

THE PARADOX OF THE MISUSE OF ADMINISTRATIVE LAW IN ERISA BENEFIT CLAIMS

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The ERISA¹ law was enacted by Congress 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.²

To that end, the statute affords every participant³ and beneficiary⁴ of employee benefit plans⁵ the right to bring suit “to recover benefits due to him under the terms of his plan, to reinforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”⁶ However, the civil procedure accorded to such suits has been deformed by the courts’ mistaken application of an administrative law paradigm to ERISA benefits litigation instead of utilizing the Federal Rules of Civil Procedure as those rules are to be applied to all civil litigation⁷ brought in the United States District Courts.

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1. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (2000).

2. *Id.* § 1001(b) (2000).

3. *Id.* § 1002(7) (2000). A “participant” in an employee benefit plan “means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.” *Id.*

4. *Id.* § 1002(8) (2000) defines “beneficiary” as “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.”

5. *Id.* § 1002(1)(A) (2000). Defined as a plan, fund or program established or maintained by an employer to provide benefits in the event of illness, disability or certain other conditions. Plans may be funded “through the purchase of insurance or otherwise.” *Id.*

6. *Id.* § 1132(a)(1)(B) (2000).

7. FED. R. CIV. P. 1. The Rule states, “These rules govern the procedure in the United States district courts in all suits of a civil nature whether cognizable as cases at law or in equity or in admiralty[.]” *Id.*

I. EARLY WARNINGS AGAINST THE USE OF THE ADMINISTRATIVE LAW PARADIGM TO RESOLVE BENEFITS CLAIMS

On their journey toward developing the law of ERISA, federal courts have somehow lost their way despite warnings by several learned judges. Two sources for the misapplication of administrative law principles are: the utilization of a deferential standard of review and the doctrine of administrative exhaustion. The arbitrary and capricious standard of review was adopted by the courts in ERISA cases as an outgrowth both of trust law and the Labor Management Relations Act.⁸ However, Judge Richard Posner of the United States Court of Appeals for the Seventh Circuit questioned the potential for harm that could result from applying a deferential standard of review in ERISA cases. He wrote in *Van Boxel v. The Journal Co. Employees' Pension Trust*,⁹ a pension benefits dispute,

pension rights are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of "arbitrary and capricious" review, relying on the company's interest in its reputation to prevent it from acting on its bias. Nor is it clear that the contractual perspective is the correct one in which to view claims under ERISA. A Congress committed to the principles of freedom of contract would not have enacted a statute that interferes with pension arrangements voluntarily agreed on by employers and employees. ERISA is paternalistic; and it seems incongruous therefore to deny disappointed pension claimants a meaningful degree of judicial review on the theory that they might be said to have implicitly waived it.

Transposed to the ERISA setting, the arbitrary and capricious standard may be inapt, a historical mistake, or a mechanical extrapolation from different settings, at once too lax and too stringent, but even if it is any or all of these things it is saved from doing serious harm by its vagueness and elasticity.¹⁰

Further, Judge Posner was also careful to note that despite the derivation of the arbitrary and capricious standard from administrative law,

Pension fund trusts are not administrative agencies and most of the decisions they make are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers. Certainly in a case such as the present one, pension fund trustees are not policy-makers; they are interpreters of contractual entitlements.¹¹

8. 29 U.S.C. § 186(c) (2000). Courts interpreting benefits cases brought under the Taft-Hartley Act, which provided for joint employer-union benefit plans, adopted the "arbitrary and capricious" standard of review of benefits decisions rendered by such plans, a standard imported into ERISA. *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987). The philosophy behind that approach was to challenge benefits decisions on the ground the plan was not "structured" for "the sole and exclusive benefit of the employees." *Id.* at 1052. Tracing the history of the "arbitrary and capricious" standard further, Judge Posner pointed out that under the common law, trustees, who are forbidden to engage in self dealing, were accorded judicial deference to their "discretionary judgments." *Id.* at 1051; *see also* *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) (tracing history of development of arbitrary and capricious standard of review in ERISA cases).

9. 836 F.2d at 1052.

10. *Id.* (citing *Lee v. Dayton Power & Light Co.*, 604 F. Supp. 987, 1001 n.11 (S.D. Ohio 1985)).

11. *Id.* at 1050.

Judge Posner expressed that it might be more apt to compare ERISA benefit plan administrators to arbitrators, but before granting trustees the same authority as arbitrators, their objectivity and neutrality is required.¹²

After *Van Boxel*, the next case to warn of the inappropriateness of applying an administrative law paradigm to litigation of ERISA benefits disputes was the seminal ruling in *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*,¹³ a case challenging the denial of hospitalization benefits. Pointing out the insurer's conflict of interest as both administrator of benefits and payor of claims, the Eleventh Circuit refused to accord any deference to the insurer's refusal to pay benefits, and required the conflicted party to "prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest."¹⁴ The court also warned of the misuse of administrative law concepts:

Because we have restated the standard as arbitrary and capricious, the temptation exists to consult precedent regarding the use of that standard to review administrative agency decisions [citations omitted]. We express caution, however, at wholesale importation of administrative agency concepts into the review of ERISA fiduciary decisions. Use of the administrative agency analogy may, ironically, give too much deference to ERISA fiduciaries. Decisions in the ERISA context involve the interpretation of contractual entitlements; they 'are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers.' *Van Boxel*, 836 F.2d at 1050. Moreover, the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies. [citation omitted]. We therefore concentrate on the common law trust principles to evaluate the application of the arbitrary and capricious standard.¹⁵

The most recent warning about misapplication of administrative law concepts to ERISA claims was once again authored by Judge Posner. In *Herzberger v. Standard Insur. Co.*,¹⁶ a case involving disability insurance benefits, the court denied deference to an insurer due to the absence of clearly-drafted language reserving discretion to determine eligibility for benefit payments.¹⁷ Explaining that deference should not automatically be granted, Judge Posner suggested the reason that courts had gone astray:

What may have misled courts in some cases is the analogy between judicial review of an ERISA plan administrator's decision to deny disability benefits and judicial review of the denial of such benefits by the Social Security Administration . . . Judicial review of the latter sort of denial is of course deferential, and it is natural to suppose that it should be deferential in the former case as well. But the analogy is imperfect, quite apart from its having been implicitly rejected by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*¹⁸ when it determined that the default standard of review in ERISA cases is plenary review, and quite apart from the fact that the social security

12. *Id.* at 1051. Judge Posner suggested deference be granted to decisions made by true trustees, while a de novo standard of review would be required if absolute neutrality was not present, especially if there was a conflict of interest. *Id.*

13. 898 F.2d 1556 (11th Cir. 1990).

14. *Id.* at 1566.

15. *See id.* at 1564 n.7 (quoting *Van Boxel*, 836 F.2d at 1050).

16. 205 F.3d 327 (7th Cir. 2000).

17. *Id.* at 331.

18. 489 U.S. 101.

statute specifies deferential (“substantial evidence”) review. 42 U.S.C. § 405(g). The Social Security Administration 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. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by plan administrators.¹⁹

II. THE ADMINISTRATIVE EXHAUSTION REQUIREMENT IN ERISA CASES

Despite these admonitions, the federal courts have mistakenly incorporated administrative law principles into ERISA benefit decisions. The use of the term “administrator”²⁰ in the ERISA statute has allowed other terminology to creep into ERISA, such as “administrative record.”²¹ Perhaps much of the confusion results from Section 503²² of the ERISA statute, which states:

In accordance with regulations of the Secretary, every employee benefit plan shall

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.²³

That provision was interpreted in *Amato v. Bernard*²⁴ to require administrative exhaustion prior to suit in the same manner that courts have applied exhaustion of administrative procedures to resolution of disputes under collective bargaining agreements.²⁵ The court explained that Section 503 was:

apparently intended by Congress to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned.²⁶

As pointed out, though, by Professor Jay Conison in his article *Suits for Benefits Under ERISA*,²⁷ the use of the word “apparently” is without support in the statutory history of the ERISA law. At one point, the statutory history reveals that Congress planned to have the Department of Labor hear

19. See 205 F.3d at 332 (citing 42 U.S.C. § 405(g)).

20. 29 U.S.C. § 1002(16)(A) (2000).

21. See, e.g., *Wade v. Life Ins. Co. of N. Am.*, 2003 U.S. Dist. LEXIS 12320 (D. Me. June 3, 2003) (granting a disability insurer operating an ERISA-governed benefit plan summary judgment under a ruling titled, “Order Regarding Judgment on the Administrative Record”); see also *Bently v. Metropolitan Life Insur. Co.*, 2003 U.S. Dist. LEXIS 12973 (W.D. Mich. July 18, 2003) (granting “Judgment on the Administrative Record” due to plaintiff’s failure to exhaust administrative remedies).

22. 29 U.S.C. § 1133 (2000).

23. *Id.*

24. 618 F.2d 559 (9th Cir. 1980).

25. *Id.* at 566.

26. *Id.* at 567.

27. 54 U. PITT. L. REV. 1, 29 (1992).

grievances or disputes relating to pensions under an earlier version of the ERISA law.²⁸ Another proposal was to provide for arbitration of disputes.²⁹ However, neither provision was retained in the final bill. Consequently, although the notion that ERISA disputes are “review” proceedings has been maintained as the result of cases such as *Amato v. Bernard*, no court since *Amato* has been willing to state that administrative exhaustion is simply an option available to claimants for benefits.

The closest a court has come to that viewpoint is the Seventh Circuit’s ruling in *Gallegos v. Mt. Sinai Medical Center*.³⁰ In *Gallegos*, the court pointed out that an disability insurer’s invitation to appeal an adverse decision was couched in precatory language; i.e., “you may appeal.”³¹ The court then noted,

In this case, UNUM attempted to comply with the requirements of ERISA by informing Gallegos of her options to pursue relief of the denial of her claim through UNUM’s administrative review procedure as well as through the federal court system. Gallegos asserts, however, that what UNUM did not tell her was that if she elected not to pursue an administrative review of her claim, UNUM would use this choice as a defense against her in any subsequent federal suit. We agree with Gallegos that the use of phrases such as “you may have [your claim] reviewed,” “should you desire a review,” “if you . . . wish to have the decision reviewed,” and “you . . . may appeal,” given their plain meaning, indicate that a plan participant has the opportunity to participate in a voluntary, rather than mandatory, review procedure. The only penalty mentioned for failure to submit to administrative review is that the claims decision will become “final.” There is no indication that this “finality” may have consequences for the bringing of a suit in federal court, an option which the claimant is also informed she “may” pursue. A natural reading of the plain language of the Summary Plan and June 11 Letter is that both a court suit and an administrative appeal are voluntary options for review of a denial of a claim. The administrative appeal has a limitations period of 60 days from the denial of the claim, and the limitations period for a court suit, while not defined in the Summary Plan, is stated in the Plan as three years from the time when proof of a claim is required.³²

Nonetheless, the court addressed the issue in terms of an estoppel and ultimately ruled that the plaintiff’s failure to establish that she was misled by the terminology of the summary plan and denial letter barred her suit.³³ However, the court was definitely on the right track since § 503 of the statute is not, by its own terminology, a mandatory provision for claimants. Yet no other court has been willing to stray from the doctrine of administrative exhaustion in ERISA claims.

III. *FIRESTONE V. BRUCH*

Whatever hope existed that the courts would regain their bearings and exclude administrative law concepts from ERISA claims was demolished by the Supreme Court in its watershed ruling in *Firestone Tire & Rubber Co. v.*

28. S. REP. NO. 93-383, at 116-17 (1974).

29. 120 CONG. REC. 29,941 (1974).

30. 210 F.3d 803, 810 (7th Cir. 2000), *cert. denied*, 531 U.S. 827 (2000).

31. *Gallegos*, 210 F.3d at 810.

32. *Id.*

33. *Id.* at 808.

Bruch.³⁴ There, the Court held that although the default standard of review in ERISA cases is plenary, trust principles allow a trustee exercising discretionary authority to reserve deferential authority to determine eligibility for benefits and construe the terms of a benefit plan. However, the Court also made a number of other crucial points in the *Bruch* ruling that are inconsistent with the Court's application of trust law. First, the Court explained that the preservation of a de novo standard of review continues the means by which employee benefit claims were resolved prior to ERISA since such claims "were governed by principles of contract law."³⁵ Thus, the de novo standard of review retains consistency with the ERISA law's protective purpose; otherwise, a blanket deferential standard of review would "impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted."³⁶ Finally, the Court rejected the fears expressed by Firestone that a de novo review could increase the cost of litigation by finding the threat of increased costs does not outweigh the legal basis for granting a de novo review.³⁷ Nonetheless, the Court then determined that principles of trust law allow benefit plan sponsors to simply write into their plans language that would trigger a deferential standard of review. The Court further indicated, though, without any guidance whatsoever to the lower courts, that if the fiduciary or plan administrator of a benefit plan is operating under a conflict of interest, the conflict must be weighed as a "factor" in determining abuse of discretion.³⁸

IV. CRITICISM OF *FIRESTONE*

Firestone's holding was attacked by Professor John Langbein in his article entitled, *The Supreme Court Flunks Trusts*.³⁹ Langbein argued the Court should have either followed trust or contract law, but instead the Court made a mish-mash of both. Langbein maintains:

If the Court had been worried that a contract-based standard of de novo review might be too easy for plan drafters to evade, ERISA offered an easy statutory basis for preventing such maneuvers. Section 404(a)(1)(D)—the measure that requires that plan documents be "consistent with the provisions of" ERISA could easily have been read to restrict or prohibit attempts to oust de novo review, at least in situations of conflict of interest. Moreover, quite apart from statute, contract law is not defenseless to such moves when protective values are offended. Just as trust law exhibits that tradition of strict scrutiny of a fiduciary's conflict-tainted transactions upon which Judge Becker [the Third Circuit Court of Appeals Judge who wrote the appellate court ruling in *Bruch* prior to its reaching the Supreme Court] relied, so in contract law there are familiar doctrines—unconscionability, contra proferentum—for responding to overreaching.⁴⁰

Professor Langbein's approach has never been accepted by any court. While well argued, and despite presenting points that remain worthy of

34. 489 U.S. at 118.

35. *Id.* at 112.

36. *Id.* at 114.

37. *Id.* at 115.

38. *See id.* at 115 (citing RESTATEMENT (SECOND) OF TRUST § 187, Comm. d (1959)).

39. 1990 SUP. CT. REV. 207, 208-09 (1990).

40. *See id.* at 227 (citing *Bruch*, 828 F.3d 134 (3d Cir. 1987)).

consideration, the Solicitor General's arguments made to the Supreme Court in *Firestone*⁴¹ are ultimately more persuasive. This is partly because Professor Langbein appears not to have taken into consideration that, particularly in the area of welfare benefits, the statute allows for the existence of unfunded benefit plans,⁴² i.e., plans that fund benefits from an employer's general assets, rather than money held in trust, or plans that fund benefit payments through the purchase of insurance.

The Solicitor General, recognizing the existence of unfunded employer-controlled or insurer-controlled plans under the ERISA law, argued for a universal de novo standard of review as being consistent with ERISA's purposes. The Solicitor General explained that ERISA's purposes of protecting promised benefits are best served by not insulating benefit plans from the self-interest of employers and insurers through a deferential standard of review. The Solicitor General contended, "[i]t is illogical to assume that the administrator of an unfunded plan whose benefits are paid from the employer's assets will function with the same impartiality as a neutral trustee of a funded plan, since the administrator's employer will sustain a financial loss with every award of benefits."⁴³ The same argument applies to insurers. The Solicitor further noted that trust analogies "are wholly inapt to an unfunded benefit plan . . . since no source of benefit payments exists separately from the employer's own operating funds."⁴⁴

Consequently, the Solicitor General sought the use of a contract law approach, citing numerous pre-ERISA cases deciding employee benefits disputes as breach of contract cases brought in the state courts.⁴⁵ Certainly, welfare benefits cases have historically been resolved as contractual disputes.⁴⁶ Further, while many cases brought prior to the enactment of the ERISA law applied an arbitrary and capricious standard of review to trust disputes,⁴⁷ a deferential standard of review was not universally applied. In *In re Trust Created by Will of Salimes*,⁴⁸ a testamentary trust providing authority "to financially assist any of the grandchildren," in the trustee's discretion, "with a higher education subsequent to high school and that such financial assistance for such higher educations may be over and above the

41. Brief of the United States as Amicus Curiae Supporting Respondents, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1988) (No. 87-1054), 1987 U.S. Briefs 1054 LEXIS.

42. See Langbein, *supra* note 37, at 209 (stating that "ERISA requires that pension and employee benefits take the trust form"). However, 29 U.S.C. § 1002(1), which contains the statutory definition of "welfare plan," explicitly contemplates "the purchase of insurance." Moreover, 29 U.S.C. §§ 1081(a)(1) and (a)(2) exempt welfare plans and insured plans from maintaining plan assets in trust.

43. *Id.*

44. Brief of the United States as Amicus Curiae Supporting Respondents, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (No. 87-1054).

45. See *id.* (citing *Phelps Dodge Corp. v. Brown*, 112 Ariz. 179, 540 P.2d 651 (1975); *Frietzsche v. First W. Bank & Trust Co.*, 168 Cal. App. 2d 705, 336 P.2d 589 (1959)) (additional citations omitted).

46. See, e.g., *Moore v. John Hancock*, 436 F.2d 823 (5th Cir. 1971) (regarding life insurance); *Justice v. Union Carbide*, 405 F. Supp. 920 (E.D. Tenn. 1975) (regarding disability benefits).

47. E.g., *Van Pelt v. Berefco, Inc.*, 60 Ill. App. 2d 415, 208 N.E.2d 858 (Ill. App. 1965); *Reese v. Admin. Comm. of the Profit Sharing Trust*, 218 Cal. App. 2d 646, 32 Cal. Rptr. 818 (1963); *Going v. S. Mill Employees' Trust*, 281 P.2d 762 (Okla. 1955).

48. 168 N.W.2d 157 (1969).

amounts paid to her son,” was held not to grant discretion to the trustee to refuse a grandchild’s request to transfer from one educational institution to another.⁴⁹ The court overturned the trustee’s determination, holding:

The mere fact that a trustee is given discretion does not authorize him to go beyond the bounds of reasonable judgment. 1 Restatement 2d, *Trusts*, p. 403, sec. 187, comment e. In general, a court does not favor a construction which confers arbitrary or capricious authority on the trustee. *See* Annot. (1948), 2 A.L.R. 2d 1383, 1400 *et seq.* The general duties of a trustee to exercise reasonable care and judgment require that even a broad discretion be exercised upon judicious and responsible consideration, subject to review by the court for abuse of discretion. 54 AM. JUR., *Trusts*, p. 142, sec. 180.⁵⁰

The import of the foregoing discussion is that despite the Solicitor General’s argument and historic practice, the Supreme Court’s *Firestone* decision provides insurers and employers offering unfunded benefit plans unfettered discretion to impose a deferential standard of review on all ERISA plan participants and their beneficiaries. However, since *Firestone*, the courts have not consistently applied the trust law view of an arbitrary and capricious standard of review, which would still allow for discovery and a court hearing. Instead, the courts have deviated from tradition trust law and imposed administrative law concepts relating to review of agency determinations, and have disallowed the usual civil procedures.

V. THE TRANSFORMATION OF ERISA CLAIMS

The fact that, as a historical matter, cases involving employee benefits have been determined as contract disputes raises a question as to how the administrative law paradigm began to be utilized in ERISA benefit claims. While we have seen how trust law concepts have been applied to the standard of court review, one of the influential decisions applying the administrative law paradigm to the scope of a court’s review is *Perry v. Simplicity Engineering*,⁵¹ a disability benefits dispute. In *Perry*, without any precedential support, the court determined that review of ERISA benefit claims is “based on the record before the administrator.”⁵² The court found:

In the ERISA context, the role of the reviewing federal court is to determine whether the administrator or fiduciary made a correct decision, applying a de novo standard. Nothing in the legislative history suggests that Congress intended that federal district courts would function as substitute plan administrators, a role they would inevitably assume if they received and considered evidence not presented to administrators concerning an employee’s entitlement to benefits. Such a procedure would frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme.⁵³

In contrast, the Eleventh Circuit, in *Moon v. American Home Assurance Co.*,⁵⁴ determined that a

contention that a court conducting a de novo review must examine only such facts as were available to the plan administrator at the time of the benefits

49. *Id.* at 158-59.

50. *Id.* at 160.

51. 900 F.2d 963 (6th Cir. 1990).

52. *Id.* at 967.

53. *Id.* at 966.

54. 888 F.2d 86 (11th Cir. 1989).

denial is contrary to the concept of a de novo review. During oral argument, American Home's counsel conceded that absent ERISA, there would be no deferential standard of review of the denial of coverage. Thus, what the Supreme Court said of a similar contention advanced in *Firestone* is equally applicable to this contention: "Adopting [this] reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than [they enjoyed] before ERISA was enacted."⁵⁵

Disagreeing with *Moon*, and characterizing that ruling as inconsistent with ERISA's purpose of providing "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously,"⁵⁶ *Perry* determined that consideration of evidence not previously presented to plan administrators would cause "employees and their beneficiaries [to] receive less protection than Congress intended."⁵⁷

Trying to find a middle ground, the court in *Luby v. Teamsters Health, Welfare & Pension Trust Funds*⁵⁸ held the admissible evidence did not have to be limited to the claim record before the plan administrator. Then the court in *Quesinberry v. Life Insurance Co. of North America*⁵⁹ counseled an approach which allowed a court, in its discretion, to consider evidence not before the plan administrator "because of concerns about impartiality and ERISA's interest in providing protection for employees and their beneficiaries."⁶⁰ The test proposed in *Quesinberry* was to allow for additional evidence under "exceptional circumstances," catalogued to include:

claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.⁶¹

However, *Quesinberry*'s approach only applies to de novo review. For review under an arbitrary and capricious standard, the Seventh Circuit stated starkly in *Perlman v. Swiss Bank Corp.*⁶² that "[d]eferential review of an administrative decision means review on the administrative record."⁶³

VI. WHY ADMINISTRATIVE LAW CONCEPTS ARE INAPPROPRIATE

But as *Herzberger v. Standard Insurance Co.* recognized, the administrative law analogy is flawed. Administrative law allows for limited review of agency decisions because administrative agencies apply trial-type

55. *Id.* (citing *Firestone*, 109 U.S. at 956).

56. 900 F.2d at 967 (citing 1974 U.S. CODE CONG. & ADMIN. NEWS 5000).

57. *Id.*

58. 944 F.2d 1176, 1187 (3d Cir. 1991).

59. 987 F.2d 1017 (4th Cir. 1993).

60. *Id.* at 1026.

61. *Id.* at 1027.

62. 195 F.3d 975 (7th Cir. 1999).

63. *Id.* at 981-82.

procedures leading to adjudications before a neutral factfinder with a right to subpoena witnesses and present evidence. Indeed, the federal Administrative Procedure Act⁶⁴ guarantees a hearing with due process protections. Looking at the Social Security process as an example, the case of *Richardson v. Perales*⁶⁵ explains that Social Security determinations, which are reviewed deferentially pursuant to statute,⁶⁶ are not litigated de novo in federal court because of the protections afforded the claimant before the administrative agency. Those protections include the right to a neutral hearing officer and the opportunity to subpoena and cross-examine the authors of adverse reports.

Articulating the reasons behind the administrative law approach to judicial review of agency determinations, Judge Henry Friendly pointed out in his landmark law review article, *Some Kind of Hearing*,⁶⁷ that several elements are necessary for 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.⁶⁸

Although the ERISA claim regulations⁶⁹ provide many of these guarantees,⁷⁰ the most crucial protections are denied ERISA claimants. This occurs especially with claims brought under insurance policies or which involve unfunded benefits since the claim review process lacks the neutrality afforded by funded plans, as Judge Posner noted in *Van Boxel*.⁷¹ Such claims are not presented to an unbiased tribunal; and claimants lack any opportunity to challenge adverse evidence through cross-examination. Another significant problem was pointed out in *Luby v. Teamsters Health, Welfare & Pension Trust Funds*,⁷² where the court explained:

Plan administrators are not governmental 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 experience 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.⁷³

The Seventh Circuit elaborated on that theme in *Ramsey v. Hercules, Inc.*,⁷⁴ where the court adhered to a plenary evaluation of a disability benefit

64. 5 U.S.C. § 553 (2003).

65. 402 U.S. 389, 410 (1971).

66. 42 U.S.C. § 405(g) (2003).

67. 123 U. PA. L. REV. 1267, 1279-95 (1975).

68. *Id.*

69. 29 C.F.R. § 2560.503-1 (2004).

70. *Id.* The Regulations provide claimants with the opportunity to know what evidence was relied on, to submit a written response, and to receive a full and fair review of the initial claim decision. *Id.*

71. 836 F.2d at 1052.

72. 944 F.2d 1176 (3d Cir. 1991).

73. *Id.* at 1183.

74. 77 F.3d 199, 204 (7th Cir. 1996).

claim, rejecting the insurer's contention that factual determinations made by a plan administrator should always be accorded deference. Finding that policy considerations militated against such an approach, the court ruled:

Crucial differences exist between findings of fact made by a private entity such as a plan administrator, and findings made by duly authorized administrative law judges, agencies, or federal district courts. Underlying the deferential review that fact findings of the latter bodies enjoy is a well established set of procedural protections that stem from the Constitution and individual statutes. Plan administrators, in contrast, neither enjoy the acknowledged expertise that justifies deferential review for agency cases, see *Luby*, 944 F.3d at 1183, nor are they unbiased fact finders like the courts. Indeed, when the initial decision in an agency lacks the crucial procedural safeguards, the Administrative Procedure Act requires the federal courts to review both fact and law de novo.⁷⁵

The sources of the Seventh Circuit's findings in *Ramsey* are drawn from both the Administrative Procedure Act (APA) and Supreme Court precedent. According to the APA, when an agency's findings lack substantive and procedural due process protections, they are subject to "trial de novo by the reviewing court."⁷⁶ As an example, the Court in *Citizens to Preserve Overton Park, Inc. v. Volpe*,⁷⁷ found that a federal highway administrator's approval of funding for a highway that traversed a public park lacked adequate factual findings relating to an alternate route as required by law. Hence, the Supreme Court ordered the district court to conduct a plenary review of the Secretary of Transportation's findings and directed that the trial court "may require the administrative officials who participated in the decision to give testimony explaining their action."⁷⁸ *Volpe* therefore illustrates that accepted principles of administrative law would allow for a trial de novo in claims where agency findings are devoid of due process and procedural protections, yet in ERISA benefits disputes, courts have been routinely according the same deference to insurers' decisions as they would a Social Security decision issued by an administrative law judge.⁷⁹

VII. ADDITIONAL REASONS FOR DISALLOWING ADMINISTRATIVE LAW CONCEPTS

Such a mistaken application of an administrative law model to ERISA benefit cases is unfortunate. While the statute refers to the party determining claims as an "administrator," that term is not interchangeable with what is meant by an agency administrator, as we have seen. Nonetheless, the ERISA statute's use of some of the same nomenclature utilized in administrative law has undoubtedly confused the courts and has led to an overly restrictive scope of review even when a deferential standard of review

75. *Id.* at 205.

76. 5 U.S.C. § 706(2)(F) (2000).

77. 401 U.S. 402 (1971).

78. *Id.* at 420.

79. Indeed, the deference accorded to insurers' decisions may be even greater than deference given to agency determinations: "The 'arbitrary or capricious' standard calls for less searching inquiry than the 'substantial evidence' standard that applies to Social Security disability cases." [Pokratz v. Jones Dairy Farm, 771 F.2d 206, 209 \(7th Cir. 1985\)](#)

is compelled.

The implications of this conclusion are numerous. First, by applying an inappropriate administrative law model in adjudicating ERISA cases, the courts unduly restrict discovery, which prevents exposure of faulty decisions rendered by biased or unqualified decisionmakers or whose determinations result from flawed or incomplete evidence. Although some courts allow discovery on the conflict of interest,⁸⁰ other rulings have disallowed plaintiffs in disability benefit disputes from deposing a consultant hired by an insurer on the ostensible ground that to allow the examination would be inconsistent with ERISA.⁸¹ *Pertman*, further suggested that:

discovery may be appropriate to investigate a claim that the plan's administrator did not do what it said it did—that, for example, the application was thrown in the trash rather than evaluated on the merits. But when there can be no doubt that the application was given a genuine evaluation, judicial review is limited to the evidence that was submitted in support of the application for benefits, and the mental processes of the plan's administrator are not legitimate grounds of inquiry any more than they would be if the decisionmaker were an administrative agency.⁸²

This approach is not only illogical; it is unfair. As previously noted, *Richardson v. Perales*⁸³ highlights the significant differences between administrative proceedings and ERISA cases. Focusing on due process in Social Security disability claims, the Supreme Court determined that a claimant's due process rights are protected by the right to issue subpoenas and cross-examine witnesses before an objective, neutral factfinder. No comparable right exists in ERISA claims. There is no subpoena power prior to suit, and rarely is there an opportunity to present testimonial evidence and elicit cross-examination during the claim process. Particularly in view of the Supreme Court's recent ruling in *Black & Decker Disability Plan v. Nord*,⁸⁴ which held that deference need not be accorded to the opinions of treating doctors in ERISA benefits cases, claimants lack a meaningful opportunity to challenge the opinions of consultants retained by plans if there is no right to cross-examination.⁸⁵ However, such unquestioned opinions may be

80. See generally *Sheehan v. Metro. Life Insur. Co.*, 2002 U.S. Dist. LEXIS 11789 (S.D.N.Y. June 28, 2002); *Waggener v. Unum Life Insur. Co. of Am.*, 2002 U.S. Dist. LEXIS 22697 (S.D. Cal. Nov. 6, 2002); *Medford v. Metro. Life Insur. Co.*, 2003 U.S. Dist. LEXIS 2288 (D. Nev. Feb. 10, 2003); *Pulliam v. Cont'l Cas. Co.*, 2003 U.S. Dist. LEXIS 10010 (D.D.C. Jan. 24, 2003).

81. See, e.g., *Abram v. Cargill, Inc.*, 2003 U.S. Dist. LEXIS 7027, *8 (D. Minn. Feb. 10, 2003) (showing one court's refusal to allow plaintiff to depose doctor who had examined plaintiff); *Semien v. Life Insur. Co. of North America*, 2004 U.S. Dist. LEXIS 6759 (N.D. Ill. 4/20/2004) (disallowing inquiry into potential financial bias of consultant retained by benefit plan). See fn. 85 below.

82. 195 F.3d at 982.

83. 402 U.S. 389 (1971).

84. 538 U.S. 822 (2003).

85. However, the Court did point out in *Nord*:

As compared to consultants retained by a plan, it may be true that treating physicians, as a rule, have a greater opportunity to know and observe the patient as an individual. (internal quotation marks and citation omitted). Nor do we question the Court of Appeals' concern 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 to preserve their own consulting arrangements.

Id. at 1971.

determinative of the outcome of the claim under a deferential standard of review.⁸⁶

Moreover, the results of discovery, when undertaken, often reveal the lack of substantial evidence supporting the insurer's decision. In *Bedrick v. Travelers Insurance Co.*,⁸⁷ a health insurance benefits case involving the refusal of an insurer to certify as medically necessary certain prescribed therapies for a child suffering from cerebral palsy, the plaintiff established, by taking the depositions of defendant's consultants, that the consultants had no relevant expertise regarding the medical necessity of treatment they had refused to certify. Thus, in this rare instance where discovery was permitted, the plaintiff was able to elicit evidence not otherwise contained in the claim record that convinced the court the decision to deny benefits was an abuse of discretion.

Of at least equal, if not greater consequence than a denial of discovery, though, is the limitation placed on the scope of the court's review when administrative law concepts are applied to ERISA claims. Consistent with the Supreme Court's injunction in *Firestone* that claimants should not fare worse under ERISA than prior to that law's enactment, no justification exists for limiting the evidence reviewable by the court, particularly with respect to "claims which would have been insurance contract claims prior to ERISA,"⁸⁸ as the court in *Quesinberry* noted.

Along those same lines, although jury trials have been denied in ERISA cases,⁸⁹ there is no justification for such a conclusion, particularly in view of *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry*,⁹⁰ which explained that to discern the availability of trial by jury, there must first be a comparison of the claim brought to actions in eighteenth century England before the merger of courts of law and equity. Second, and most important, the court must "examine the remedy sought and determine whether it is legal or equitable in nature."⁹¹ ERISA claims seek recovery for what is, in essence, a breach of contract. Thus, *Bona v. Barasch*⁹² found a right to a jury trial for benefit claims based on the Supreme Court's ruling in *Great West Life & Annuity Insurance Co. v. Knudson*,⁹³ which drew a distinction between "equitable" claims brought pursuant to Section 502(a)(3)⁹⁴ of ERISA and "legal" claims brought pursuant to Section 502(a)(1)(B).⁹⁵ The court elaborated:

86. See *Rhodes v. Metro. Life Insur. Co.*, 2003 U.S. Dist. LEXIS 11779 (N.D. Tex. July 10, 2003) (offering a clear example of this point). Despite an independent medical examination favoring an award of disability benefits, the court upheld a benefit denial based on the opinion of a consultant retained by the insurer to review the evidence without conducting a medical examination of the claimant. *Id.* Applying a deferential standard of review, the court found that it was not arbitrary and capricious to deny benefits in the face of such evidence. *Id.*

87. 93 F.3d 149 (4th Cir. 1996).

88. 987 F.2d at 1027.

89. See *Thomas v. Or. Fruit Prod. Co.*, 228 F.3d 991 (9th Cir. 2000) (holding that due to the type of remedy involved, and the lack of a constitutional requirement, there is no right to a jury trial in ERISA claims).

90. 494 U.S. 558, 564-65 (1990).

91. *Id.* at 565.

92. 2003 U.S. Dist. LEXIS 4186 (S.D.N.Y. Mar. 20, 2003).

93. 534 U.S. 204 (2002).

94. 29 U.S.C. § 1132(a)(3) (2000).

95. *Id.* § 1132(a)(1)(B) (2000).

Although [*Great-West*] did not deal with the right to a jury trial per se, the Supreme Court's explication of the distinction between law and equity, discussed in detail in Part III, is relevant here as well. As I concluded in Part III, the monetary relief sought by plaintiffs in this case cannot be characterized as equitable relief under *Great-West*. Rather, plaintiffs seek damages from the trustees on behalf of the Employee Benefit Funds. Because they seek money damages rather than an equitable remedy, both *Miranda* and Individual Plaintiffs are entitled to a jury trial on their ERISA claims. Cf. *White v. Martin*, 2002 U.S. Dist. LEXIS 6899, 2002 WL 598432, at 4 (D. Minn. Apr. 12, 2002) (concluding that a plaintiff seeking equitable restitution is not entitled to a jury trial in a suit based on section 502(a)(2) but implying that after *Great-West* a plaintiff seeking money damages under ERISA would be entitled to a jury trial).

All of these factors add up to a conclusion that ERISA benefits cases should be decided as they were resolved prior to the passage of the ERISA law and not under an administrative law paradigm.

VIII. THE MISUSE OF SUMMARY JUDGMENT

Because of ongoing confusion relating to the application of administrative law to ERISA claims, the use of summary judgment as a means of resolving disputes has been distorted. Summary judgment is governed by Rule 56 of the Federal Rules of Civil Procedure which provides:

The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.⁹⁶

The Supreme Court explained that in order to avoid summary judgment, the opponent must show "the evidence is such that a reasonable jury could return a verdict for the nonmoving party" in *Anderson v. Liberty Lobby, Inc.*⁹⁷ Abandoning that paradigm in ERISA cases, though, courts have granted summary judgment by applying a substantial evidence test. The recent ruling in *Brigham v. Sun Life of Canada*,⁹⁸ a disability benefit case, provides an example. Applying a deferential standard of review, the court held:

The question we face in this appeal is "not which side we believe is right, but whether [the insurer] had substantial evidentiary grounds for a reasonable decision in its favor." Doyle, 144 F.3d at 184. We share the district court's sentiment that this is a difficult case because of "the obvious courage plaintiff has shown in facing his disability," 183 F. Supp. 2d at 438.

Beyond this, it seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. Moreover, it seems clear that Sun Life has taken a minimalist view of the record. But it is equally true that the hurdle plaintiff had to surmount, establishing his inability to perform any occupation for which he could be trained, was a high one. As to that issue, we have to agree with the district court that the undisputed facts of record do not permit us to find

96. FED. R. CIV. P. 56(c) (2003).

97. 477 U.S. 242, 248 (1986).

98. 317 F.3d 72 (1st Cir. 2003).

that Sun Life acted in an arbitrary or capricious manner in terminating appellant Brigham's benefits.⁹⁹

Despite the court's reference to "undisputed facts," as the dissent pointed out, "there was significant and un rebutted evidence that in his current condition [Brigham] was unable to work consistently."¹⁰⁰ Thus, instead of examining the evidence to determine whether a genuine issue of material fact could be discerned, the court simply affirmed the termination of disability payments because it did not find the insurer's decision irrational.

It works the other way as well. The Ninth Circuit decision reversed by the Supreme Court is a perfect example. In *Nord v. Black & Decker Disability Plan*,¹⁰¹ the court was faced with a conflict in the evidence—the insured, who was claiming disability benefits due to a spinal impairment, submitted evidence from treating physicians finding him disabled. *Black & Decker's* independent examining physician, however, opined that Nord, while impaired, was not disabled from performing the duties of his occupation.

After reciting the standards for summary judgment noted above, and despite the obvious conflict in the evidence, the court reversed the district court's grant of judgment to the defendant. Even though the plan language granted discretion to the disability benefit plan administrator, the court found the administrator was operating under a conflict of interest manifested by the plan's rejection of the treating physicians' opinions without articulation of legitimate reasons based on the record.¹⁰² After finding the failure to credit the treating physicians' opinions created a conflict of interest, which altered what would otherwise be a deferential standard of review to a plenary standard, the court then analyzed whether a genuine issue of material fact existed. Amazingly, the court then stated:

The only evidence advanced by Black & Decker to dispute the evidence of Nord's disability is Dr. Mitri's opinion [the independent medical examiner] that Nord is capable of performing sedentary work. A scintilla of evidence or evidence that is not significantly probative does not present a genuine issue of material fact. We conclude that the lone opinion of Dr. Mitri, the doctor hired by Black & Decker, could not reasonably overcome all the other evidence demonstrating that Nord is disabled. Dr. Mitri's opinion is overwhelmed by substantial evidence in the record, including the opinions of three treating physicians that Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner. Viewing the administrative record as a whole, we conclude that no reasonable trier of fact could conclude that Nord is not disabled. Therefore,

99. *Id.* at 85-6.

100. *Id.* at 86 (Stahl, J., dissenting).

101. 296 F.3d 823 (9th Cir. 2002) *vacated by* 538 U.S. 822, *remanded to* 2004 U.S. App. LEXIS 996 (9th Cir. Cal., Jan. 23, 2004).

102. *Id.* at 831. The Court stated:

Nowhere in the record is any reason advanced as to why the treating physicians' opinions were unreliable and Dr. Mitri's more reliable. No evidence has been advanced that Nord's treating physicians considered inappropriate factors in making their diagnosis or that Nord's physicians lacked the requisite expertise to draw their medical conclusions. Instead, the administrator appears merely to have preferred to rely upon the more favorable conclusions of its own examiner.

Id.

we grant Nord's motion for summary judgment.¹⁰³

This statement is clearly an expression of administrative law principles since the "substantial evidence" test is derived from administrative law.¹⁰⁴ However, despite the court's determination that no reasonable factfinder could conclude Nord was not disabled, common sense suggests the opinion of the specialist examiner hired to evaluate Nord represented more than a "scintilla of evidence," and was an evidentiary opinion that created a genuine issue of fact.

Certainly, in reversing the Ninth Circuit's opinion, the Supreme Court was troubled by that conclusion, although for different reasons. The basis of the Supreme Court's ruling was that adherence to the treating physician's opinion was not mandatory as it is in Social Security adjudications. In Social Security disability adjudications, by regulation,¹⁰⁵ the Social Security Administration has determined the treating physician's opinion is entitled to deference where the doctor is a specialist, has a lengthy treatment relationship with the patient, and offers an opinion consistent with the objective test results and in harmony with the record as a whole. No similar regulation has been promulgated by the United States Department of Labor,¹⁰⁶ though; an omission crucial to the Supreme Court's¹⁰⁷ refusal to adopt a "treating physician rule."

IX. THE SOLUTION

Therefore, to halt the slide toward administrative law, it is obvious the courts must either return to the summary judgment paradigm or find a suitable replacement. Several courts have suggested that Rule 52 of the Federal Rules of Civil Procedure, which provides for the entry of findings of fact and conclusions of law in bench trials, is the appropriate means of resolving ERISA benefits disputes (assuming jury trials are disallowed). Such a procedure was recommended in *Kearney v. Standard Insurance Co.*¹⁰⁸ and in *Wilkins v. Baptist Healthcare System Inc.*¹⁰⁹ Other courts have followed suit. For example, the Seventh Circuit, in *Hess v. Hartford*,¹¹⁰ suggested the use of a "paper trial" as akin to a bench trial. Under such a proceeding, rather than examining the record to search for genuine issues of material fact, the court weighs the evidence and decides which party has presented a more persuasive case.

While the paper trial approach offers simplicity and an expeditious means of resolving employee benefit disputes under a de novo standard of review, both full-blown trials and paper trials are problematic under a

103. *Id.* at 832 (citations omitted).

104. Substantial evidence is defined in administrative law as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson*, 402 U.S. at 401.

105. 20 C.F.R. §§ 404.1527; 416.927 (2000).

106. The Department of Labor is the federal agency having jurisdiction over administration and enforcement of the ERISA law.

107. *See Black & Decker Disability Plan*, 538 U.S. 822 (holding that the appellate court erred by employing a "treating physician rule" and refusing to adopt such a rule).

108. 175 F.3d 1084, 1095 (9th Cir. 1999).

109. 150 F.3d 609, 620 (6th Cir. 1998) (Gilman, R., concurring).

110. *Hess v. Hartford Life & Acc. Ins. Co.*, 274 F.3d 456, 461 (7th Cir. 2001). *See also Muller v. First Unum Life Insur. Co.*, 341 F.3d 119, 124-25 (2d Cir. 2003) (stating that trial court failed to make express findings of fact as required by FED. R. CIV. P. 52(a)).

deferential standard of review since that standard implies an inherent conflict in the evidence resolved by a party having discretion to determine disputes. Unless the courts suddenly decide that a deferential standard of review is inappropriate in ERISA claim litigation, the question of what constitutes a “genuine issue of material fact” is difficult to resolve. Under a deferential standard of review,

the fiduciary must examine the relevant data and articulate a satisfactory explanation for its action including a “rational connection between the facts found and the choice made.” . . . In reviewing that explanation, we must “consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.” . . . Normally, [a decision by a plan administrator] would be arbitrary and capricious if the [administrator] relied on factors which Congress had not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it] or is so implausible that it could not be ascribed to a difference in view or the product of [its] expertise.¹¹¹

Other examples of arbitrary and capricious conduct include situations where the plain language or structure of the plan or simple common sense will require the court to pronounce an administrator’s determination arbitrary and capricious.¹¹² Likewise, “the fact that an administrator blatantly disregards an applicant’s submissions can be evidence of arbitrary and capricious action.”¹¹³

Yet just because a decision may fail one of these tests does not necessarily make it wrong. Thus, if the court finds a benefit determination is deficient in one or more of the above respects but is not necessarily the incorrect decision, the court could then conduct a “paper trial” to resolve the claim. Of course, there will be some cases where a determination is completely rational and without any genuine conflict, and summary judgment against the claimant would be the appropriate course. In other cases, the evidence will be one-sided in the other direction, and the plaintiff will be granted summary judgment. However, in the “garden variety” case, there will almost always be a conflict in the evidence, and neither summary judgment nor the application of an administrative law paradigm is an appropriate means of disposing of the claim. A “paper trial” or comparable summary adjudication is therefore necessary.

That approach is more consistent with civil litigation practice than a remand of a case, which again shows a mistaken application of

111. *Motor Vehicle Mfrs. Ass’n. of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

112. *See Hess*, 274 F.3d 456, 461 (7th Cir. 2001) (finding denial of disability benefits arbitrary and capricious). RESTATEMENT (SECOND) OF TRUSTS § 187 Comm. d states:

Factors in determining whether there is an abuse of discretion. In determining the question whether the trustee is guilty of an abuse of discretion in exercising or failing to exercise a power, the following circumstances may be relevant: (1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or nonexistence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee’s conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

113. 274 F.3d at 463.

administrative law concepts, a point duly noted by Judge Frank Easterbrook in *Perlman v. Swiss Bank Corporation*:

Although it is doubtful as an original matter that a district court may “remand” ERISA claims, as if to administrative agencies, we have held that courts may treat welfare benefit plans just like administrative law judges implementing the Social Security disability-benefits program. *Quinn v. Blue Cross & Blue Shield Ass’n*, 161 F.3d 472, 476-78 (7th Cir. 1998); *Schleibaum v. Knart*, 153 F.3d 496, 503 (7th Cir. 1998).¹¹⁴

Nowhere in the ERISA law is there authority for a remand; certainly, in other civil disputes of a comparable nature, no insurer would seriously argue to the court for the right to a remand. Yet the courts continue to make ridiculous distinctions about the resolution of ERISA benefit cases. In *Hackett v. Xerox Corporation Long-Term Disability Plan*,¹¹⁵ the court concluded the decision to remand should be based on whether the claim involves an initial determination or if the matter involves a termination of benefits, such as disability insurance payments, which had been ongoing. *Hackett* explains:

[i]n a case where the plan administrator did not afford adequate procedures in its initial denial of benefits, the appropriate remedy respecting the *status quo* and correcting for the defective procedures is to provide the claimant with the procedures that she sought in the first place. *Wolfe*, 710 F.2d at 394. If the claimant prevails on remand before the plan administrator, then the claimant would be entitled to retroactive benefits from the time at which the initial denial occurred. *Id.* However the court is not in the place to make the determination of entitlement to benefits. The court must not substitute its own judgment for that of the administrator. *Quinn*, 161 F.3d at 478; *see also Gallo v. Amoco Corp.*, 102 F.3d 918, 923 (7th Cir. 1996). The fact that the plan administrator failed to provide the adequate procedures does not mean that the claimant is automatically entitled to benefits—such a holding might provide the claimant “with an economic windfall should she be determined not disabled upon a proper reconsideration.” *Quinn*, 161 F.3d at 478.

On the other hand are cases where the plan administrator terminated benefits under defective procedures. In these cases the *status quo* prior to the defective procedure was the continuation of benefits. Remedying the defective procedures requires a reinstatement of benefits.¹¹⁶

This ruling may be appropriate in analyzing Social Security disability benefit disputes, but it has no support in the ERISA statutory language. If a decision regarding benefit eligibility is both defective and wrong, there is no reason why a claimant should be denied benefits. The court in *Hackett* speaks of a potential “windfall” to claimants, but there is no unjust enrichment where the evidence before the court justifies the benefit payment. The court further notes, in cases involving ongoing benefit payments, the employee benefit plan remains free to investigate ongoing eligibility to receive benefits.

Philosophically, the notion of a remand is antagonistic to our system of civil jurisprudence; moreover, it defeats the Congressional purpose of the

114. *Perlman v. Swiss Bank Corp.*, 195 F.3d at 978.

115. 315 F.3d 771, 776 (7th Cir. 2003).

116. *Id.*

ERISA statute. A law designed for the protection of plan participants and their beneficiaries fails to meet that goal where plan administrators are given multiple opportunities to shore up a defective record and benefits due are either delayed or denied. After the parties conduct a pre-suit appeal, the matter is ripe for judicial determination; and the courts fail in their role as arbiters of disputes when they remand claims rather than deciding them, even in cases where there may only be procedural defects but not necessarily a wrong decision. Although courts are loathe to become claim administrators, they necessarily fulfill that function in numerous comparable instances such as employment disputes and insurance coverage litigation; and without any statutory basis for a remand, courts are required to fulfill that role in ERISA cases as well.

X. CONCLUSION

The congressional purpose behind the enactment of the ERISA law has been thwarted by the courts' misapplication of an administrative law framework in resolving benefit disputes. By forgetting that ERISA benefit disputes are dissimilar from administrative proceedings in several key respects, courts have created a system of unfair, summary claim dispositions inconsistent with the Federal Rules of Civil Procedure. This is both an historic anomaly and contrary to the ERISA legislation and the goals Congress sought to achieve.

Courts must be wary of avoiding the temptation to use the term "administrative record," or to speak of "administrative exhaustion." Such language has no place in the ERISA law. As we have seen, the "review" in ERISA cases is markedly different from review of administrative decisions; and there is no basis for according either the same degree of deference to such findings or the same review procedures. Nonetheless, pending reversal by the Supreme Court, the *Firestone* ruling commits the courts to a deferential standard of review where an employee benefit plan contains the appropriate language, although we have seen that even the trust law approach is inappropriate where the benefit plan is unfunded or funded by insurance. Although the potential for a conflict of interest by the party determining benefits which also pays the benefits out of its general assets may be fertile ground for diminishing the discretion accorded, the Supreme Court has never clarified how a conflict is to be evaluated. While some courts find the presence of a conflict to render the claim decision presumptively void,¹¹⁷ ¹¹⁸ other courts either give no consideration to a conflict¹¹⁹ or apply a sliding scale, diminishing deference based on the degree to which the conflict infected the decision.¹²⁰ Thus, given the inconsistency in the courts' application of the conflict of interest, a more workable rule needs to be developed to reconcile a deferential standard of

117. *Brown v. Blue Cross & Blue Shield*, 898 F.2d 1556, 1563 (11th Cir. 1990) *cert. denied* 498 U.S. 1040 (1991).

118. Also see, *Fought v. Unum Life Ins. Co. of America*, 357 F.3d 1173 (10th Cir. 2004)(third party insurer required to establish reasonableness of decision by preponderance of the evidence in order to avoid taint of conflict of interest)

119. *Mers v. Marriott Intern. Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998).

120. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 379 (3d Cir. 2000).

review with the civil procedure accorded by the Federal Rules of Civil Procedure.

An additional consideration is to meet a desired goal of having claims processed “efficiently and fairly.”¹²¹ It makes little sense to conduct broad-ranging discovery in every case where a health insurer has denied reimbursement for a \$50.00 medical procedure. Nonetheless, in certain cases where the insurer has arguably engaged in bad faith or a pattern of denying similar claims, it may be justifiable to allow latitude to the plaintiff to expose the defendant’s misconduct.

Federal courts have the authority to invoke Rule 16 of the Federal Rules of Civil Procedure to manage cases. In the example above, it may be suitable to allow a minimal number of depositions to gain a better understanding of the insurer’s actions, and if a pattern can be developed, further discovery might be granted. It may also be appropriate to conduct jury trials in certain cases. However, as a practical matter, no claimant will seek broad discovery and a jury trial over a claim of modest value. It would be uneconomical for the client to pay fees that outweigh the value of the claim. It would also create a significant risk that a court would apply its discretion to deny an award of attorneys’ fees¹²² on the ground that the recovery was too insignificant to justify a fee award.

The Federal Rules of Civil Procedure contain a great deal of flexibility to assist the courts in expeditiously resolving disputes under ERISA in a fair and efficient manner. The trend of utilizing paper trials as an alternative to summary judgment has been a creative and well-received approach¹²³ that balances the value of employee’s claim against the cost of a full-blown jury trial. The paper trial mechanism also works under a deferential standard of review where the plaintiff can establish that the claim determination demonstrates arbitrary or capricious behavior. In such a case, the plan or insurer would still retain the ability to demonstrate the decision was correct.

However, the single most important goal is to meet Congress’s intent that the ERISA law assures protection and provides remedies to plan participants and their beneficiaries.¹²⁴ The administrative law model of adjudicating ERISA cases completely frustrates that end and merely encourages more claim denials that are all but immune to challenge when claimants are denied routine civil procedures such as discovery and the right to a hearing before a neutral, unbiased factfinder. As *Bedrick* so dramatically demonstrated, discovery fulfils a necessary purpose and exposes the poverty of Judge Easterbrook’s comment in *Perlman* that claimants should not be allowed to investigate the underpinnings of claim decisions. Nor can anyone disagree with Professor Wigmore’s assertion that cross-examination is “beyond any doubt the greatest legal engine ever invented for the discovery of truth.”¹²⁵ Claimants need those protections, which will only be available when courts dispense with the myth that ERISA

121. Halpin v. W.W. Grainger, Inc., 962 F.2d 685, 696 (7th Cir. 1992).

122. 29 U.S.C. § 1132(g) (2000) provides courts with discretion to award attorneys’ fees.

123. See generally Morton Denlow, *Trial on the Papers: An Alternative to Cross-Motions for Summary Judgment*, THE FEDERAL LAWYER, Aug. 1999, at 30-34 (exploring a trial on the papers as a time and work-saving judicial device).

124. 29 U.S.C. § 1001(b) (2000).

125. 5 J. WIGMORE, EVIDENCE § 1367 (J. Chadbourn rev. 1974).

cases are governed by administrative review proceedings and recognize that the Federal Rules of Civil Procedure apply to all civil actions, including ERISA cases.