 2013) (“we see no justification for isolating the long-term disability policy from [the employer’s] insurance package for purposes of our ERISA inquiry.”); Glass v. United of Omaha Life Ins. Co., 33 F.3d 1341, 1345 (11th Cir. 1994) (supplemental life insurance policy provided at discount rates to participants of group plan was “part and parcel of the whole group insurance plan and thus ERISA governs it.”); Gaylor v. John Hancock Mut. Life Ins. Co., 112 F.3d 460, 463 (10th Cir.1997) (rejecting attempt to sever optional disability coverage from the greater benefits package received through employment); Peterson v. Am. Life & Health Ins. Co., 48 F.3d 404, 407 (9th Cir.1995) (concluding that individual policy “was just one component of [the] employee benefit program and ... the program, taken as a whole, constitutes an ERISA plan”); see also, Shipley v. Provident Life & Accident Ins. Co., 352 F.Supp.2d 1213, 1216 (S.D.Ala.2004) (enrollment in employer-paid long-term disability plan allowed enrollment in supplemental disability policy at a discount; employer’s contribution to long-term plan was therefore a contribution to supplemental plan).

3. What Is the Nature of “Contributions” for Safe Harbor Purposes?

There continues to be disagreement among the federal courts as to what constitutes a financial “contribution” for safe harbor purposes. While employer-paid coverage generally does not enjoy safe harbor protection, controversy remains over whether indirect subsidies, such as increased levels of insurance or reduced insurance premiums, constitute employer contributions under the first criterion of the safe harbor regulation. Some courts agree a discounted premium offered on account of the employment relationship is a “constructive contribution” that fails the “no contributions” requirement. E.g., House v. American United Life Ins. Co., 499 F.3d 443, 449 (5th Cir. 2007) (“while the partners paid their own premiums for the optional disability coverage, they benefited from the unitary rate structure the firm was able to negotiate by bargaining for disability coverage as a package for all classes [and they] therefore effectively received a premium discount or constructive contribution from the firm.”); D’Ella v. Unum Life Ins. Co. of America, 2016 WL 4366979, at *3 n. 36 (E.D. Pa. Aug. 15, 2016) (“the Court finds it persuasive that an employee’s receipt of a group discount by virtue of participation in a group plan established by the employer constitutes a ‘contribution’ for purposes of the Safe Harbor Regulation.”)
Other recent cases, by contrast, have refused to recognize a discounted premium as constituting a contribution. E.g., Gooden v. Unum Life Ins. Co. of America, 181 F. Supp. 3d 465, 471-72 (E.D. Tenn. 2016) (“a non-negotiated group discount that applies only because premiums are paid through payroll deduction is not a ‘contribution’ under the first criterion of the safe harbor.”); Rosen v. Provident Life & Accident Ins. Co., 2015 WL 260839, at *12 (N.D. Ala. Jan. 21, 2015) (discount based on payroll deduction would not remove policy from safe harbor; holding otherwise would be contrary to text of regulation and would swallow the third and fourth safe-harbor requirements); Turner v. Liberty Nat. Life Ins. Co., 2012 WL 711357, at *4 (E.D. Tenn. Mar. 5, 2012) (clear meaning of first criterion is “an actual contribution in the form of a partial (or full) payment of premiums,” not merely allowing employees to pay premiums through payroll deduction with pre-tax dollars).

Given the tendency among some courts to give employers more leeway when it comes to allowable degrees of involvement in so-called “payroll deduction” plans, the practitioner should try to develop a record to show the employer abandoned its neutrality with respect to the insurance program to the point of “endorsement.” Subpoenas to employers requesting production of employee handbooks, cafeteria and flexible plan “wrap” documents, personnel files, employment agreements, severance agreements, and benefit election forms can be fruitful sources of material to suggest endorsement. The deposition of the employer should be considered in the appropriate case. The broker’s sales file may contain historical information such as insurance proposals, written offers, and correspondence long-discarded and forgotten by the employer. In addition to group risk files maintained by your clients, these can be potential sources of valuable information to help build the endorsement case.

IV. Conflict Discovery

Discovery designed to explore the influence of the structural conflict of interest continues to vex. In Metropolitan Life Insurance Company v. Glenn, 554 U.S. 105, 128 S. Ct. 2343 (2008), the Supreme Court recognized that plan insurers vested with broad discretion to decide benefit claims operate under an inherent financial conflict in exercising the dual functions of claims adjudicator and benefits payer. The Court ruled that this conflict is one factor courts may consider in assessing whether the benefits decision was the product of an arbitrary and capricious claims process, but also recognized that if sufficient measures are installed to reduce bias and promote accuracy in the adjudication of claims, the conflict factor may “prove less important (perhaps to the vanishing point)[.]” Id. at 2351. Following Glenn plan insurers have seen persistent and increasing demands for costly discovery in the attempt to show financial bias “tainted” the outcome. Since the Glenn majority did not expressly address, much less endorse, so-called “conflict discovery” in the insured plan setting, no doubt much of the rise in ERISA discovery can be pinned to Chief Justice Roberts’ observation in
his concurrence that “[i]t is the actual motivation that matters in reviewing benefits decisions for an abuse of discretion, not the bare presence of the conflict itself.” *Glenn*, 554 U.S. at 123 (Roberts, J., concurring) (listing the various means by which a claimant might establish a conflict, including by evidence of improper financial incentives, or through proof of a pattern or practice of unreasonably denying meritorious claims).

While some federal circuits impose a heavy burden on ERISA claimants to first demonstrate a compelling rationale for allowing discovery beyond the administrative record, e.g., *Troiano v. Aetna Life Ins. Co.*, 844 F.3d 35 (1st Cir. 2016), other courts strive to balance ERISA’s objective of inexpensive and expeditious claims resolution with a party’s right under the federal rules to engage in limited discovery. The Tenth Circuit has explained the toggle between Rule 26 and ERISA efficiency objectives this way:

In exercising its discretion over discovery matters under Rule 26(b), district courts will often need to account for several factors that will militate against broad discovery. First, while a district court must always bear in mind that ERISA seeks a fair and informed resolution of claims, ERISA also seeks to ensure a speedy, inexpensive, and efficient resolution of those claims. And while discovery may, at times, be necessary to allow a claimant to ascertain and argue the seriousness of an administrator’s conflict, Rule 26(b), although broad, has never been a license to engage in an unwieldy, burdensome, and speculative fishing expedition. The party moving to supplement the record or engage in extra-record discovery bears the burden of showing its propriety. *Murphy v. Deloitte & Touche Grp. Ins. Plan*, 619 F.3d 1151, 1162-63 (10th Cir. 2010). A careful balance is thus often presented, as claimants pursue discovery sufficiently broad to try to suggest the conflict effected the benefits determination, and courts maintaining the focus on evidence of actual bias and procedural due process violations.

More often than not, the result has been to allow some discovery with restraints varying from court-to-court and case-by-case. Three areas that have received particular attention are (1) so-called “batting average statistics” in which the claimant seeks to explore other instances in which a medical resource or third-party vendor has lent support for an adverse benefits decision; (2) discovery related to organizational structure; and (3) discovery related to incentive or bonus compensation programs for claims adjusters and medical consultants. Recent cases illustrate that our courts still struggle to reach an appropriate balance between economic and efficient claims resolution and the impact of the insurer’s structural conflict.

A. “Batting Average” Discovery

Many courts remain skeptical of the reliability of statistical information about the number of instances in which a medical resource has been used to support an outcome adverse to the claimant. In *Rickaby v. Hartford Life and Accident Insurance Company*, 2016 WL 1597589, at *4 (D. Colo. Apr. 21, 2016), the court was unpersuaded that a “simple tally of the number of grants and denials” delivers much by way of probative value, recognizing that statistical information, without knowing the particular facts underlying each claim, was of “limited value” to the conflict analysis. The burden such demands place on the insurer has also been acknowledged. *See Price v. Hartford Life & Accident Ins. Co.*, 746 F.Supp.2d 860, 869 (E.D. Mich. 2010) (benefit of file-by-file review was outweighed by the cost of production); *Neubert v. Life Ins. Co. of North Am.*, 2013 WL 5595292, at *6 (N.D. Ohio Oct. 10, 2013) (requiring a file-by-file review of claim files for statistical information imposes an undue burden incompatible with inexpensive resolution); *Warner v. UNUM Life Ins. Co. of Amer.*, 2013 WL 3874060 (N.D. Ill. July 26, 2013) (characterizing such statistical evidence involving the number of claims handled by a particular medical reviewer and concluded in any particular direction as being “at best weak circumstantial evidence of bias”).

Several district courts, most notably in Kentucky and California, have proved far more receptive to sweeping statistical “batting average” discovery, finding it useful to flesh out the structural conflict. *See Myers v. Anthem Life Ins. Co.*, 316 F.R.D. 186, 203 (W.D. Ky. 2016) (holding “the history of remuneration flowing to
third-party service providers and the statistics concerning the number of claims reviewed in relation to the number of claims denied is now ‘fair game’ for discovery.’); Bruce v. Hartford, 21 F. Supp. 3d 590 (E.D. Va. 2014) (statistics concerning claims referred to outside medical reviewers, including the number of cases in which claimants were found to be suffering from restrictions preventing work, and any agreements or guidelines pursuant to which the third-party vendor operated goes to potential bias and is therefore relevant); Wilkens v. Disability Benefit Plan Procter & Gamble, 2012 WL 4364277, at *3 (S.D. Ohio Sept. 24, 2012) (permitting discovery on “compensation arrangements” between the administrator and third-party reviewers, annual financial payments to reviewers, and statistical data about the instances that such reviewers found disability claimants able to work or not disabled) (citing Mullins v. Prudential Ins. Co., 267 F.R.D. 505 (W.D. Ky. 2010)); Klein v. Northwestern Mut. Life Ins. Co., 806 F. Supp. 2d 1120, 1128 (S.D. Cal. 2011) (number of claims handled and approved are proper subjects of discovery and “under certain circumstances, the approval rate by doctor may be appropriate as well.”).

B. Organizational Structure

“The best defense is a good offense” is an adage that some insurers have marshalled to success in conflict discovery disputes. Demonstrating that safeguards have been installed to minimize the potential for bias and promote accurate outcomes can be an effective way to thwart abusive discovery practices. In Geiger v. Aetna Life, 845 F. 3d 357 (7th Cir. 2017), the Seventh Circuit upheld the district court’s refusal to allow discovery depositions of the insurer’s vocational and medical consultants after the insurer demonstrated the steps it had taken to minimize its inherent conflict by implementing multiple safeguards, including obtaining several reviews by independent physicians; contacting the claimant’s treating physicians to discuss their findings; and providing treating physician with a copy of surveillance video and inviting comment. In Bailey v. United of Omaha Life Insurance Company, 2014 WL 5822846 (W.D. Tenn. Nov. 10, 2014), the district court refused to allow conflict discovery after considering the insurer’s detailed affidavit that explained it does not refer claims for evaluation to specific external reviewers, requests external reviews from its vendors responsible for assigning the reviewers, and does not control the roster of reviewers that may be assigned to a claim. It demonstrated that external reviewers do not determine whether claims are paid or denied, that the claims analyst may either accept or reject the reviewer’s opinion in reaching a decision, and that reviewer compensation is fixed and not outcome dependent.

Although a consensus of courts agree that the ERISA claimant bears the initial burden to come forth with sufficient evidence showing the structural conflict warrants enhanced skepticism, once he or she has done so the burden shifts to the administrator to produce evidence mitigating the conflict. As was noted in Montour v. Hartford Life and Accident Insurance Company, 588 F. 3d 623 (9th Cir. 2009), both the plaintiff and the administrator run a risk in not developing evidence of bias or lack thereof. In that case, before addressing the claimant’s failure to submit extrinsic evidence of bias such as statistics of claims denied or frequency of file reviews, the court criticized the administrator’s “failure to present extrinsic evidence of any effort on its part to assure accurate claims assessment.” Id. at 634. Last year, Demer v. IBM Corporation LTD Plan, 835 F. 3d 893 (9th Cir. 2016), reinforced this view. In Demer, the claimant produced evidence of the annual compensation paid to the insurer’s medical reviewers. The court found that the insurer “missed an opportunity” to mitigate that evidence by failing to maintain records of its reviewers’ findings with respect to other claims “to show their neutrality .” Id. at 903. Demer reinforces the importance of having plan insurers anticipate and demonstrate in response to discovery the safeguards it uses to ensure accuracy and reduce bias in the administration of claims.

C. Compensation of Claims Adjusters and Medical Consultants

The organization structure cases overlap with another area of discovery that is being aggressively pursued. Several courts now agree that claimants may explore whether there are incentives or rewards paid

Courts within the Ninth Circuit scrutinize the annual compensation medical reviewers receive. Again, the recent case of Demer is instructive, in which the court observed: “We do not quarrel with the notion that using outside medical evaluators can be an important step toward the goal of obtaining neutral assessments, but it is not hard to imagine an outside medical examiner who does not engage in a neutral, independent review, such as where the examiner receives hundreds of thousands of dollars from a single source and performs hundreds of reviews for that source every year.” 835 F.3d at 904. Discovery along these lines has been more liberally allowed in the district courts of the Ninth Circuit. E.g., Gonda v. Permanente Medical Group, Inc., 300 F.R.D. 609, 614 (N.D. Cal. 2014) (allowing deposition of third-party vendor regarding number of benefit claims reviewed by medical evaluator and amount of compensation received); Klein v. Northwestern Mut. Life Ins. Co., 806 F. Supp. 2d 1120, 1127 (S.D. Cal. 2011) (discovery allowed into the compensation of in-house medical personnel, including how much money they receive and what percentage of their total salary is provided by insurer). Showing that reviewer compensation is not tied to findings might be one approach to curbing the degree to which courts permit expensive discovery.

V. Conclusion

ERISA benefits litigation continues to rise, and your adversary’s objectives remain constant—maximize his or her client’s recovery, either by a favorable outcome in court or through settlement, and potentially harm your client’s reputation in the process. Efforts to persuade judges that a delegation of discretion falls outside the plan, that optional insurance is exempt from the statute, or that intrusive and immoderate discovery is essential to expose “biased” decision-making are just a few of the tactics our clients must meet and defend in the current environment. For these reasons, the defense practitioner is wise to evaluate the record soon after receipt and alert the client to possible procedural irregularities or merit-based concerns and, when appropriate, make informed settlement recommendations early. But whether faced with recurring challenges or newly emerging ones, the practitioner must stay rooted in ERISA’s core objectives of cost-containment and uniform regulation that Congress intended to encourage the adoption of employee benefit plans in the first place, and an argument to the court so framed is a safe and sound beginning.