ERISA DISABILITY CLAIMS IN THE EIGHTH CIRCUIT

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I. INTRODUCTION

The Employee Retirement Income Security Act of 1974, commonly known as ERISA, is a federal law that affects a vast majority of private sector employees in the Eighth Circuit. ERISA regulates both retirement plans and health and welfare benefit plans that are sponsored by employers. Included within the framework of health and welfare benefit

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1. This Article discusses the processing of disputed ERISA disability claims in the United States Court of Appeals for the Eighth Circuit. It is important to note that many of the case citations deal with several types of employment benefits, including disability, health plans, and life insurance benefits. The case law that has developed with respect to the different types of employment benefits is, for the most part, interchangeable. The one area in which it is important to carefully distinguish the type of benefit involved is when dealing with statute of limitations questions. See infra Part II.D.


3. ERISA only regulates those plans that are established or maintained by
plans are short- and long-term disability plans.\textsuperscript{4} According to a report from the United States Department of Labor’s Bureau of Labor Statistics, 8,421,900 individuals were employed in the states that comprise the Eighth Circuit as of January 2008.\textsuperscript{5} The United States Department of Labor estimates that short- and long-term disability benefits are available to thirty-nine and thirty-one percent of private sector workers, respectively, in the United States.\textsuperscript{6} When available, approximately ninety-six percent of workers participate in these benefit plans.\textsuperscript{7} If one applies those figures to the Eighth Circuit, the theoretical result is roughly 3,153,271 participants in short-term disability plans and 2,506,446 participants in long-term disability plans in the Eighth Circuit.\textsuperscript{8} Each of these participants whose claim is denied is a potential client.\textsuperscript{9} However, before undertaking to represent employers or any employee organization. \textit{Id.} § 1003(a). ERISA does not regulate disability insurance policies that are purchased by individuals outside the employment arena; additionally, ERISA does not regulate governmental plans, church plans, or workers’ compensation plans established to comply with applicable workers’ compensation laws. \textit{Id.} § 1003(b).

\textsuperscript{4} \textit{Id.} § 1002(1).

\textsuperscript{5} \textit{See Bureau of Labor Statistics, U.S. Department of Labor, State & Metro Area Employment, Housing, & Earnings, available at} http://www.bls.gov/sae/sm_mrs.htm (last visited Oct. 8, 2008) (providing statistics on a state-by-state basis). This page allows the reader to select statistics for each state. The 8,421,900 estimate of private sector employees in the Eighth Circuit was obtained by subtracting the total number of reported government employees (seasonally adjusted) from the total number of non-farm employees (seasonally adjusted) for the states of Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota as of January 2008. Because ERISA does not apply to government employees, and it is believed that most farm employees are not covered by short- or long-term disability plans, the 8,421,900 figure is a reasonable approximation of the private sector work force in these states. The numbers of employees per state contained within this 8,421,900 figure are as follows: Arkansas (995,200), Iowa (1,272,900), Minnesota (2,367,200), Missouri (2,359,400), Nebraska (804,900), North Dakota (287,200), and South Dakota (335,100). \textit{Id.}


\textsuperscript{7} \textit{Id.}

\textsuperscript{8} \textit{Id.}

\textsuperscript{9} ERISA includes an attorney fee provision that provides, “In any action under this subchapter . . . the court in its discretion may allow a reasonable attorney’s fee and costs of action to either party.” 29 U.S.C. § 1132(g) (2000). If the attorney is successful in prevailing for his client at the administrative level, then no action will be filed and the statutory attorney fee provision does not come into play. Therefore, it would be prudent to enter into an attorney fee agreement—either hourly, flat fee, or
such a client, the attorney needs to be familiar with relevant procedures.

In enacting ERISA, Congress declared its intention:

to protect . . . the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.10

It is often difficult to discern how Congress’s expressed intention to protect the interests of the participants is achieved given the case law that has developed in ERISA benefit claim cases. Few attorneys involved in ERISA litigation would privately contend the body of ERISA case law serves to protect the interests of ERISA participants and beneficiaries. Similar concerns were expressed by Judge Bennett of the United States District Court for the Northern District of Iowa: “This case exemplifies why there is a ‘rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly entangled ERISA regime.’”11 Judge Bennett continued,

Thus, often it is the case that ‘persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief,’ and a finding of preemption under ERISA, as is the case here, severely limits the type of remedies a claimant may seek. As such, ERISA, which was enacted to safeguard the interests of employees and their beneficiaries, has metastasized into what is essentially a shield of immunity that protects health insurers and other managed care entities from liability for the consequences of their allegedly wrongful actions . . . . As this court is bound to follow both Eighth Circuit and Supreme Court

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precedent, this case compels a like result. Consequently, this case becomes yet another glaring example of the need for Congress and the Supreme Court to put an end to the sisyphian frustration that has resulted from the Serbonian bog of ERISA preemption precedent. Until such action is taken, it is clear to this court that ERISA will continue to act as a shield of immunity, thwarting the often legitimate and serious claims of the very people ERISA was promulgated to protect.12

Essentially, the current dissatisfaction stems from the fact that the Supreme Court has coupled a comprehensive interpretation of ERISA’s preemptive force with a confined construction of the “equitable relief” allowable under § 502(a)(3), which has resulted in a “regulatory vacuum” caused by the fact that “virtually all state law remedies are preempted but very few federal substitutes are provided.”13 Nevertheless, the defendant-friendly case law is a reality that the attorney representing the claimant must understand if the attorney has any chance of successfully assisting the client.

The preceding discussion regarding an “unjust and increasingly entangled ERISA regime” refers to ERISA’s preemptive force and limited remedies.14 The remainder of this article discusses the defendant-friendly law that governs the resolution of one of those limited remedies—a claim for disability benefits under an ERISA welfare benefit plan.

12. Id. at 940–42. Chief Judge Bennett is not alone in his sentiments. See, e.g., DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 467 (3d Cir. 2003) (Becker, J., concurring) (“The vital thing . . . is that either Congress or the Court act quickly, because the current situation is plainly untenable.”); id. at 467 (Ambro, J., concurring) (“I implore for a better way to make these kinds of decisions.”); Cicio v. Does, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, J., dissenting in part) (the “gaping wound” caused by the breadth of preemption and limited remedies under ERISA, as interpreted by this court, “will not be healed until the Supreme Court reconsiders . . . the statute or Congress revisits the law.”); John H. Langbein, What ERISA Means by “Equitable”: The Supreme Court’s Trail of Error in Russell, Mertens, and Great-West, 103 COLUM. L. REV. 1317, 1365 (2003) (“The Supreme Court needs to . . . realign ERISA remedy law with the trust remedial tradition that Congress intended . . . [when it provided in § 502(a)(3) for] ‘appropriate equitable relief.’”)


II. BENEFITS CLAIMS

A. Types of Claims

At the outset, it is important to recognize that state insurance contract laws and state tort law have no applicability to ERISA disability benefit claims. All state statutory and common law claims are preempted by ERISA. Therefore, any effort to bring a breach of insurance contract claim, a bad faith claim, an intentional infliction of emotional distress claim, or a combination thereof, will fail because they will be dismissed by the court. In most cases, the only claim that may be advanced is a simple claim for benefits under the policy, which will be governed by federal law. In some cases, however, it may be appropriate to bring a breach of fiduciary duty claim. Prior to February of 2008, most claims for breach of fiduciary duty under ERISA were dismissed if the claim was simply a claim for benefits. But in Varity Corp. v. Howe, the Court allowed a group of former employees and retirees to bring a breach of fiduciary duty claim, which sought to reinstate certain benefits. In addressing the concern raised by various amici that allowing claims for benefits to be advanced under the guise of breach of fiduciary duty claims would allow claimants to bypass ERISA case law developed under benefit claims—decisions that were favorable to plans, sponsors, and employers—the Court stated as follows: “Thus, we should expect that where Congress elsewhere provided adequate relief for a beneficiary’s injury, there will likely be no need for further equitable relief, in which case such relief would normally not be ‘appropriate.’” While the lower courts have relied on this language to routinely dismiss breach of fiduciary duty claims seeking reinstatement of benefits, their propensity to do so may diminish in light of the February 2008 United States Supreme Court decision in LaRue v. DeWolff, Boberg & Associates, Inc. In LaRue, the Court allowed an individual participant to pursue a breach of fiduciary duty claim in an effort to compel the administrator to place additional amounts in a pension plan that would be

17. Id. at 491–92.
18. Id. at 515 (citations omitted).
allocated for the participant’s benefit. Whether courts will be more likely to allow individual benefit claims to be characterized as breach of fiduciary duty claims in light of *LaRue* remains to be seen.

While this issue may appear a distinction without a difference, there are practical reasons why this distinction may mean the difference between success and failure. For example, as discussed later in this Article, a breach of fiduciary duty claim has a three-year statute of limitations under ERISA. Since the statute of limitations on a benefit claim is determined by reference to state law, some benefit claims may face a one- or two-year statute of limitations. If a benefit claim in these jurisdictions was advanced after the benefit claim statute of limitations had passed, but before the ERISA breach of fiduciary statute of limitations had passed, the plaintiff would need to characterize the claim as a breach of fiduciary duty rather than as a benefit claim.

While the possibility of a breach of fiduciary duty claim exists, this Article discusses the federal law that will be applied in those cases in which a simple claim for benefits under the policy is the only claim advanced. Before discussing the applicable law, it is important to understand how most disability denial claims are processed. First of all, the claimant must file a claim to initiate the process. Following the filing, the administrator gathers information and evaluates the claim. Once the administrator denies the claim, the claimant appeals the ruling on the grounds of unfairness—usually without ever requesting discoverable file materials or submitting additional materials. Unsurprisingly, the appeal authority will deny the appeal.

Once denial by the appeal authority has occurred, a claimant usually seeks the advice of an attorney. When the attorney files suit, the court is then provided with a copy of the administrative record. Unfortunately, in most cases, the court will apply an abuse of discretion standard. Because this standard is so high, the court routinely upholds the appeal authority’s decision, resulting in judgment for the defendant.

In all cases, the best chance for a claimant to prevail occurs during the appeal process. Surprisingly, many claimants seek the advice of an attorney prior to filing an appeal and are told they should file the appeal on their own and seek further legal advice only if the appeal is denied. This is

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20. *Id.* at 1022.
21. *See infra* Part II.D.
22. *See infra* notes 105–16 and accompanying text.
the worst advice an attorney can give the claimant and, in most instances, should constitute legal malpractice. Yet, this advice is frequently given by attorneys who are unfamiliar with ERISA. The purpose of this Article is to provide a summary of ERISA benefit claim procedures and the body of case law that has developed concerning these procedures.

B. Claim Procedures

ERISA requires all employee benefit plans to include claim procedures. The Secretary of Labor is responsible for implementing regulations governing claim procedures. Accordingly, the Secretary has promulgated claim procedure regulations, which are found at 29 C.F.R. § 2560.503–1 (2007). These regulations require ERISA plans to establish appeal procedures for a participant whose initial disability claim is denied. Following a denial of the appeal, the participant may file suit to recover benefits in the appropriate court. A participant’s failure to exhaust administrative remedies through the appeal process will almost always result in the dismissal of the participant’s lawsuit. The Eighth Circuit has recognized two exceptions to the exhaustion requirement. The first is when resort to administrative remedies would be futile. The second is when the administrator of the plan fails to comply with a provision that requires a claimant to be notified of the availability of a contractual review process in the denial letter. Furthermore, due to the standard of review most often applied in these cases, it is critical that the

24. Id.
25. Id.
26. See Wert v. Liberty Life Assurance Co. of Boston, Inc., 447 F.3d 1060, 1063 (8th Cir. 2006) (“[W]e hold that exhaustion of contractual remedies is required in the context of a denial of benefits action under ERISA when there is available to a claimant a contractual review procedure that is in compliance with 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503–1(f) and (g). This exhaustion requirement applies so long as the employee has notice of the procedure, even if the plan, insurance contract, and denial letters do not explicitly describe the review procedure as mandatory or as a prerequisite to suit.”).
27. See Union Pac. R.R. Co. v. Beckham, 138 F.3d 325, 332 n.4 (8th Cir. 1998) (“When exhaustion is futile, an ERISA beneficiary’s claim ‘accrue[s] at the time it became futile to apply for benefits, because . . . at that time there was a de facto denial of [the beneficiary’s] claim.’”) (citation omitted).
28. Conley v. Pitney Bowes, 34 F.3d 714, 717–18 (8th Cir. 1994) (“A defense under the exhaustion clause [of a plan contract], therefore, may not be asserted absent performance of the notice clause, since they are presumed to be the subject of promises made in exchange for each other.”).
participant’s attorney approach the administrative appeal process as though it is the client’s best chance to prevail.

The first step in any ERISA appeal process is the gathering of all relevant information. Presumably, the claimant will present you with information he has gathered with respect to his claim. Significantly, federal law requires the employer-sponsor\(^{29}\) and the claims administrator\(^{30}\) to produce two types of documents for the claimant.

First, upon filing a request with the administrator, the employee is entitled to receive a copy of the plan documents, including the latest updated summary plan description.\(^{31}\) The failure to provide the requested documents subjects the plan administrator to a potential fine of $100 per day.\(^{32}\) Generally, if the request for plan documents is made to a third-party administrator, the requestor is informed that the request must be directed to the plan administrator. While the validity of such a response is questionable, to forestall delay the request for plan documents should be directed to both the plan administrator and the claims administrator.

The second category of documents that are discoverable includes

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\(^{29}\) Under ERISA, when an employer or employee organization establishes or maintains a disability plan, the employer or employee organization is referred to as the plan sponsor. 29 U.S.C. § 1002(16)(B) (2000). Frequently, the plan sponsor establishes the plan through the purchase of an insurance policy, which is thereafter referred to as the plan document. See, e.g., Robinson v. Linomaz, 58 F.3d 365, 368 (8th Cir. 1995) (holding that employer’s purchase of a group insurance policy qualified as an employee welfare benefit plan under ERISA). Another frequently used procedure is for the plan sponsor to establish a written plan document and then hire a third-party administrator to handle the claims-processing function. Regardless of whether it is an insurance policy or a plan written by the employer, it is this document which is referred to as the “plan.”

\(^{30}\) Under ERISA, the administrator is generally the plan sponsor, or the individual or entity named as the administrator in the plan. 29 U.S.C. § 1002(16)(A). Most often, the plan sponsor retains the title of plan administrator, but delegates claim administrative functions to an insurance company or third-party administrator that is responsible for determining the claimant’s eligibility for disability benefits. Regardless of who makes the benefit determination, when exercising discretionary authority to determine eligibility for disability benefits, that individual or entity is acting as a fiduciary. Id. § 1002(21)(A).

\(^{31}\) Under § 1024(b)(4), the administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description. Id. § 1024(b)(4). Additionally, each participant in an employee benefit plan shall be furnished a summary plan description (SPD), which must contain certain specified information. Id. § 1022(a).

\(^{32}\) Id. § 1132(c)(1).
copies of all documents, records, and other information relevant to the employee's claim for benefits. The Department of Labor has defined “relevant” to include any document that:

- Was relied upon in making the benefit determination;
- 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;
- Demonstrates compliance with the administrative processes and safeguards [designed to ensure and verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants]; or
- 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 . . . benefit for the claimant's diagnosis without regard to whether such advice or statement was relied upon in making the benefit determination.

In essence, these federal laws and regulations allow the attorney to gather all material contained in the administrative record up to the point the attorney becomes involved in the case. Having obtained these records, the attorney must then carefully review the plan documents to determine under what circumstances the claimant is entitled to benefits. In some cases, there are conflicts between the plan and the summary plan description (SPD) with respect to the relevant issue. In these circumstances, the SPD will control.35

The attorney must then review the administrative record to determine

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34. Id. § 2560.503-1(m)(8).
35. See, e.g., Jensen v. SIPCO, Inc., 38 F.3d 945, 952 (8th Cir. 1994). However, this rule does not apply “when the plan document is specific and the SPD is silent on a particular matter.” Id. In some cases, there may be an allegation that the alleged SPD is not really an SPD because it does not comply with the federal requirements for SPDs. In these cases, the alleged SPD is said to be “faulty.” In order to secure relief based on a faulty SPD, “the claimant must show some significant reliance on, or possible prejudice flowing from, the summary.” Marolt v. Alliant Techsystems, Inc., 146 F.3d 617, 621 (8th Cir. 1998) (quoting Maxa v. John Alden Life Ins. Co., 972 F.2d 980, 984 (8th Cir. 1992)).
whether it supports the claimant’s claim and whether the record needs to be supplemented with additional materials to support the claim. After the gathering and review process has taken place, the attorney is then able to prepare a meaningful appeal.

The appeal should always include a request for the production of additional relevant documents that have been placed in the file following the submission of the appeal but before the appeal decision is reached. This is necessary because the administrator, depending on the strength of the appeal, may gather additional evidence that will be used to rebut the evidence submitted by the claimant. Such information typically would include additional medical reports, vocational studies, or both. The Eighth Circuit has held that the claimant is entitled to review and comment on this additional documentation.36

After the appeal is submitted, the plan administrator will evaluate it. If the appeal is denied, the claimant may then choose to file a claim for relief in court.37 At this point, many attorneys file a petition in state court that includes claims for breach of contract, insurance bad faith, intentional infliction of emotional distress, and breach of fiduciary duty. A jury demand is often included in the petition. Filing such a petition will almost always result in the following: First, the defendant will remove the action from state to federal court.38 Second, the defendant will successfully move to strike all state law claims on the grounds that they are preempted by ERISA.39 Third, the defendant may be able to successfully move to strike the breach of fiduciary duty claim.40 Fourth, the defendant will successfully move to strike the jury demand.41 In the end, it is likely that only the claim for disability benefits will remain, and it will be decided by a federal judge without the benefit of a trial and based solely on a review of the agreed

36. *See* Abram v. Cargill, Inc., 395 F.3d 882, 886 (8th Cir. 2005) (holding a claimant was not granted proper full and fair review, and thus could not meaningfully participate in the appeals process, when she was not given access to a doctor’s second report, on which her denial of benefits was based).


39. *See supra* Part II.A.

40. *See id.*

41. *See In re* Vorpahl, 695 F.2d 318, 319 (8th Cir. 1982) (no right to a jury trial on an ERISA benefits claim).
upon administrative record. Knowing this to be the case, the wise practitioner will, in most cases, simply file a complaint in federal court asserting a count for the wrongful denial of disability benefits.42

C. Standards of Review

A denial of benefits under an ERISA plan is generally reviewed under a de novo standard, unless the plan confers discretionary authority upon the plan administrator or fiduciary to interpret the terms of the plan or determine eligibility for benefits.43 If the disability plan contains a discretionary grant of authority, then the administrator’s decision is most often reviewed under an abuse of discretion standard.44 Hence, the initial issue for the reviewing court is whether the plan contains a grant of discretion to the plan administrator.45

Most disability plans contain express discretion-granting language; however, some plans do not. Words and phrases such as “to be considered disabled,” “normally,” and “as long as the definition of total disability is

42. There may be situations when it is appropriate to fight federal jurisdiction. See Judge Bennett’s detailed discussion of ERISA preemption and federal jurisdiction in ERISA cases in Van Natta v. Sara Lee Corp., 439 F. Supp. 2d 911, 935–41 (N.D. Iowa 2006).

43. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). The Eighth Circuit has characterized the Supreme Court’s holding in Bruch as follows: “In other words, unless the plan language specifies otherwise, courts should construe any disputed language ‘without deferring to either party’s interpretation.’” Wallace v. Firestone Tire & Rubber Co., 882 F.2d 1327, 1329 (8th Cir. 1989) (quoting Bruch, 489 U.S. at 112).

44. See Layes v. Mead Corp., 132 F.3d 1246, 1250 (8th Cir. 1998). In reviewing ERISA decisions discussing the standard of review to be applied when the plan grants discretion to the administrator, courts have typically used an “arbitrary and capricious” or “abuse of discretion” standard. According to the Eighth Circuit, the “arbitrary and capricious” standard of review is a pre-Bruch standard, whereas the “abuse of discretion” standard is used post-Bruch. See Donaho v. FMC Corp., 74 F.3d 894, 900 n.11 (8th Cir. 1996). While noting that these standards may be a “distinction without a difference,” the Eighth Circuit has determined that it will nonetheless use the “abuse of discretion” standard. Id. at 898 n.5 (citation omitted). However, sometimes, even when the plan contains a discretionary grant of authority, the court applies a less deferential standard of review. The circumstances in which a less deferential standard of review—commonly referred to as a “sliding scale of review”—will be applied are discussed more fully later in this Article. See infra Part II.C.3.

45. An ancillary rule provides that if the administrator or fiduciary interprets a provision of law in making its decision, this decision is reviewed de novo. Meyer v. Duluth Bldg. Trades Welfare Fund, 299 F.3d 686, 689 (8th Cir. 2002).
satisfied” do not imply a grant of discretionary authority.46 “The proper way to secure deferential court review of an ERISA plan administrator’s claims decisions is through express discretion-granting language.”47 An example of discretion-granting language is found in Donaho v. FMC Corp.48 In Donaho, the claimant sought disability benefits under FMC’s disability plan, which provided that “‘FMC, as Plan Administrator, has discretionary authority to construe and interpret the terms of the Plan, including, but not limited to, deciding all questions of eligibility . . . .’”49

Once the court determines whether the plan contains a grant of discretionary authority, the court then applies the applicable standard of review: (1) de novo review; (2) abuse of discretion review; or (3) a sliding scale review. Each will be discussed in turn.

1. **De Novo Standard**

When construing the language of an ERISA plan under a de novo review standard, the court begins by examining the language of the plan documents.50 “In interpreting ERISA plans, the plainly stated terms ‘should be accorded their ordinary, and not specialized, meanings.’”51 In other words, the court is to give “‘the language its common and ordinary meaning as a reasonable person in the position of the [plan] participant, not the actual participant, would have understood the words.’”52 “Each provision should be read consistently with the others and as part of an integrated whole.”53 The plan should be construed so as to give effect to all

46. *See* Brown v. Seitz Foods, Inc. Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998) (“ERISA plan provision stating claims will be paid after plan’s administrator ‘receives adequate proof of loss’ does not express intent to confer discretion” (quoting Bounds v. Bell Atl. Enters. Flexible Long-Term Disability Plan, 32 F.3d 337, 339 (8th Cir. 1994))).

47. *Id.*; see also Wald v. Sw. Bell Corp. Customcare Med. Plan, 83 F.3d 1002, 1006 (8th Cir. 1996) (holding that as long as the plan contains a grant of discretionary authority to the administrator, an abuse of discretion standard of review will be applied even if the SPD does not contain such language).


49. *Id.* (quoting the FMC employee health benefit plan).

50. Bond v. Cerner Corp., 309 F.3d 1064, 1067 (8th Cir. 2002).


52. Barker v. Ceridian Corp., 122 F.3d 628, 632 (8th Cir. 1997) (quoting Chiles v. Ceridian Corp., 95 F.3d 1505, 1511 (10th Cir. 1996)).

53. DeGeare v. Alpha Portland Indus., Inc., 837 F.2d 812, 816 (8th Cir. 1988),
of its provisions. Similarly, “if two clauses of a contract appear to be in conflict, the preferred interpretation is the one that gives a harmonious interpretation to the clauses in order to avoid rendering either one nugatory,’” and also “‘to avoid illusory promises.’”54 “A [summary plan description] is intended to be a document easily interpreted by a layman; an employee should not be required to adopt the skills of a lawyer and parse specific undefined words throughout the entire document to determine whether they are consistently used in the same context.”55 Any disputed language is construed “‘without deferring to either party’s interpretation’ unless the plan language specifies otherwise.”56 If, after applying these rules of construction, the court finds the plan provisions are ambiguous, “extrinsic evidence is admissible to determine the meaning of the contract.”57 If, after considering admissible extrinsic evidence, the ambiguities remain, then the court must construe the ambiguities against the drafter, but only as a last resort.58

2. Abuse of Discretion Standard

Most plans contain a grant of discretionary authority similar to the following: “FMC, as Plan Administrator, has discretionary authority to construe and interpret the terms of the Plan, including, but not limited to, deciding all questions of eligibility . . . .”59 It is important to note this sample grant of discretion extends to two functions. It gives the administrator the discretion to both “interpret the terms of the Plan” and determine “eligibility.” Though the abuse of discretion review standard applies to both functions, the Eighth Circuit uses different tests to conduct these reviews.60
In order to determine whether the administrator’s interpretation is reasonable, the court applies a five-part test: (1) whether the interpretation is consistent with the goals of the plan; (2) whether it renders any language in the plan meaningless or internally inconsistent; (3) whether it conflicts with the substantive or procedural requirements of the ERISA statute; (4) whether the administrator has interpreted the provisions at issue in a consistent fashion; and (5) whether the interpretation is contrary to the clear language of the plan. The court weighs the answers to these questions and then determines whether the administrator abused its discretion in its interpretation.

In determining whether the administrator’s interpretation is contrary to the plain language of the plan, the Eighth Circuit has indicated that “‘[r]ecourse to the ordinary, dictionary definition of words is not only reasonable, but may be necessary.’” “‘[W]ords are to be given their plain and ordinary meaning as understood by a reasonable, average person.’” If the court finds that the administrator’s interpretation of the disputed term is contrary to the plain language of the plan, then significant weight is placed on the misinterpretation and an abuse of discretion is more likely to be found. Furthermore, even if the plan administrator has consistently misinterpreted a term, the misinterpretation may still be an abuse of discretion.

61. Wald v. Sw. Bell Corp. Customcare Med. Plan, 83 F.3d 1002, 1007 (8th Cir. 1996) (citing Finley, 957 F.2d at 621). Although the analytic framework set forth above (i.e., factor four) compels the conclusion that the court looks to evidence outside the record, the Eighth Circuit has not explicitly addressed this issue. However, the Fifth Circuit utilizes a similar analytic approach and has specifically held that a district court is not confined to the administrative record in determining whether an administrator abused its discretion in interpreting a plan provision. See, e.g., Wildbur v. Arco Chem. Co., 974 F.2d 631, 638 (5th Cir. 1992) (holding that evidence outside the administrative record may be necessary to show “whether the administrator has given a uniform construction to a plan”).


63. Finley, 957 F.2d at 622 (quoting Cent. States, Se. & Sw. Areas Pension Fund v. Indep. Fruit & Produce Co., 919 F.2d 1343, 1350 (8th Cir. 1990) (citation omitted), cert. denied, 502 U.S. 811 (1991)).

64. Id.


66. Id. Lickteig actually used the phrase “arbitrary and capricious” in this 1995 decision. Id. It took this language from a pre-Bruch Eighth Circuit case. See Morgan v. Mullins, 643 F.2d 1320, 1324 n.4 (8th Cir. 1981). However, since the 1996
In most cases, the interpretation of a plan term is not at issue. Rather, the most frequently disputed issue by far is whether the claimant, based on the facts of the claim, is entitled to benefits. In these types of cases, “‘the plan administrator’s decision to deny benefits will stand if a reasonable person could have reached a similar decision.’”\textsuperscript{67} “In evaluating reasonableness, the court determines ‘whether the decision is supported by substantial evidence, which is more than a scintilla but less than a preponderance.’”\textsuperscript{68} “Substantial evidence ‘means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.’”\textsuperscript{69} Therefore, the court must affirm the administrator’s decision if “a reasonable person could have reached a similar decision, given the evidence before him, not that a reasonable person would have reached a similar decision.”\textsuperscript{70} Further, the court considers only the evidence that “was before the administrator when the claim was denied.”\textsuperscript{71} The court does not, however, substitute its “weighing of the evidence for that of the

\textit{Donaho} decision, the Eighth Circuit has applied the “abuse of discretion” standard rather than the “arbitrary and capricious” standard. In order to be consistent with current usage, this Article substitutes the phrase “abuse of discretion” for the phrase “arbitrary and capricious.”

\textsuperscript{67} Sahulka v. Lucent Techs., Inc., 206 F.3d 763, 767 (8th Cir. 2000) (quoting Woo v. Deluxe Corp., 144 F.3d 1157, 1162 (8th Cir. 1998)).

\textsuperscript{68} Id. at 767–68. In \textit{Donaho}, the court noted that it had previously upheld an administrator’s decision in abuse of discretion cases based on a number of standards: decision supported by “substantial evidence” (citing Short v. Cent. States, Se. & Sw. Areas Pension Fund, 729 F.2d 567, 571 (8th Cir. 1984)); decision was “reasonable” (citing Cox v. Mid-Am. Dairymen, Inc., 13 F.3d 272, 274 (8th Cir. 1993)); decision not “extraordinarily imprudent or extremely unreasonable” (citing \textit{Lickteig}, 61 F.3d at 583). \textit{Donaho} v. FMC Corp., 74 F.3d 894, 898 (8th Cir. 1996). According to \textit{Donaho}, “the proper inquiry is whether the plan administrator’s decision was reasonable; i.e., supported by substantial evidence. The pejorative adjectives of ‘extraordinarily’ (imprudent) or ‘extremely’ (unreasonable) are encompassed in a reasonableness test.” \textit{Id.} at 899. The \textit{Donaho} court stated that “under the abuse of discretion standard of review, the district court . . . may overturn a decision of the plan administrator only if it is ‘without reason, unsupported by substantial evidence or erroneous as a matter of law.’” \textit{Id.} at 900 (quoting Abnathya v. Hoffmann-La Roche, Inc., 2 F.3d 40, 45 (3d Cir. 1993)); see also \textit{Johnson} v. Ark. State Police, 10 F.3d 547, 552 (8th Cir. 1993) (findings clearly erroneous when they fail to draw inferences the reviewing court finds inescapable from the record).

\textsuperscript{69} Donaho, 74 F.3d at 900 n.10 (quoting Consol. Edison Co. v. NLRB, 305 U.S. 197, 299 (1938)).

\textsuperscript{70} Sahulka, 206 F.3d at 769 (quoting Cash v. Wal-Mart Group Health Plan, 107 F.3d 637, 641 (8th Cir. 1997)).

\textsuperscript{71} Id.
administrator.”

Furthermore, on review by the court, the plan’s reasons for denying the claim will be limited to those that appear in the record and not those developed after the fact and devised for the purposes of litigation. In Marolt, an abuse of discretion review case, the appeal authority did not provide a written explanation for the basis of its decision as it was required to do under ERISA. Thereafter, on review before the district court, the plan attempted to justify its decision with a rationale that did not appear in the record. The court held that it “will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation.”

3. Sliding Scale Standard

In cases involving a plan that contains a grant of discretionary authority in which the administrator’s decision would normally be reviewed under an abuse of discretion standard, it is important to recognize when a less deferential standard of review may apply. The Eighth Circuit has routinely held that the deferential standard of review applies unless the claimant comes forward with evidence establishing that the administrator acted under a conflict of interest, dishonestly, with an improper motive, or without using judgment. The Eighth Circuit has also held that in order to obtain a less deferential review, a claimant must present material, probative evidence demonstrating that a palpable conflict of interest or

72. Id. at 769–70.
73. Marolt v. Alliant Techsystems, Inc., 146 F.3d 617, 620 (8th Cir. 1998).
74. Id. at 619–20.
75. Id. at 620.
76. Id. at 619–20. Similarly, a plan that denies a claim should not be allowed to change its rationale for its decision by presenting new arguments to the district court that were not set forth in an ERISA compliant denial decision. But see Farley v. Benefit Trust Life Ins. Co., 979 F.2d 653, 659 (8th Cir. 1992) (holding that in a de novo review case the court may consider policy provisions not cited in the administrator's denial letter).
77. This is the point at which the attorney will rise or fall. The attorney will only rise if he or she has conducted the discovery previously discussed. See supra notes 29–36 and accompanying text.
79. Woo v. Deluxe Corp., 144 F.3d 1157, 1160 (8th Cir. 1998). The United
serious procedural irregularity caused a serious breach of the plan administrator's duty to the claimant. To satisfy the second part of this test, the claimant must show that the conflict or procedural irregularity has "some connection to the substantive decision reached." "

The United States Supreme Court's recent decision in *Metropolitan Life Insurance Co. v. Glenn* calls into question the continued validity of Eighth Circuit cases that impose additional burdens on a claimant seeking a sliding scale standard of review when a conflict of interest is demonstrated. In *Glenn*, the Court held that when the "entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket," a conflict of interest is created. If these facts are shown to exist, a reviewing court "should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and that the significance of [this] factor will depend upon the circumstances of the particular case." This language compels the

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States Supreme Court's decision in *Metropolitan Life Insurance Co. v. Glenn* makes it clear that when the "entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket . . . this dual role creates a conflict of interest." *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2346 (2008). With respect to the palpable conflict of interest, *Glenn* does not establish new law in the Eighth Circuit because under existing Eighth Circuit law, one way to meet this prong of the *Woo* test was by demonstrating that the entity that funds a plan is also the plan administrator. In such circumstances, a rebuttable presumption arises that a palpable conflict existed. *Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192, 1194 (8th Cir. 2002) (citing *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 589 (8th Cir. 1999)).

80. *Woo*, 144 F.3d at 1160.
81. *Buttram*, 76 F.3d at 901.
82. *Glenn*, 128 S. Ct. at 2343.
83. *Id.* at 2346. While *Glenn* involved an insurance company acting as both the decision maker and the payor, the Court made clear that the same reasoning applies equally, if not more so, when an employer is the decision maker and the payor. *Id.* at 2349 (suggesting that the conflict issue may be less clear if it is an insurance company playing the dual role rather than an employer).
84. *Id.* at 2346.

In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. The conflict of interest at issue here . . . [dual role status] should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims
conclusion that when a conflict exists because of the administrator’s dual role—as both the decider and the payor—it is no longer necessary to demonstrate that the conflict caused a serious breach of the plan administrator’s duty to the claimant by demonstrating the conflict had “some connection to the substantive decision reached” before applying a sliding scale of review. It is unknown, however, whether a claimant who presents material, probative evidence demonstrating that a serious procedural irregularity existed must also show that the irregularity caused a serious breach of the plan administrator’s duty to the claimant.

If a claimant can convince the court that a dual role conflict situation exists or that the two-part procedural irregularity test has been met, then the issue becomes a determination of what sliding scale standard of review will be applied. The circuit courts developed two responses to such situations. One approach was to apply a “presumptively void’ test, under which a decision rendered by a conflicted plan administrator is presumed to be an abuse of discretion . . . .” The Eighth Circuit rejected this approach and instead adopted a “sliding scale” approach. Under this approach, the reviewing court “will always review for an abuse of discretion, but it will decrease the deference given to the administrator in proportion to the seriousness of the conflict of interest or procedural irregularity.”

The United States Supreme Court’s decision in Glenn discusses factors that are relevant in determining whether an abuse of discretion exists under the sliding scale standard of review. In Glenn, the Court approved of the lower court’s reasoning when the lower court found the following factors persuasive as evidence of an abuse of discretion:

1. the conflict of interest; 2. MetLife’s failure to reconcile its own administration.

Id. at 2351.

85. See Buttram, 76 F.3d at 901.
86. See Woo v. Deluxe Corp., 144 F.3d 1157, 1160 (8th Cir. 1998).
87. Buttram, 76 F.3d at 900 n.6.
88. See Woo, 144 F.3d at 1161. While the United States Supreme Court did not address this issue in Glenn, it clearly came down on the side of the “sliding scale” standard of review employed by the Eighth Circuit. See Glenn, 128 S. Ct. at 2346.
89. Woo, 144 F.3d at 1161. On one occasion the court was persuaded to slide the scale all the way and apply a de novo standard when the plan administrator, Aetna, had implemented a payment plan that provided incentives and bonuses to its claim reviewers based on criteria that included a “claims saving” category. Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997).
conclusion that Glenn could work in other jobs with the Social Security Administration’s conclusion that she could not; (3) MetLife’s focus on one treating physician’s report suggesting that Glenn could work in other jobs while at the expense of other, more detailed treating physician reports indicating that she could not; (4) MetLife’s failure to provide all of the treating physician reports to its own hired experts; and (5) MetLife’s failure to take account of evidence indicating that stress aggravated Glenn’s condition.90

In a pre-\textit{Glenn} case, the Eighth Circuit applied a sliding scale when the administrator operated under a financial conflict and committed a serious procedural irregularity in not having an independent specialist review the claimant’s medical record.91 The court found these circumstances sufficiently egregious to “require that the record contain substantial evidence bordering on a preponderance to uphold Hartford’s decision.”92

The Eighth Circuit has held that the “lack of a thorough investigation by a fiduciary can result in a serious procedural irregularity requiring a less deferential standard of review.”93 Similarly, failing to provide a written reply to an appeal has been held to be a “serious procedural irregularity.”94 As noted earlier, the mere presence of a procedural irregularity is not enough to strip a plan administrator of the deferential standard of review. A claimant must also present evidence that the irregularity raises serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator’s whim.”95 The Eighth Circuit has

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90. Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 2347 (2008). This is the Court’s summarization of the Sixth Circuit’s decision setting aside MetLife’s denial of benefits. \textit{Id.} Later in the opinion, the Court stated that these “serious concerns, taken together with some degree of conflicting interests on MetLife’s part, led the court to set aside MetLife’s discretionary decision.” \textit{Id.} at 2352. The Court then held: “We can find nothing improper in the way in which the court conducted its review.” \textit{Id.} In reviewing the Sixth Circuit’s reasoning, the Court said MetLife’s encouraging Glenn to apply for Social Security disability benefits in order to reduce MetLife’s financial obligation (due to offset provisions) and then ignoring the agency’s finding that Glenn was disabled “suggested procedural unreasonableness.” \textit{Id.} Additionally, the Court noted that a lower court would be justified in giving greater weight to the conflict created by MetLife’s dual role status when “MetLife’s seemingly inconsistent positions were both financially advantageous.” \textit{Id.}

91. \textit{Woo}, 144 F.3d at 1161.

92. \textit{Id.} at 1162.

93. Sahulka v. Lucent Techs., Inc. 206 F.3d 763, 769 (8th Cir. 2000).


95. Buttram v. Cent. States, Se. & Sw. Areas Health & Welfare Fund, 76 F.3d
suggested serious doubts would be raised when

the [administrator] does not inquire into the relevant circumstances at issue; where the [administrator] never offers a written decision, so that the [claimant] and the court cannot properly review the basis for the decision; or where procedural irregularities are so egregious that the court has a total lack of faith in the integrity of the decision making process . . . \textsuperscript{96}

In such cases, “a court may infer that the trustee did not exercise judgment when rendering the decision.”\textsuperscript{97}

In most cases it will be necessary to examine evidence outside the administrative record in order to determine whether justification exists for applying a less deferential standard. For example, in \textit{Armstrong v. Aetna Life Insurance Co.}, the claimant was able to demonstrate the existence of Aetna’s payment plan that provided “incentives and bonuses to its claims reviewers based on criteria that include[d] a category called ‘claims savings.’”\textsuperscript{98} This information would not have been included in the administrative record generated by Aetna. Similarly, if the interpretation of a plan term is at issue, discovery to determine whether the plan has consistently interpreted the provision is necessary under factor four of the \textit{Finley} test (i.e., whether the administrator has interpreted the provisions at issue in a consistent fashion).\textsuperscript{99} The only way an attorney is going to obtain such information is to request it during the administrative appeal process. The administrator will probably refuse to produce information at that time and the attorney will be forced to pursue it once a lawsuit is filed.\textsuperscript{100}

While supplementing the administrative record with evidence to support a claim for less deferential review is allowed, it is more difficult to

\textsuperscript{896, 900 (8th Cir. 1996).}
\textsuperscript{96} Id.
\textsuperscript{97} Id.
\textsuperscript{98} Armstrong v. Aetna Life Ins. Co., 128 F.3d 1263, 1265 (8th Cir. 1997) (citation omitted).
\textsuperscript{100} Menz v. Procter & Gamble Health Care Plan, 520 F.3d 865, 871 (8th Cir. 2008) (“If a conflict of interest is not apparent from the [administrative] record, the district court may permit discovery and supplementation of the record to establish these facts if the plaintiff makes a showing of good cause.”); \textit{see also} Barnhart v. UNUM Life Ins. Co. of Am., 179 F.3d 583, 589 (8th Cir. 1999) (stating that plaintiff’s efforts to demonstrate procedural irregularities could have been established by “properly conducted discovery”).
convince the court to consider evidence outside the administrative record on the merits of the appeal. “Such additional evidence gathering is ruled out on deferential review, and discouraged on de novo review to ‘ensure expeditious judicial review of ERISA benefit decisions and to keep district courts from becoming substitute plan administrators,’”101 However, “a district court may admit additional evidence in an ERISA benefit-denial case . . . if the plaintiff shows good cause for the district court to do so.”102

D. Applicable Statute of Limitations

The above discussion has focused primarily on how to develop the administrative record in an ERISA case and the applicable standard of review. Another equally compelling concern for the claimant’s advocate is whether the statute of limitations has passed in a given case. This issue turns, in part, on the question of whether the claim advanced is a breach of fiduciary duty claim or a benefit claim.

If the claim presented is a breach of fiduciary duty claim under 29 U.S.C. § 1132(a)(2) or (3), the statute of limitations is set forth in 29 U.S.C. § 1113 (2000).103 Under § 1113, the statute of limitations is the earlier of six years after the date of the last action that constituted part of the breach or three years after the earliest date on which the plaintiff had actual knowledge of the breach.104 If, however, the claim presented is a benefit claim under § 1132(a)(1)(B), additional analysis is required.

“Because ERISA has no statute of limitations for actions to recover plan benefits,” federal courts apply “the most analogous state statute of limitations.”105 In most cases, this will mean turning to the most applicable

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102. Id. (citing Ravenscraft v. Hy-Vee Employee Benefit Plan & Trust, 85 F.3d 398, 402 (8th Cir. 1996)); see also Davidson v. Prudential Ins. Co. of Am., 953 F.2d 1093, 1095 (8th Cir. 1992) (providing a discussion of factors relevant when showing good cause).
105. Ducheck v. Blue Cross & Blue Shield of Neb., 153 F.3d 648, 649 (8th Cir. 1998); see also Robbins v. Iowa Road Builders Co., 828 F.2d 1348, 1353 (8th Cir. 1987) (“The characterization of [a federal claim] for statute of limitations purposes is derived from the elements of the cause of action, and Congress’ purpose in providing it. These, of course, are matters of federal law . . . . Only the length of the limitations period, and closely related questions of tolling and application, are to be governed by state law.”)
state contract statute of limitations. Some states’ statutes contain more than one contract statute of limitations; in these states, the court chooses the most analogous of the competing contract statutes of limitations. For those states located within the Eighth Circuit, the applicable breach of contract statute of limitations applied to ERISA benefit claims are as follows: Arkansas, five years; Iowa, two years for disability claims and ten years for health insurance benefits claims; Minnesota, three years for


107. For example, in the state of Minnesota, it is not clear whether the two-year statute of limitations for wage payment collection claims under Minn. Stat. § 541.07(5) or the three-year statute of limitations under Minn. Stat. § 62A.04 applies to ERISA disability claims. See Cavegn v. Twin City Pipe Trades Pension Plan, 223 F.3d 827, 830 (8th Cir. 2000) (applying the two-year statute of limitations under Minn. Stat. § 541.07(5) in a case involving a claim of ERISA disability retirement benefits); Adamson v. Armco, Inc., 44 F.3d 650, 652 (8th Cir. 1995) (holding applicable in a Minnesota case involving a claim for ERISA welfare benefits, a two-year statute applicable to wage claims as required by Minn. Stat. §541.07(5), rather than a six-year statute applicable to contracts not falling within a more specific statute of limitations).

But see Weyrauch v. Cigna Life Ins. Co. of New York, 416 F.3d 717, 720 (8th Cir. 2005) (holding that the most applicable Minnesota statute of limitations in an ERISA long-term disability claim was the three-year statute found in Minn. Stat. § 62A.04); Blaske v. UNUM Life Ins. Co. of Am., 131 F.3d 763, 764 (8th Cir. 1997) (holding that the applicable statute of limitations to be applied in an ERISA disability claim case was the three-year statute mandated for health and accident insurance policies by Minn. Stat. § 62A.04). One way to harmonize these decisions is to conclude that when an insurance company is the source of the disability payments, the three-year statute of limitations under Minn. Stat. § 62A.04 applies; on the other hand, if the source of the disability payments is a self-funded ERISA plan, the two-year statute of limitations under Minn. Stat. § 541.07(5) applies.

108. ARK. CODE ANN. § 16-56-111(a) (2005); see Wilkins v. Hartford Life & Accident Ins. Co., 299 F.3d 945, 948 (8th Cir. 2002) (holding Arkansas’ five-year statute under section 16-56-111(a) applies as a maximum period for ERISA benefit lawsuits; however, plan contracts can limit that statutory period so long as the limit is not unreasonably short).

109. In Mead v. Intermec Techs. Corp., the court held that the applicable Iowa statute of limitations for short-term disability claims under an ERISA plan was the two-year statute of limitations under the Iowa Wage Payment and Collection Act. IOWA CODE § 614.1(8) (2001); Mead v. Intermec Techs. Corp., 271 F.3d 715, 717 (8th Cir. 2001). On the other hand, in an Iowa case involving a claim for ERISA health insurance benefits, the court held that the ten-year statute of limitations for contract actions under Iowa Code section 614.1(5) would apply, rather than the two-year statute for wage claims under Iowa Code section 614.1(8). Shaw v. McFarland Clinic, P.C., 363
disability insurance policy claims and two years for disability pension claims;\textsuperscript{110} Missouri, ten years;\textsuperscript{111} Nebraska, five years;\textsuperscript{112} North Dakota, six years;\textsuperscript{113} and South Dakota, six years.\textsuperscript{114}

Many plans include a statute of limitations provision that any claim for benefits must be brought within a specified time period. In most cases, this contractual statute of limitations is less than the state statute of limitations for breach of contract actions. This contractual provision becomes an issue when the claim is timely under the state statute of limitations, but is untimely under the contractual period for bringing suit. In the Eighth Circuit, if the state allows parties to agree to shorten the statute of limitations, the courts have upheld such shortened periods.\textsuperscript{115} However, not all states allow parties to agree to a shorter statute of limitations.\textsuperscript{116}

F.3d 744, 750 (8th Cir. 2004).
\textsuperscript{110} See supra note 107.
\textsuperscript{111} MO. ANN. STAT. § 516.110(1) (West 2002); see Johnson, 942 F.2d at 1265–66 (holding Missouri’s ten-year statute under section 516.110(1) applies to ERISA benefit claims).
\textsuperscript{112} NEB. REV. STAT. § 25-205(1) (2004); see Union Pac. R.R. v. Beckham, 138 F.3d 325, 330 (8th Cir. 1998) (holding Nebraska’s five-year statute of limitations under section 25-205(1) applied to an ERIŞA pension benefit case). But see Ducek v. Blue Cross & Blue Shield of Neb., 153 F.3d 648, 650 (8th Cir. 1998) (in a case in which ERISA did not apply, holding the applicable statute of limitations for a group health insurance claim was not less than three years under Neb. Rev. Stat. sections 44-767 and 44-710.03(11)); Brodine v. Blue Cross Blue Shield of Neb., 724 N.W.2d 321, 326–27 (Neb. 2006) (holding in an ERISA case that the applicable statute of limitations for a group health insurance claim was not less than three years under Neb. Rev. Stat. sections 44-767 and 44-710.03(11)).
\textsuperscript{114} S.D. CODIFIED LAWS § 15-2-13(1) (2004); see Anderson v. John Morrell & Co., 830 F.2d 872 (8th Cir. 1987) (applying section 15-2-13(1) to an ERISA retirement health benefit claim).
\textsuperscript{115} See Wilkins v. Hartford Life & Accident Ins. Co., 299 F.3d 945 (8th Cir. 2002) (applying Arkansas law and approving a contractual limitation which shortened the state five-year statute of limitations to three years on the grounds that the “stipulated time was not unreasonably short”); Davidson v. Wal-Mart Assocs. Health & Welfare Plan, 305 F. Supp. 2d 1059, 1074 (S.D. Iowa 2004) (applying Iowa law and finding a contractual limitations period in an ERISA health insurance policy that shortened the ten-year statute of limitations to forty-five days was reasonable); Henning Nelson Const. Co. v. Fireman’s Fund Am. Life Ins. Co., 361 N.W.2d 446, 450–51 (Minn. Ct. App. 1985) (“Limitation of suit clauses in insurance policies are strictly construed against the party invoking them . . . and will only be enforced when the party seeking enforcement shows it will be prejudiced.”) (citation omitted).
\textsuperscript{116} See MO. ANN. STAT. § 431.030 (West 2002) (“All parts of any contract or
III. CONCLUSION

In summary, a multitude of private sector employees are covered by disability plans that are governed by ERISA. When an employee’s claim for disability benefits is denied, it is critical that the attorney representing the claimant exercise diligence in obtaining all documents the administrator relied on to deny the claim. Having acquired this information, the attorney must determine what additional material is necessary to supplement the existing administrative record. When writing an appeal for the claimant, the attorney must understand the body of Eighth Circuit case law applied to the review of ERISA disability claims and, accordingly, highlight evidence that will support an argument for application of the most favorable standard of review under the facts of the case. If the attorney follows these recommendations, his client’s chances of success at the administrative and judicial levels are significantly increased.