

Disability Insurance Under the ERISA Law: Economic Security or Litigation Nightmare?

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Introduction

Insurance company statistics show that "one out of five 35-year-olds will experience a disability that lasts three months or more before age 65." n1 Working women are even more adversely affected and are deemed "three times more likely than men to miss work due to a disability related illness." n2 According to the Social Security Administration, which pays benefits to disabled individuals incapable of engaging in any work whatsoever, n3 more than 2.1 million individuals applied for Social Security disability insurance in 2005, a 4.39% increase over the prior year. n4 Thus, meeting one's economic needs in the event of disability is a major concern.

n1 www.massmutual.com/mmfg/service/di/whygetdi.html.

n2 www.efinooddy.com/insurance/disabilitystatistics.html.

n3 For a definition of "disability" under the Social Security disability program, see 42 U.S.C. § 423(d)(1)(A).

n4 www.ssa.gov/OACT/STATS/dibStat.html.

Most individuals who are covered by disability insurance receive that coverage from their employers as a benefit of their employment. n5 As such, any dispute over the benefit payment is governed by the Employee Retirement Income Security Act (ERISA). n6 Unquestionably, the ERISA law was enacted to provide substantial protection to employees based on the statute's preamble, stating its intent to:

protect . . . 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. n7

n5 *See, generally, J. Wooten, The Employee Retirement Income Security Act of 1974 -- A Political History* (U.Cal. Press 2005).

n6 29 U.S.C. § 1001 *et seq.* The ERISA law's scope extends to benefits provided for the welfare of employees, which includes disability insurance. 29 U.S.C. § 1002(1). However, it does not include situations where the employer simply makes insurance coverage available for employees to purchase. *See, Johnson v. Watts Regulator Co.*, 63 F.3d 1129 (1st Cir. 1995).

n7 29 U.S.C. § 1001(b), quoted in *Varity Corporation v. Howe*, 116 S.Ct. 1065, 1078 (1996); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 123 S.Ct. 1965, 1970 (2003). "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989) (internal quotation marks and citations omitted).

Assurance that disability benefits will be available in time of need is crucial because, as one judge has recognized, "decisions whether and how to ensure that disability does not lead to poverty are obviously of great societal importance." n8 Social Security does not completely fill that role because it provides only a small portion of earnings re-

placement, society relies on private insurers. Yet, preemption of disability insurance claims by the ERISA law has, despite its salutary purpose, been fraught with peril as one court noted:

There are also obvious drawbacks to relying on private insurers, however. Although the profit motive drives companies toward efficiency, it creates a substantial risk that they will cut costs by denying valid claims. The market is somewhat inapt to punish insurers for engaging in such practices, particularly if the denials are not too flagrant, because the complexity of the insurance market and the imperfect information available to consumers make it difficult to determine whether an insurer is keeping its costs down through legitimate or illegitimate means. An individual claimant who encounters an insurance company that is disposed to deny valid claims must struggle to vindicate his rights at a time when he is at his most vulnerable. Often a newly disabled person will simultaneously confront increased medical bills and either termination of employment or diminished pay.

The judiciary provides a check on these potential abuses; under ERISA, aggrieved claimants can seek redress in the courts of justice. Congress and the courts have made two decisions, however, that limit this checking effect. The first is to place limitations on judicial review of plan administrators' and fiduciaries' decisions similar to the ones placed on judicial review of governmental agency action, even though, unlike officials in governmental agencies, administrators and fiduciaries are not answerable to the public or to elected officials. Second, and perhaps more troubling, the courts have interpreted ERISA to restrict or eliminate the role of juries in deciding disputes between claimants and insurers. n9

n8 *Radford Trust v. Unum Life Insur. Co. of America*, 321 F.Supp.2d 226, 240 (D.Mass. 2004).

n9 *Id.*

Another court expressed similar worry:

Caveat Emptor! This case attests to a promise bought and a promise broken. The vendor of disability insurance now tells us, with some legal support furnished by the United States Supreme Court, that a woman determined disabled by the Social Security Administration because of multiple disabilities which prevent any kind of work cannot be paid on the disability insurance she purchased through her employment. The plan and insurance language did not say, but the world should take notice, that when you buy insurance like this you are purchasing an invitation to a legal ritual in which you will be perfunctorily examined by expert physicians whose objective it is to find you not disabled, you will be determined not disabled by the insurance company principally because of the opinions of the unfriendly experts, and you will be denied benefits. n10

n10 *Loucks v. Liberty Life Assur. Co. of Boston*, 337 F.Supp.2d 990 (W.D.Mich. 2004) (vacated following settlement).

Judicial commentary has led to media scrutiny. The story of how a law intended to protect employee benefits has been used to shield insurers was told in the *Los Angeles Times* by Peter G. Gosselin in his article, "The Safety Net She Believed in Was Pulled Away When She Fell." n11 The *Wall Street Journal* similarly reported that the ERISA statute "has evolved into one that covers far broader territory and can have an unanticipated effect, tilting the playing field in favor of employers and serving as a legal shield for them." n12 Unfortunately, there is much to be concerned about; a law enacted for the protection of plan participants has been construed by the courts in a manner that has caused great uncertainty, if not outright harm.

n11 *Los Angeles Times*, August 21, 2005.

n12 Ellen Schultz, "A Hobbled Star Battles the NFL," *Wall Street Journal*, December 3, 2005.

The Transformation Wrought by ERISA

Transforming "garden variety" insurance cases into ERISA claims has always been viewed with skepticism by the federal judiciary. The 7th U.S. Circuit Court of Appeals remarked in the health benefits context:

All this is not to deny the strangeness, as an original matter, of transforming disputes between employees and insurance companies over the meaning of the insurance contract into suits under ERISA. But the Supreme Court crossed this Rubicon in *Metropolitan Life Ins. Co. v. Taylor*, supra, reversing *Taylor v. General Motors Corp.*, 763 F.2d 216 (6th Cir. 1985), which had held that a suit under the group insurance policy was not a suit under the ERISA plan pursuant to which the policy had been issued. Although we find it difficult to understand why such cases should be litigated in federal court, we are unable to escape the pull exerted by the statute, the administrative regulation, and the precedents. n13

n13 *Brundage-Peterson v. Compcare Health Services Ins. Corp.*, 877 F.2d 509, 512 (7th Cir. 1989).

Another judge, writing in a law review commented about the ERISA law's effect:

Occasionally, a statute comes along that is so poorly contemplated by the draftspersons that it cannot be saved by judicial interpretation, innovation, or manipulation. It becomes a litigant's plaything and a judge's nightmare. ERISA falls into this category. In *Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield*, n14 I started my opinion with these three sentences:

A hyperbolic wag is reputed to have said that E.R.I.S.A. stands for "Everything Ridiculous Imagined Since Adam." This court does not take so dim a view of the Employee Retirement Income Security Act of 1974. Instead, this court is willing to believe that ERISA has lurking somewhere in it a redeeming feature. n15

Since writing *Florence Nightingale*, I have changed my mind. ERISA is beyond redemption. No matter how hard the courts have tried, and they have not tried hard enough, they have not been able to elucidate ERISA in ways that will accomplish the purposes Congress claimed to have in mind. For more than ten years, I have consistently and constantly criticized ERISA, and I feel no compunction in lifting passages from my prior opinions as I write this article. I cannot plagiarize myself. n16

n14 832 F. Supp. 1456 (N.D. Ala. 1993), aff'd, 41 F.2d 1476 (11th Cir. 1995).

n15 *Id.* 1457.

n16 William Acker, Jr., "Can the Courts Rescue ERISA?" 29 *Cumb.L.Rev.* 285, 285-86(1999).

Perhaps the U.S. Congress imagined the paternalistic goals of the ERISA law would protect claimants. Sadly, that has not proven to be the case at all. On October 3, 2005, the California Department of Insurance accused the world's largest disability insurer, UnumProvident Corporation of unfair claims practices. California's report was the third market conduct investigation of the UnumProvident Corporation and its subsidiaries n17 that corroborated the conclusions made in numerous court rulings finding pervasive claim abuses by affiliates of the UnumProvident Corporation. n18

n17 See, report of John Oxendine, Georgia Insurance Commissioner, November 30, 2000, and a multi-state market conduct investigation report (covering 49 states and the U.S. Department of Labor) issued November 18, 2004.

n18 See, *Radford Trust, supra.*, 321 F.Supp.2d at 247-48 n.20 (cataloguing cases).

Few questions have been raised, however, about why an insurer would risk the consequences of engaging in such pervasive misconduct. The answer, perhaps, lies in the regime created by the courts' interpretation and application of the ERISA law. Insurers have become well-aware of the advantages that have been handed to them as a result of court rulings that claims brought under their policies are pre-empted n19 by the ERISA law. Although ERISA preemption ostensibly does not extend to state laws that regulate insurers, the U.S. Supreme Court has narrowly interpreted that exception to find the ERISA law insulates insurers from punitive damages and "bad faith" awards that exist in the non-ERISA context. n20 Not surprisingly, insurers have reacted to that development by seeking to expand ERISA preemption, as one insurer's internal memo shows:

A [company] task force has recently been established to promote the identification of [disability] policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, [a company employee] identified 12 claim situations where we settled for \$ 7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and \$ 0.5 million.

In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. [While] our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action. n21

n19 Section 514 of the ERISA statute, 29 U.S.C. § 1144, preempts any state law that "relates to" an employee benefit plan.

n20 *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S.Ct. 2488 (2004).

n21 "Provident Internal Memorandum," titled "Re: ERISA," from Jeff McCall to IDC Management Group and Glenn Felton, October 2, 1995, Bates No. GSCONF 2893, available at www.micethatroar.com/erisa-memo.pdf.

A leading ERISA-law scholar, professor John Langbein of the Yale Law School, has taken note of this situation and has written:

Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga lacks legal policy implications. On this view, a rogue insurance company behaved exceptionally badly; it got caught and sanctioned; and its fate should deter others. My reading of the events is less sanguine: . . . a self-interested plan decisionmaker will take advantage of its license under *Bruch* to line its own pockets by denying meritorious claims. Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect. n22

n22 Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA" at 12 (June 26, 2006, draft available at www.law.yale.edu/faculty/2940.asp). (Accepted for publication in *Northwestern University Law Review*.)

Professor Langbein is entirely correct. It was not the preclusion of punitive damages alone that led to the current situation. The real transformation of insurance claims governed by the ERISA law occurred after the U.S. Supreme Court's 1989 ruling in *Firestone Tire & Rubber Co. v. Bruch*,ⁿ²³ which had the effect of conferring a special status on insurers who issue policies governed by the ERISA law by giving them unparalleled authority to determine claims in their discretion. *Firestone* ruled that any benefit plan, be it funded or insured, is entitled to a standard of judicial review that gives deference to the insurer's findings so long as the plan says that benefits will be paid only if the plan administrator determines in its discretion that the claimant is entitled to them.ⁿ²⁴ This was a startling conclusion in light of the observation made in *Luby v. Teamsters Health, Welfare and Pension Trust Funds*,ⁿ²⁵ where a federal court of appeals explained:

Plan administrators are not government agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting or other training preparing them for their responsible position, often without any expertise in or understanding of the complex problems arising under ERISA, and, as this case demonstrates, little knowledge of the rules of evidence or legal procedures to assist them in factfinding.ⁿ²⁶

ⁿ²³ 489 U.S. 101(1989).

ⁿ²⁴ For more detail on this topic, read the author's article, titled "Discretionary Clauses and Insurance," which was published in the Fall 2006 issue of the JIR.

ⁿ²⁵ 944 F.2d 1176 (3d Cir. 1991).

ⁿ²⁶ 944 F.2d at 1183.

However, *Luby* has been ignored while the discretionary powers of insurers have been expanded. The regime that has followed has been the courts' betrayal of the protections of employee benefits promised by the U.S. Congress by limiting claimants' rights and remedies, and by encouraging increasingly aggressive claims denial tactics by insurers.

Fundamental Due Process?

In addition to questions about insurers' fairness in administering claims, ERISA cases are litigated in a *sui generis* manner that departs dramatically from other forms of litigation. While some courts have characterized ERISA claims as "review proceedings," that interpretation lacks statutory support. Civil actions authorized by § 502 of the Employee Retirement Income Security Actⁿ²⁷ are not "review proceedings" of a claim record. The U.S. Congress' authorization of a "civil action . . . to recover benefits due . . . under the terms of [a] plan"ⁿ²⁸ should entitle claimants to a plenary court proceeding rather than a claim record review under the principles enunciated in *Chandler v. Roudebush*.ⁿ²⁹

ⁿ²⁷ 29 U.S.C. § 1132(a) (2006).

ⁿ²⁸ *Id.*

ⁿ²⁹ 425 U.S. 840 (1976).

In *Chandler*, the identical issue arose with respect to employees bringing civil actions to redress discrimination in federal employment pursuant to § 717(c) of the Civil Rights Actⁿ³⁰ While some lower courts had ruled that such actions involved a review of the record made at prior administrative proceedings, the U.S. Supreme Court overruled those decisions and held that federal employees were entitled to discovery and a trial rather than a review proceeding, explaining: "Nothing in the legislative history indicates that the federal-sector "civil action" was to have this chameleon-like

character, providing fragmentary de novo consideration of discrimination claims where "appropriate," *ibid.*, and otherwise providing record review." n31 The U.S. Supreme Court added:

In most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like "substantial evidence," which has "become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." *Ibid.* e.g., 5 U.S.C. § 706 (scope-of-review provision of Administrative Procedure Act); 12 U.S.C. § 1848 (scope-of-review provision applicable to certain orders of the Board of Governors of the Federal Reserve System); 15 U.S.C. § 21(c) (scope-of-review provision applicable to certain orders of the Interstate Commerce Commission, the Federal Communications Commission, the Civil Aeronautics Board, the Federal Reserve Board, and the Federal Trade Commission); 21 U.S.C. § 371(f)(3) (scope-of-review provision applicable to certain orders of the Secretary of Health, Education, and Welfare). n32

n30 42 U.S.C. § 2000e *et seq.*

n31 425 U.S. at 861.

n32 425 U.S. at 862 n.37.

Applying *Chandler's* analysis, it is evident that nowhere in the statute itself or in the legislative history of the ERISA law is the term "substantial evidence" used; nor is there any support for a conclusion that the U.S. Congress intended that ERISA civil actions would be review proceedings.

Many courts have cited ERISA's statutory history as a rationale for deeming ERISA claims review proceedings, deriving that conclusion from a congressional report describing ERISA as providing "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously," n33 However, a closer examination of that quotation shows it can be traced to Senate Report 93-383 accompanying S.1179, a predecessor to the bill that eventually became the ERISA law. The draft bill afforded pension claimants the opportunity to pursue a grievance or arbitration proceeding before the U.S. Secretary of Labor; and the report refers to such a proceeding as providing "the opportunity to resolve any controversy over [] retirement benefits under qualified plans in an inexpensive and expeditious manner. . . Accordingly, the committee has decided to provide that controversies as to retirement benefits are to be heard by the Department of Labor." n34

n33 *Perry v. Simplicity Engineering*, 900 F.2d 963, 967 (6th Cir. 1990).

n34 S.Rep. 93-383, reprinted in 1974 U.S. Code Cong. and Admin. News 5000.

That provision was dropped from the final bill, however; n35 and nowhere in the ERISA statute are there provisions limiting the manner in which the courts are to resolve civil actions brought by plan participants. On the contrary, the conference report explained that ERISA civil actions "are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor-Management Relations Act of 1947." n36 According to *Textile Workers Union v. Lincoln Mills*, n37 Section 301 n38 requires the federal courts to "fashion from the policy of our national labor laws" a federal common law governing the interpretation of collective bargaining agreements that includes plenary proceedings that even encompass trials before juries. n39

n35 Sen. Jacob Javits, one of ERISA's main sponsors, explained that House conferees were opposed to an administrative dispute mechanism "on grounds it might be too costly to plans and a stimulant to frivolous benefit disputes, and at their insistence it was dropped in conference." 3 Legislative History of ERISA, n. 4 at 4769.

n36 H.R. Conf. Rep. 93-1280, 93d Cong., 2d Sess. 327 (1974).

n37 353 U.S. 448, 456 (1957).

n38 29 U.S.C. § 185.

n39 See, *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*, 494 U.S. 558 (1990).

Nor can any argument be made that pre-suit appeals authorized by ERISA § 503 n40 substitute for plenary judicial proceedings. The statutory history of that provision makes it clear that the absence of an evidentiary hearing or even an arbitral forum prior to suit mandates plenary procedures. n41 Further, the absence of an administrative hearing or discovery proceedings from the claim regulations applicable to § 503, n42 while such provisions are included in relation to adjudication of other ERISA violations, n43 underscores the need for plenary proceedings for plan participants who initiate civil actions to redress benefit claim denials.

n40 29 U.S.C. § 1133 (2006).

n41 According to the House conference report, § 1133 was included as a compromise between the original House bill, which had no such provision and the Senate bill, which provided for review and arbitration of benefit disputes. H.R.Rep.No.93-1280, 93d Cong., 2d Sess., reprinted in 1974 U.S.Code Cong. & Ad.News 5038, 5108.

n42 29 C.F.R. § 2560.503-1 (2006).

n43 29 C.F.R. §§ 2560.502i-1, 2570.7 and 2570.11 (2006).

Moreover, the U.S. Supreme Court has also signaled that ERISA suits were intended to be plenary proceedings. In *Firestone*, the court explained: "Unlike the LMRA n44 [29 U.S.C. § 186(c)(2) 2006], ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans." n45 Subsequently, the U.S. Supreme Court commented in *Rush Prudential HMO, Inc. v. Moran*, n46

[ERISA] requires plans to afford a beneficiary some mechanism for internal review of a benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)(1)(B). Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations* (citation omitted) (emphasis added).

n44 Cases such as *Beam v. Intl. Org. of Masters, Mates and Pilots*, 511 F.2d 975, 980 (2d Cir. 1975) had characterized Labor Management Relations Act of 1947 (LMRA) proceedings as seeking review of trustees' determinations after pointing out that "review in this case is not the examination of a dispute between an insurance company with a boilerplate contract on one hand and a consumer on the other." In contrast, that is exactly what occurred here; and unlike benefit trusts established under the LMRA, where both management and the employees appoint trustees, the decision-maker here was an insurance company, further supporting this court's distinction between claims under the LMRA and ERISA claims.

n45 489 U.S. at 110.

n46 536 U.S. 355, 385 (2002).

Of at least equal importance is the U.S. Supreme Court's finding that the U.S. Congress created a civil action for plan participants with the intent that the law not result in "less protection to employees and their beneficiaries than they

enjoyed before ERISA was enacted." n47 Before ERISA, federal courts applied contract law to resolve employee benefits disputes. n48 Unquestionably, but for the ERISA law, disputes involving benefit denials issued by insurers would be resolved through plenary court proceedings. n49 Moreover, even under the common law of trusts, which underpins much of the ERISA statute according to *Firestone*, plenary proceedings were the norm prior to ERISA. n50 Thus, in the words of a commentator critical of how the ERISA law has been interpreted:

Yet even if there were some basis for believing that the treatment of a benefit suit as an evidentiary proceeding would interfere with "prompt resolution of claims by the fiduciary," the rationale would still fail. For it to be plausible, one would have to add two premises: that "prompt resolution of claims" is something Congress intended for the protection of sponsors and fiduciaries; and that such protection of sponsors and fiduciaries is more important than protection of the participants' right to receive benefits due. Merely to state these premises is to reveal their untenability. n51

n47 489 U.S. at 114.

n48 See, *Brief of Solicitor General as Amicus Curiae in Firestone*, 1987 U.S. Briefs 1054, at 5 n.7xo.

n49 See, e.g., *Cox v. Washington Natl. Insw. Co.*, 520 S.W.2d 76 (Ct.App.Mo. 1974) (employer sponsored disability benefit claim accorded plenary civil procedure); *Antram v. Stuyvesant Life Insur. Co.*, 287 So.2d 837 (Ala. 1973) (same).

n50 See, e.g., *Barnett v. Ross*, 333 Pa. 510, 3 A.2d 923, 925 (Pa. 1939) (in an action for breach of implied trust by fiduciary, plaintiff beneficiary may seek a bill of discovery in equity to support a claim of existence of trust and misconduct of alleged trustee); *Phelps Dodge Corp. v. Brown*, 112 Ariz. 179, 540 P.2d 651 (1975) (jury trial conducted); *Matthews v. Swift & Co.*, 465 F.2d 814 (5th Cir. 1972) (plenary bench trial of pension and disability claim despite arbitrary and capricious standard of review).

n51 Jay Conison, "Suits for Benefits under ERISA," 54 U.Pitt.L.Rev. 1, 57-60 (1992).

Even if one accepts the premise of allowing a deferential standard of review to apply to claim adjudications, courts should not blur the distinction between a plenary proceeding and a *de novo* standard of court review. Even under an arbitrary and capricious standard of review, a court must examine in the first instance whether the decision-maker "entirely failed to consider an important aspect of the problem [or] offered an explanation for its decision that runs counter to the evidence." n52 Another expression of the content of a review under an arbitrary and capricious standard suggests that such an examination, while deferential:

inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan was able to find a single piece of evidence -- no matter how obscure or untrustworthy -- to support a denial of a claim for ERISA benefits. n53

n52 *Motor Vehicle Mfr. Ass'n v. State Farm Mutual Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

n53 *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172-173 (6th Cir. 2003) (citation omitted).

Consequently, a showing of whether a plan administrator's determination is arbitrary and capricious requires that the claimant be afforded the same tools as any other litigant bringing a civil action in the district court. Rule 1 of the Federal Rules of Civil Procedure mandates applicability of the rules to all civil actions other than those enumerated in Rule 81, with no exception made for ERISA cases. Indeed, in *New Hampshire Fire Ins. Co. v. Scanlon*, n54 the U.S.

Supreme Court explained the presumption against summary proceedings in any claim governed by the Federal Rules of Civil Procedure:

Summary trial of controversies over property and property rights is the exception in our method of administering justice. Supplementing the constitutional, statutory, and common-law requirements for the adjudication of cases or controversies, the Federal Rules of Civil Procedure provide the normal course for beginning, conducting, and determining controversies. Rule 1 directs that the Civil Rules shall govern all suits of a civil nature, with certain exceptions stated in Rule 81 none of which is relevant here. Rule 2 directs that "There shall be one form of action to be known as 'civil action.'"

n54 362 U.S. 404, 406 (1960).

By imposing a lenient regime of claim review, outside of the scope of the normal rules of procedure, claimants are denied a fair consideration of their claims by the court. As professor Langbein remarks:

Deciding a case on the merits is indeed more time-consuming than presuming the correctness of somebody else's self-serving decision. Because, however, Congress determined to subject ERISA-plan denials to federal judicial review, and because ERISA's draconian preemption provision suppresses the state law causes of action that existed for many such cases before ERISA, the proper role of the federal courts is to decide these cases fairly and not slough them off onto biased decisionmakers. n55

n55 Langbein, *Trust Law*, *supra*, at 34-35.

Thus, the courts need to more carefully examine the regime they have created.

The Value of Discovery

The only feasible way to ensure fairness in ERISA claim disputes is if the right to take discovery is preserved. Because courts are being called upon, even under an arbitrary and capricious standard of review, to assess the quality of the evidence presented, the only means by which the courts can be assured the evidence presented is scientifically and clinically valid and free from bias is through discovery. For precisely that reason, in *Calvert v. Firststar Finance, Inc.*, n56 the 6th U.S. Circuit Court of Appeals noted concern about consultants hired by insurers to review claims: "As the plan administrator, Liberty had a clear incentive to contract with individuals who were inclined to find in its favor that Calvert was not entitled to continued LTD benefits." n57 Consequently, the 6th Circuit made it clear that discovery would provide "a better feel for the weight to accord this conflict of interest." 409 F.3d at 293 n.2. The court was referring to the insurer's conflicting roles as plan administrator and benefit payor.

n56 409 F.3d 286 (6th Cir. 2005).

n57 409 F.3d at 292. The U.S. Supreme Court also commented in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832 (2003) that "physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers[] money and preserve their own consulting arrangements." (citation omitted).

The majority of federal courts approve of discovery aimed at uncovering potential bias. n58 However, the 7th Circuit has remained adamant in denying claimants the opportunity to take any discovery whatsoever. Most recently, in *Semien v. Life Insurance Co. of North America*, n59 the court reiterated a general prohibition against discovery, allowing discovery only if the insured could first produce credible evidence justifying discovery. However, the court's reasoning is circular because it is usually impossible to present such evidence without first conducting discovery. Without discovery, an insured is left with no means of proving bias or establishing the insurer's decision was arbitrary and capri-

cious. Indeed, discovery fulfills professor John Henry Wigmore's assertion that cross-examination is "beyond any doubt the greatest legal engine ever invented for the discovery of truth." n60

n58 For example, the 1st Circuit allows discovery relating to corruption in the claim review process. *Liston v. Unum Corp. Officer Severance Plan*, 330 F.3d 19 (1st Cir. 2003). Conflict of interest discovery is also permitted in the 2nd Circuit (*Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163 (2d Cir. 2001)); the 3rd Circuit (*Pinto v. Reliance Standard Life Insur. Co.*, 214 F.3d 377 (3d Cir. 2000)); the 5th Circuit (*Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004) ("There is no practical way for the extent of the administrator's conflict of interest to be determined without the arbitrator going beyond the record of the administrator.")); the 8th Circuit (*Farley v. Arkansas Blue Cross & Blue Shield*, 147 F.3d 774 (8th Cir. 1998)); the 9th Circuit (*Tremain v. Bell Industries*, 196 F.3d 970 (9th Cir. 1999)); and the 11th Circuit (*Moon v. American Home Assur.Co.*, 888 F.2d 86 (11th Cir. 1989)).

n59 436 F.3d 805 (7th Cir. 2006) -- cert. denied 166 L.Ed.2d 251 (2006).

n60 5 J. Wigmore, *Evidence* § 1367, p. 32 (J. Chadbourn rev. 1974).

Where discovery has been allowed in ERISA cases, the results have been enlightening. For example, in *Bedrick v. Travelers Insur. Co.*, n61 depositions of the insurer's consultants taken by the plaintiff in a claim challenging a health insurer's denial of physical, speech and occupational therapy to a child suffering from cerebral palsy showed bias and a lack of adequate expertise. *Miller v. United Welfare Funa* n62 also relied on deposition testimony of a disability benefit plan administrator to find that none of the decision-makers involved in denying a claimant's request for benefits understood the medical information in the claimant's file, thus leading to a conclusion that the benefit determination was arbitrary and capricious. Thus, as *Nagele v. Electronic Data Sys. Corp.* n63 observed:

as the arbitrary and capricious standard requires courts to scrutinize, although deferentially, decisions by plan fiduciaries for lack of reasonableness, including the absence of substantial evidence, such deficiencies in the administrative review function can be significantly illuminated through the reasonable exercise of standard discovery devices available in federal civil practice. n64

n61 93 F.3d 149 (4th Cir. 1996).

n62 72 F.3d 1066, 1072 (2d Cir. 1995).

n63 193 F.R.D. 94 (W.D.N.Y. 2000).

n64 193 F.R.D. at 104.

Therefore, because the arbitrary and capricious standard of review is made more meaningful, rather than diminished, by allowing discovery, the disallowance of discovery appears unfounded.

The Misapplication of Administrative Law

It is hard to understand how the courts have created their unique adjudicative procedures for ERISA claims. The only possible answer is that rather than applying the framework established by the Federal Rules of Civil Procedure for the adjudication of civil actions, the courts have transformed the ERISA law into a quasi-administrative law devoid of the protections that comprise a fair administrative hearing. n65 Instead of recognizing insurers' conflicts, courts have analogized insurance companies' claim processes to the equivalent of a judge presiding over a trial. However, that model has been rejected. *Gaither v. Aetna Life Ins. Co.* n66 relied on an earlier ruling, *Gilbertson v. Allied Signal, Inc.*, n67 in rejecting a judicial model of claim administration in a disability benefit case governed by the ERISA law:

Aetna's position seems to be that as a plan fiduciary, it plays a role like that of a judge in a purely adversarial proceeding, where the parties bear almost all of the responsibility for compiling the record, and the judge bears little or no responsibility to seek clarification when the evidence suggests the possibility of a legitimate claim. The authority just cited suggests that Aetna has the wrong model. Indeed, one purpose of ERISA was "to provide a nonadversarial method of claims settlement" (citation omitted). In *Gilbertson v. Allied Signal, Inc.*, we explained what this nonadversarial process should look like:

[ERISA and its implementing regulations require] a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied . . . the reason for the denial must be stated in reasonably clear language, . . . [and] if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it's how civilized people communicate with each other regarding important matters.

328 F.3d 625, 635 (10th Cir. 2003) (emphasis added) (citation omitted).

While a fiduciary has a duty to protect the plan's assets against spurious claims, it also has a duty to see that those entitled to benefits receive them. It must consider the interests of deserving beneficiaries as it would its own. An ERISA fiduciary presented with a claim that a little more evidence may prove valid should seek to get to the truth of the matter. n68

n65 See, generally, DeBofsky, "The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims," 37 *John Marshall Law Review* 727 (2004).

n66 394 F.3d 792 (10th Cir. 2004).

n67 328 F.3d 625 (10th Cir. 2003).

n68 394 F.3d at 807-808 (10th Cir. 2004).

Indeed, the reason *Gaither* rejected the analogy between ERISA plan administrators and federal judges is that a self-interested insurer lacks the judiciary's independence. Surely, any judge asked to decide a dispute where the judge's personal physician was a crucial witness would recuse. n69 Paradoxically, however, many courts find no impropriety in insurers' reliance on their employee-physicians' opinions rather than independent reviews or examinations.

n69 According to 28 U.S.C. § 455(a), "[a]ny justice, judge, or magistrate judge of the United States shall disqualify himself in any proceeding in which his impartiality might reasonably be questioned." The goal of 28 U.S.C. § 455(a) is to "avoid even the appearance of partiality." *Liljeberg v. Health Servs. Acquisition Corp.*, 486 U.S. 847, 860 (1988).

Nor are disability benefit claims adjudicated under the ERISA law comparable, as some courts apparently believe, to Social Security benefit disputes. Unlike the "Social Security Administration [which] is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge," n70 insurers are private entities who are under no statutory duties to conduct hearings before neutral decision-makers. Hence, in comparing claim decisions made by insurers in disability benefit cases to Social Security benefit determinations, the courts need to question why they have given private insurers more authority and why there is less penetrating review of insurers' claim determinations than an administrative agency receives.

n70 *Herzberger v. Standard Insur. Co.*, 205 F.3d 327, 332 (7th Cir. 2000).

Further, without giving the plaintiff the opportunity to cross-examine the insurer's consultants, the Court of Appeals' conclusion in *Semien* n71 that the reviewing doctors' opinions "demonstrate a thorough consideration of the available information" n72 has no evidentiary support. Acceptance of the consultants' reports as substantial evidence without the plaintiff being given the opportunity to cross-examine the witnesses would even run afoul of administrative procedures. Based on the U.S. Supreme Court's seminal ruling on due process in *administrative law* claims, *Richardson v. Perales*, n73 a case involving Social Security disability benefits, non-examining consultants' reports are insufficient. In *Perales*, the court ruled an *examining* physician's report may constitute substantial evidence in an administrative proceeding only when nine separately enumerated assurances of trustworthiness were met. n74 None of those protections, which include the tribunal's acceptance of reports only if prepared by percipient witnesses who had personally conducted a clinical, scientifically valid medical examination, and only when the claimant retained the opportunity to cross-examine the authors of the reports, are present in ERISA cases. Nor are pre-suit appeals in ERISA claims, which are decided by the insurance company that has already denied benefits, adjudicated by a body possessing the same neutrality and objectivity as an administrative agency, or even by an arbitrator. n75

n71 *Supra*, note 59.

n72 43 6 F.3d at 812.

n73 402 U.S. 389 (1971).

n74 402 U.S. at 402-406.

n75 *See*, H. Friendly, "Some Kind of Hearing," 123 U. Pa. L. Rev. 1267, 1279-95 (1975) in which the author identified the necessary characteristics of a fair administrative hearing: 1) an unbiased tribunal; 2) notice of the proposed action and the grounds asserted for it; 3) an opportunity to present reasons why the proposed action should not be taken; 4) the right to call witnesses, including the right to cross-examine adverse witnesses; 5) the right to know the evidence at issue; 6) the right to have a decision based on the evidentiary record; 7) the right to counsel; 8) a record; 9) articulated reasons for the decision; 10) public attendance; and 11) judicial review. Most of these factors are completely absent from ERISA claims.

Accordingly, ERISA benefit adjudications performed by insurance companies are fundamentally different from Social Security disability claims because "the agency operates essentially, and is intended so to do, as an adjudicator and not as an advocate or adversary." n76 Despite such marked differences, as one federal appellate judge pointed out in a dissenting opinion, claimants in ERISA benefit disputes are "effectively precluded as a matter of law any procedural challenge to an ERISA plan administrator's decisions, thereby giving those decisions a uniquely privileged position in the entire field of administrative or quasiadministrative law." n77 Consequently, some courts have begun to recognize that the inaptness of drawing an analogy between Social Security claims and disability insurance cases and have cautioned against importing "administrative agency concepts into the review of ERISA fiduciary decisions." n78

n76 *Perales*, 402 U.S. at 403.

n77 *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 983 (7th Cir. 1999) (Wood, J., dissenting).

n78 *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1564 n. 7 (quoting *Van Boxel*) (11th Cir. 1990).

The U.S. Supreme Court has also weighed in on evidentiary considerations in ERISA claims. In *Black & Decker Disability Plan v. Nord*, n79 the court ruled that while an ERISA plan administrator need not give special deference to the opinions of treating doctors in disability benefit disputes, plan administrators must still base their findings on "reliable evidence." n80 However, that begs the question of what constitutes reliable evidence. Courts have been crediting the opinions of non-examining medical consultants without giving claimants the opportunity to cross-examine those consultants for evidence relating to potential bias, insufficient expertise or disregard of relevant evidence. Therefore, in

order to assess whether the plan administrator's evidence is "reliable," as *Nord* requires, claimants must have the opportunity to conduct appropriate discovery and be accorded a plenary hearing.

n79 538 U.S. 822 (2003).

n80 538 U.S. at 834.

In all other federal civil litigation, the Federal Rules of Civil Procedure and Federal Rules of Evidence guard against inadmissible evidence. On summary judgment proceedings, Rule 56 of the Federal Rules of Civil Procedure and Federal Rule of Evidence 802 prohibit consideration of hearsay evidence; and Federal Rule of Evidence 702 precludes consideration of expert opinions unless the scientific reliability of such opinions has been established as a threshold matter. Absent admissible evidence, it is inappropriate for courts to avoid trials and to enter a summary judgment. n81 Lacking any evidentiary proceeding, courts have no means of assessing whether the evidence on which the plan denial was based is admissible or even "reliable."

n81 Fed.R.Civ.P. 56(e).

In a context comparable to ERISA claims, in *Gehin v. Wisconsin Group Insurance Bd.*, n82 the Wisconsin Supreme Court held that hearsay medical reports may not sustain a denial of disability benefits -- even in an administrative agency setting -- because:

The harm to claimants in having their income continuation insurance benefits terminated on the basis of controverted written hearsay medical reports, without an opportunity to cross-examine the authors of those reports exceeds the burden on the Group Insurance Board to call a witness to corroborate those hearsay medical reports. n83

n82 278 Wis.2d 111, 692 N.W.2d 572 (Wis. 2005).

n83 692 N.W. at at 590.

Gehin relied heavily on *Richardson v. Perales* in finding administrative hearings that denied the claimant the right to cross-examine the authors of adverse medical reports lacked sufficient due process guarantees. The court also cited a Mississippi Supreme Court ruling that held:

It is quite likely that the bench and bar would be scandalized if this Court should approve the receiving in evidence of ex parte, unsworn statements of persons other than doctors, even in Workmen's Compensation cases.

While doctors occupy an important role in our scheme of things, they are, after all, merely human, and may not be considered wholly free from the frailties that beset the rest of us. There is nothing, therefore, in the fact that a witness may be a member of the medical profession that reasonably may be said to justify his exemption from the requirements and restriction which would apply to others giving testimony in an adversary proceeding. The admission of the reports constitutes reversible error. n84

n84 692 N.W.2d at 589 (citing *Georgia-Pacific Corp. v. McLaurin*, 370 So.2d 1359, 1362 (Miss. 1979)).

Gehin teaches an important lesson that has yet to be learned in ERISA disputes.

Potential Solutions

Given the huge economic disparity between consumers and insurers, the law of insurance bad faith developed to force insurers to apply fair and reasonable claims practices or face lawsuits seeking punitive damages. Similar standards ostensibly exist under the ERISA law that place an obligation on insurers and other plan administrators to act exclusively in the interest of plan participants and their beneficiaries for the purpose of paying benefits. n85 However, that provision was substantially weakened by a U.S. Court of Appeals ruling that found the ERISA law imposes no obligation for the fiduciary to place its "thumb on the scale in the participant's favor." n86 Although that finding might have been appropriate in the *Wallace* case because even the claimant's treating physician refused to certify ongoing disability, without a mechanism to enforce ERISA's fiduciary obligations, as the multi-state and California regulators learned, the tendency is to deny claims that would likely have been payable had appropriate claim practices been applied. Nor is this a new phenomenon. Several years ago, a federal district judge in California observed in a disability benefit case:

[T]he facts of this case are so disturbing that they call into question the merit of the expansive scope of ERISA preemption. UNUM's unscrupulous conduct in this action may be closer to the norm of insurance company practice than the Court has previously suspected. This case reveals that for benefit plans funded and administered by insurance companies, there is no practical or legal deterrent to unscrupulous claims practices. Absent such deterrents, the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.

Consequently, ERISA may need to provide a greater deterrent to bad faith conduct in the administration of ERISA plans. The Court continues to believe that providing for punitive, "bad faith," or compensatory damages beyond the amount of the claimed damages would adversely disturb the balance struck by ERISA. However, for the first time, it believes that at least in the case of insurance-funded and administered plans the public interest would be advanced if ERISA contained a statutory penalty which could be imposed by the Court in extraordinary cases. n87

n85 29 U.S.C. § 1104(a)(1) (2005).

n86 *Wallace v. Reliance Standard Life Insur. Co.*, 318 F.3d 723, 724 (7th Cir. 2003).

n87 *Dishman v. Unum Life Insur. Co. of America*, 1997 WL 906147 *11 (CD. Cal. 5/9/1997).

To be sure, no one is suggesting that insurers should pay non-meritorious claims. However, it is apparent that insurance companies have not been meeting their responsibility to compensate deserving policyholders and the courts have inadequately policed the insurers' conduct.

Ultimately, the goal for both insurers and claimants is that meritorious claims receive compensation. The impact of the ERISA law on disability benefits has made that goal much harder for claimants to reach, however. It is evident that there needs to be a reassessment by the U.S. Congress, the courts and the U.S. Department of Labor (the agency that oversees the administration of the ERISA law) as to whether the law is meeting its purpose and what can be done to remedy the situation. Disability benefits are too important to entrust to resolution by private insurers whose findings receive greater deference than that accorded to government agencies and judges. Instead of creating incentives leading to claim denials, insurers must be motivated to give more careful and fairer consideration to disability benefit claims.