

Bringing an ERISA Claim: A Step-by-Step Guide

By Mark D. DeBofsky

Insurance benefits offered by most private employers are governed by the Employee Retirement Income Security Act, one of the most comprehensive but least understood federal laws. This article explains how to bring ERISA claims and reviews important cases governing them, focusing on Illinois and the seventh circuit.

I. Introduction

It is impossible today to represent clients in the health, life, or disability insurance areas without a rudimentary understanding of ERISA, one of the most comprehensive but least understood federal laws.

When insurance benefits are offered by a private employer that is not a religious entity, they are governed by ERISA, thus transforming disputes under those plans to substantially different administrative and legal procedures than would govern individual insurance claims, which are litigated essentially as breach of contract actions. ERISA is an acronym for the "Employee Retirement Income Security Act of 1974," which was established 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.¹

ERISA applies to group insurance claims because the law was broadly drafted to encompass any "employee welfare plan[s]" or "welfare plan[s]," which are defined to include any

plan, fund, or program which...was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or

1. 29 USC §1001(b), quoted in *Varity Corporation v Howe*, 116 S Ct 1065, 1078 (1996).

benefits in the event of sickness, accident, disability, death or unemployment, or vacations benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services...."²

This definition applies both to insured and self-insured plans, a point made clear by the Supreme Court in companion decisions, *Pilot Life Insurance Co. v Dedeaux*³ and *Metropolitan Life Insurance Co. v Taylor*.⁴ Both involved claims for disability insurance benefits, but the significance of those cases in relation to any welfare benefit is that the decisions firmly established three issues: (1) ERISA applies to insured as well as self-insured employee benefit claims, (2) any suit seeking "welfare" benefits is removable to the federal court, and (3) ERISA preempts any attempt to seek common law remedies.

When ERISA applies, it preempts all other efforts and means to regulate employee benefit plans. The only exceptions are state laws that directly regulate insurance, an illustration of which was recently issued by the Supreme Court in *UNUM Life Insurance Company of America v Ward*.⁵ There, the Court ruled that a principle of insurance law known as the notice-prejudice rule is saved from preemption by ERISA to allow for late filing of disability claims. However, under another provision of ERISA's preemption clause, state regulation will not apply to self-funded plans, which are not "deemed" insurance companies.

As a result of *Taylor* and *Dedeaux*, employers and insurers have a nearly impenetrable shield in employee benefits litigation. They can remove all claims to federal court to avoid the risk of inconsistent state court rulings and are insulated from extra-contractual damages. Moreover, as will be explained below, this transformation of garden-variety insurance claims into ERISA lawsuits gave insurers/employers their most effective weapon of all: deferential review.

II. Pre-Suit Considerations/ Exhaustion of Administrative Remedies

If a claim is denied by an insurance company or a self-insured plan's administrator, the ERISA statute affords the claimant the right to a "full and fair

review"⁶ before litigation. Indeed, that requirement is virtually mandatory, being based on a strong federal policy that favors exhaustion of the administrative remedies afforded by the review. Although an exhaustion requirement is not explicitly set forth in the ERISA statute, the policy behind requiring exhaustion is to prevent "premature judicial intervention," to assure the courts that a claim has been fully considered by the plan administrator,⁷ and to "decrease the cost and time of claims settlement."⁸

Exhaustion of remedies is not always mandatory, though. Exhaustion is not required where 1) there is no meaningful access to the review procedures and 2) it would be futile.⁹ The first exception applies where the "claimant attempts to initiate higher levels of review procedure, but a party has denied claimant access to higher levels of review."¹⁰

Thus, if the administrator refuses to allow the claimant to participate in a review, or a letter denying benefits does not advise of the appeal procedures, administrative exhaustion is excused. In such cases, the duty to exhaust administrative appeals is excused because of the plan administrator's failure to meet the condition precedent of notifying the claimant of the appeal procedures.¹¹

Cases involving excused administrative review due to futility have interpreted that exception to apply to situations where a plan administrator has allowed an appeal but informed the claimant that the decision would not be changed; i.e., that the appeal is "doomed to fail."¹²

A third exception, although rarely used, is when there is a danger of irreparable harm - for example, denial of a medical treatment that must be administered immediately to save the patient's life. In such cases, ERISA procedures need not be exhausted.¹³

The consequence of a claimant's failure to exhaust required administrative remedies is that the court may not consider the merits of the dispute. In *Smith v Blue Cross*,¹⁴ the penalty imposed was summary judgment. More typically, though, the court will remand the claim for reconsideration by the plan administrator.¹⁵ However, as a warning to claimants who skip the appeal process and proceed directly to litigation, the court in *Tiger v AT&T Technologies Plan*

for Employees' Pensions, Disability Benefits¹⁶ found that the failure to appeal a benefit denial within the 60-day period set forth in the ERISA plan was a bar to judicial review.

Similarly, in *Graham v Federal Express Corporation*,¹⁷ the court barred a judicial action when the plaintiff failed to appeal a claim within the 60-day period allotted by the plan. Moreover, because the 60-day appeal period had long since elapsed when the action was brought, all further appeals were deemed untimely. Thus, the appeal period could act as a statute of limitations that precludes judicial review when a claimant fails to exhaust administrative remedies.

Note also that the review may be the only opportunity to submit evidence. In *Quesinberry v Life Insurance Company of North America*,¹⁸ the court held that in most benefits claims, the court should only consider the evidence presented to the plan administrator. Only exceptional circumstances in claims that receive a *de novo* review by the district court will justify receipt of additional evidence.

2. 29 USC §1002(1).

3. 481 US 41 (1987).

4. 481 US 58 (1987).

5. 119 S Ct 1380 (1999).

6. 29 USC §1133.

7. *Powell v AT&T Communications, Inc.*, 938 F2d 823, 826 (7th Cir 1991).

8. *Wilczynski v Lumbermens Mutual Casualty Co.*, 93 F3d 397, 402 (7th Cir 1996) (citing *Powell*).

9. *Smith v Blue Cross & Blue Shield United of Wisconsin*, 959 F2d 655, 658-59 (7th Cir 1992).

10. *Id.* at 659.

11. *Conley v Pitney Bowes*, 34 F3d 714 (8th Cir 1994).

12. *Diaz v United Agric. Employee Welfare Benefit Plan & Trust*, 50 F3d 1478, 1485 (9th Cir 1995).

13. *Henderson v Bodine Aluminum, Inc.*, 70 F3d 958 (8th Cir 1995).

14. 959 F2d 655, 658-59 (7th Cir 1992).

15. *Makar v Health Care Corp. of Mid-Atlantic*, 872 F2d 80, 83 (4th Cir 1989).

16. 633 F Supp. 532 (EDNY 1986).

17. 725 F Supp 429 (WD Ark 1989).

18. 987 F2d 1017 (4th Cir 1993).

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The court catalogued those circumstances 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.¹⁹

III. Procedure for Administrative Review

The trigger for the administrative appeal is the denial letter. ERISA regulations impose specific requirements for such letters, but, as stated by the seventh circuit, those requirements may be summarized as follows: "In a nutshell, ERISA requires that specific reasons for denial be communicated to the claimant and that the claimant be afforded an opportunity for 'full and fair review' by the administrator."²⁰

To meet those basic requirements, denial notices must contain (1) the specific reason or reasons for the denial, (2) specific reference to pertinent plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, and (4) appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.²¹

Absent substantial compliance with these requirements, the claimant is deemed to have been denied a full and fair review, and the benefit denial is subject to being vacated.²² Likewise, in *Boaton v Lockheed Medical Benefit Plan*,²³ the court cited the immortal line from *Cool Hand Luke* ("What we got here is a failure to communicate") to overturn a dental claim denial because the defendant's denial letter was unintelligible.

Upon receipt of the notice of denial, the claimant must be allowed a minimum of 60 days to submit an appeal. Then, after the appeal is submitted, the plan administrator is allowed 60 days to determine the appeal; or, if special cir-

cumstances exist (such as the need for a face to face hearing), the decision can be deferred for up to 120 days.²⁴

For the review to meet the statutory requirement of being "full and fair," the procedure must allow the claimant or his or her representative to "(i) [r]equest a review upon written application to the plan; (ii) [r]eview pertinent documents; and (iii) [s]ubmit issues and comments in writing."²⁵

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A frequent point of contention in the review process is the meaning of the requirement that the plan administrator allow review of "pertinent documents." The seventh circuit recently ruled that production of the entire claim file is not required.²⁶ Instead, the court limited the requirement to the somewhat amorphous obligation of "provid[ing] claimants with access to 'the evidence the decisionmaker relied upon' in denying their claim."²⁷ A more thorough explanation was presented in a case that preceded *Wilczynski*. In *Halpin v W.W. Grainger, Inc.*,²⁸ the court explained the intent of these regulations:

[T]he persistent core requirements of review intended to be full and fair include knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision.²⁹

The foregoing discussion incorporates the fundamental requirements of due process and

ensures that a full and fair review is conducted by the administrator, enables the claimant to prepare adequately for appeal to the federal courts or further

administrative review, and makes it possible for the courts to perform the task, entrusted to them by ERISA, of reviewing that denial.³⁰

Without these requirements, a claimant is unfairly hindered in an appeal by not knowing what evidence needs to be challenged. Requiring the administrator to articulate its view of the evidence keeps the claimant informed about possible misperceptions of medical reports and gives him or her the opportunity to supplement the record with additional medical evidence.

Indeed, the administrative appeal is usually the best opportunity to reverse an unfavorable determination. Because of the "full and fair review" requirement, a denial of benefits cannot be rubber-stamped. Also, because most of these claims will be reviewed in court under a deferential standard of review, failure to win at the administrative review will often significantly diminish the chances of succeeding in court.

This issue is currently under further consideration by the Department of Labor. In revisions to the regulations published in the *Federal Register* on September 9, 1998 (63 Fed Reg 48390), many of the controversial points discussed above would be clarified. Hearings on the regulations took place on February 17-19, 1999, although final regulations have yet to be issued. Among other changes, the revisions would

- clarify timeframes for decisionmaking;
- shorten timeframes in emergencies to 72 hours;
- require that the entire claim file be shared with the claimant;
- require that the plan provide inter-

19. 987 F2d at 1027; also see *Chambers v Family Health Plan Corporation*, 100 F3d 818 (10th Cir 1996) (catalogues cases on whether, and under what circumstances, additional evidence may be submitted in court).

20. *Halpin v W.W. Grainger Inc.*, 962 F2d 685, 688 (7th Cir 1992).

21. 29 CFR §2560.503-1(f).

22. *Halpin*, 962 F2d 685, 688 (7th Cir 1992); *Conley*, 34 F3d 714 (8th Cir 1994) (proper denial letter is condition precedent to claimant's duty to appeal).

23. 110 F3d 1461, 1465 (9th Cir 1997).

24. 29 CFR §2560.503-1(h).

25. 29 CFR §2560.503-1(g)(1).

26. *Wilczynski*, 93 F2d 397, 402 (7th Cir 1996).

27. *Id.*

28. 962 F2d 685 (7th Cir 1992).

29. *Halpin*, 962 F2d at 689 (citations omitted).

30. 962 F2d at 693.

nal rules, guidelines, protocols, and criteria under which it operates;

- require that claimants in certain circumstances be given documentation regarding how similar claims were handled;

- specify that the same party who made the initial decision cannot conduct the review;

- clarify that claimants can have considered on appeal all relevant information regardless of whether it was submitted as part of the initial claim;

- eliminate deference upon judicial review for plans that do not follow the regulatory guidelines;

- expose the plan to fiduciary liability for failure to follow guidelines.

IV. Jurisdiction

Of course, not all administrative reviews will be successful, and claimants must sometimes resort to litigation. Civil enforcement of claims brought under ERISA is provided by section 502 of the statute (codified at 29 USC section 1132). Principally, claims for insurance benefits are brought under 29 USC section 1132(a)(1)(B), which states as follows: "A civil action may be brought (1) by a participant or beneficiary — to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

Another possible source of jurisdiction is 29 USC section 1132(a)(3), which allows suits to be brought "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

Such claims, however, which allege breach of fiduciary duty, are usually dismissed by the courts, because an adequate remedy can be had under section 502(a)(1)(B) (29 USC section 1132(a)(1)(B)). In *Varity Corporation v Howe*,³¹ the court warned that claims for breach of fiduciary duty may only be brought sparingly and are not available where there is an adequate remedy under section 502(a)(1)(B). Usually, fiduciary-duty breach claims are limited to misrepresentation of benefits, although misrepresentations are not

actionable if the claimant could not justifiably rely on the information conveyed.³²

Another key jurisdictional issue is the proper forum in which to bring suit. ERISA provides for concurrent state court jurisdiction over benefit claims brought pursuant to section 502(a)(1)(B). However, the vast majority of these claims are determined in federal court, even if originally filed in state court, because of removal jurisdiction.³³

Finally, it is important to consider the proper parties in a suit under ERISA. Courts have relied primarily on the language of 29 USC section 1132(d)(2) ("[a]ny money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter") to hold that the only party defendant to an ERISA claim is the plan itself.³⁴

V. Litigation – The Standard of Review

Among the most significant issues in any ERISA claim, and the one most likely to determine the outcome, is the standard of review applied by the court. Because there are elements of trust law inherent in ERISA, the plan administrator is able to reserve discretionary authority to construe the terms of its plan and to determine claims. However, if such discretion is not reserved, the court must apply a *de novo* standard of review to the plan administrator's determinations.³⁵

If discretion is reserved, the court reviews the claim under an abuse of

31. 116 S Ct 1065, 1079 (1996).

32. *Pohl v National Benefits Consultants, Inc.*, 956 F2d 126 (7th Cir 1992).

33. *Metropolitan Life Insurance Co. v Taylor*, 481 US 58 (1987).

34. *Jass v Prudential Health Care Plan, Inc.*, 88 F3d 1482, 1490 (7th Cir 1996).

35. *Firestone Tire and Rubber Co. v Bruch*, 489 US 101, 109 S Ct 948 (1989).



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discretion standard or will determine whether the decision was arbitrary and capricious (although the two terms are often used interchangeably).³⁶ A claim determination is arbitrary and capricious under the following standard as expressed by the seventh circuit:

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.³⁷

An abuse of discretion is found "where the decision is in bad faith, not supported by substantial evidence, or erroneous on a question of law"³⁸ or where an ERISA plan administrator makes a decision that "conflicts with the plain language of the plan."³⁹ Case law also holds that because treating physician reports are entitled to greater weight than those from non-examining

doctors and consultants, the refusal to give appropriate weight to such reports is an abuse of discretion.⁴⁰

Ascertaining the appropriate standard of review requires examining the ERISA plan language. For example, in *Kearney v Standard Insurance Company*,⁴¹ based on a disability claim filed by a trial attorney who claimed he was unable to continue in his profession, one of the key issues was whether language in the disability insurance policy requiring submission of "satisfactory written proof" of disability conferred discretion to determine claim eligibility. The court found that the language was ambiguous and did not imply a reservation of discretion.

Similarly, in *Kinstler v First Reliance Standard Life Insurance Company*,⁴² the court ruled that the *de novo* standard of review applies both to plan interpretations and factual determinations. *Kinstler*, which also involved a disability claim brought under ERISA, found that language in the plan requiring the insured to submit proof satisfactory to

the insurer was still insufficient to reserve discretion. The court ruled its opinion was "reenforced...by recognition of the relative ease with which ERISA plans may be worded explicitly to reserve to plan administrators the discretionary authority that will insulate all aspects of their decisions from *de novo* review." The court added:

But a more fundamental point than this fine distinction about wording is that the word "satisfactory," whether in the phrase "satisfactory proof" or the phrase "proof satisfactory to [the decision-maker]" is an inadequate way to convey the idea that a plan administrator has discretion. Every plan that is administered requires submission of proof that will "satisfy" the administrator. No plan provides benefits when the administrator thinks that benefits should not be paid! Thus, saying that proof must be satisfactory "to the administrator" merely states the obvious point that the administrator is the decision-maker, at least in the first instance. Though we reiterate that no one word or phrase must always be used to confer discretionary authority, the administrator's burden to demonstrate insulation from *de novo* review requires either language stating that the award of benefits is within the discretion of the plan administrator or language that is plainly the functional equivalent of such wording. Since clear language can be readily drafted and included in policies, even in the context of collectively bargained benefit plans when the parties really intend to subject claim denials to judicial review under a deferential standard, courts should require clear language and decline to search in semantic swamps for arguable grants of discretion.⁴³



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36. *Chambers v Family Health Plan Corporation*, 100 F3d 818 (10th Cir 1996).

37. *Reilly v Blue Cross and Blue Shield United of Wisconsin*, 846 F2d 416, 420 (7th Cir 1988) (citations omitted), relying on *Motor Vehicle Manufacturers Assn. of the United States, Inc. v State Farm Mut. Auto. Ins. Co.*, 463 US 29, 43, 103 S Ct 2856 (1983).

38. *Williamson v UNLIM Life Insurance Company of America*, 943 F Supp 1226, 1228 (CD Cal 1996); citing *Neuill v Shell Oil Co.*, 835 F2d 209, 212 (9th Cir 1987); also see, *Morton v Smith*, 91 F3d 867, 870 (7th Cir 1996) (abuse of discretion found when a decision is "not just clearly incorrect but downright unreasonable" (citation omitted)).

39. *Saffle v Sierra Pacific Power Company*, 85 F3d 455, 458 (9th Cir 1996) (citing *Taft v Equitable Life Assurance Soc.*, 9 F3d 1469, 1472 (9th Cir 1993)).

40. *Donaho v FMC Corporation*, 74 F3d 894, 901 (8th Cir 1996); *Dodson v Woodmen of the World Life Insurance Society*, 109 F3d 436, 439 (8th Cir 1997).

41. 175 F3d 1084 (9th Cir 1999).

42. 181 F3d 243, 251 (2d Cir 1999).

43. *Id.* at 252.

However, another decision, *Perez v Aetna Life Insurance Company*,⁴⁴ ruled that deference may be granted even based on language stating that evidence need merely be satisfactory, because such language implies deference to determine whether the evidence is indeed satisfactory. A similar decision was reached in *Patterson v Caterpillar, Inc.*,⁴⁵ where the court ruled deference could be found from language that "benefits will be payable only upon receipt by the Insurance Carrier or Company of such notice and such due proof, as shall be from time to time required, of such disability" (although the viability of that ruling is questionable in light of a later decision, *Ramsey v Hercules, Inc.*,⁴⁶ where the court ruled a more specific grant of deference is required⁴⁷).

Even if courts apply the "arbitrary and capricious" or "abuse of discretion" standards to reviews of employee benefit claims, those standards are not always absolute. In the *Firestone Tire & Rubber Co. v Bruch* decision, the Court briefly discussed the possibility of a conflict of interest that exists where the plan administrator is also the payor of benefits, holding that such a conflict "must be weighed as a 'facto[r]' in determining whether there is an abuse of discretion."⁴⁸

The seventh circuit has expressed varying positions on the issue. For example, in *Hightshue v AIG Life Ins. Co.*,⁴⁹ a disability benefits case involving environmental illness in which the court ruled the denial of benefits was not an abuse of discretion, the court recognized the potential for a conflict of interest and stated as follows:

We recognize that AIG has a conflict of interest, because of its interests as both claims administrator and insurer....*Firestone* noted that the existence of a conflict of interest must be considered in determining whether the fiduciary acted arbitrarily and capriciously....When it is "possible to question the fiduciaries' loyalty, they are obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to insure that they act in the best interests of the plan beneficiaries."... Seeking independent expert advice is evidence of a thorough investigation, and provided that the fiduciary has investigated the expert's qualifications, has provided the expert with complete and accurate information, and determined that reliance on the expert's

advice is reasonably justified under the circumstances, the fiduciary's decision will be respected, despite the conflict of interest.

A few months later, though, the seventh circuit held in *Mers v Marriott International Group Accidental Death and Dismemberment Plan*,⁵⁰ a life insurance benefits case, that merely because an insurer is both claim administrator and claim payor, a conflict of interest cannot be presumed. Therefore, absent specific proof of actual bias, the court will not reduce the degree of deference accorded the benefits administration decision.

However, other courts find such conflicts render the plan's decisions "presumptively void." In *Brown v Blue Cross and Blue Shield*,⁵¹ the court explained the "presumptively void" standard by ruling that in the presence of a substantial conflict of interest,

the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the

conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.⁵²

Following these standards, a recent

44. 150 F3d 550 (6th Cir 1998).

45. 70 F3d 503, 505 (7th Cir 1995).

46. 77 F3d 199 (7th Cir 1996).

47. Other cases find a grant of discretion when the following language is used: *Donato v Metropolitan Life Insur. Co.*, 19 F3d 375 (7th Cir 1994) ("[a]ll proof must be satisfactory to us"); *Miller v Metropolitan Life Ins. Co.*, 925 F2d 979 (6th Cir 1991) ("on the basis of medical evidence satisfactory to the [company]"); *Bali v Blue Cross and Blue Shield Association*, 873 F2d 1043 (7th Cir 1989) ("on the basis of medical evidence satisfactory to the Committee").

48. 489 US at 115.

49. 135 F3d 1144, 1148 (7th Cir 1998).

50. 144 F3d 1014 (7th Cir 1998).

51. 898 F2d 1556 (11th Cir 1990); cert denied 498 U.S. 1040 (1991).

52. 898 F2d at 1566-67; also see *Atwood v Newmont Gold Co.*, 45 F3d 1317, 1323 (9th Cir 1995) (court "should not defer to the administrator's presumptively void decision"); *Kotrasits v GATX Corp.*, 970 F2d 1165, 1173 (3d Cir 1992); cert denied, 506 US 1021 (conflict of interest "counsels in favor of withholding deference").



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decision involving disability benefits ruled an insurance company had an inherent conflict of interest when it terminated a claim for disability benefits by applying an exclusion for mental disorders limiting payments to a maximum of two years. In *Lang v Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.*,⁵³ the court ruled an insurer's decision would be reviewed *de novo* despite the insurance plan's reservation of discretion on the ground that the insurer could not show its decision was not tainted by self-interest.

Similarly, in *Mitchell v Eastman Kodak*⁵⁴ the court overturned a disability insurer's requirement that a claimant suffering from chronic fatigue syndrome could not collect benefits absent objective proof of disability. The court determined that no plan language supported such a requirement; nor is compliance with such a requirement feasible in cases involving conditions such as chronic fatigue syndrome, where medical science has failed to develop objective testing. In light of such factors, the court held that it would defeat the legitimate expectations of policyholders to impose extracontractual requirements that the claimant could not meet.

VI. Litigation of ERISA Claims and Limitations on Recovery of Extracontractual Damages

The standard of review is not the only problem facing claimants in ERISA litigation. The scope of damages is also an important consideration because unlike typical "bad faith" insurance litigation, ERISA strictly limits damages that may be recovered. Since *Pilot Life*, there have been a variety of decisions precluding recovery for extracontractual damages in ERISA claims. For example, the seventh circuit ruled in *Reilly v Blue Cross and Blue Shield United of Wisconsin*,⁵⁵ that claims alleging intentional infliction of emotional distress and loss of consortium are preempted by ERISA, along with claims for conspiracy, fraud and common law bad faith.⁵⁶

Similarly, state laws imposing penalties on insurers who act in bad faith or unreasonably delay payment of claims (e.g., 215 ILCS 5/155) are also preempted by ERISA and are not available to ERISA claimants.⁵⁷ However, this issue

may be reopened in light of the Supreme Court's apparent retreat from preemption in the recent ruling in *UNUM v Ward*.⁵⁸

Accordingly, at least for the present time, damages in ERISA claims are limited to the remedies available under the plan. No matter how egregiously wrong or improper the plan administrator's behavior, a claimant will not be allowed any additional compensatory and punitive damages. The limitations of such an approach were discussed in *Dishman v UNUM*,⁵⁹ where a court found an insurer's termination of disability payments egregious and unscrupulous. Nonetheless, the court's ability to punish the offending insurer was limited by its statutory authority.

VII. Jury Trials

Under the present state of the law, the ERISA statute's silence regarding the availability of jury trials precludes the right to trial by jury. The reasoning of the courts is that ERISA claims are equitable rather than legal in nature; and many of the issues require a judge's determination, such as whether the plan administrator's decision was arbitrary and capricious or an abuse of discretion. In the seventh circuit, the principal case is *Wardle v Central States, Southeast and Southwest Areas Pension Fund*.⁶⁰

VIII. Attorney Fees

Although extracontractual damages are generally disallowed in ERISA litigation, pursuant to 29 USC section 1132(g), the court in its discretion may award attorney fees and costs to the prevailing party in an ERISA suit. While not required, an award of fees is expected absent "special circumstances [which] would render such an award unjust."⁶¹ The majority of courts apply a five-factor test to determine whether a prevailing plaintiff is entitled to fees in an ERISA benefit case. In *Bittner v Sadoff & Rudoy Industries*,⁶² the court set forth those factors:

- (1) [T]he degree of the offending parties' culpability or bad faith; (2) the degree of the ability of the offending parties to satisfy personally an award of attorneys' fees; (3) whether or not an award of attorneys' fees against the offending parties would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on members of the pen-

sion plan as a whole; and (5) the relative merits of the parties' "positions."⁶³ *Bittner* also stands for the proposition that there is a modest presumption in favor of awarding fees. Attorneys' fees may also be awarded to a prevailing defendant; however, such awards are rare and generally made only when the plaintiff acts in bad faith or the case is wholly frivolous.⁶⁴

As to the amount of fees that may be awarded, under the Supreme Court's ruling in *City of Burlington v Dague*⁶⁵ it is no longer permissible for a court to award a fee multiplier; however, it may still be possible to have the lodestar adjusted to reflect the risk of nonrecovery.

IX. The Future

The future of the applicability of ERISA on life, health and disability insurance (see sidebar) is presently uncertain. Given Congress' consideration of varying Patients' Bill of Rights bills and the lack of final Department of Labor regulations, the broad ERISA preemption is subject to attack from many sides, including the Americans with Disabilities Act. Many such battles should be lost or won within the next year and ERISA preemption will likely be a campaign issue in the 2000 election. ◀

53. 125 F3d 794 (9th Cir 1997).
 54. 113 F3d 433 (3d Cir 1997).
 55. 846 F2d 416 (7th Cir 1988).
 56. 846 F2d at 425-426.
 57. *Kamie v Connecticut General Life Ins. Co.*, 867 F2d 489 (9th Cir 1988); *Anschultz v Connecticut General Life Ins. Co.*, 850 F2d 1467 (11th Cir 1988). Also see *Bishop v Provident Life and Casualty Insurance Co.*, 749 F Supp 176 (ED Tenn 1990) (Tennessee bad faith claims processing statute); and *Harris v Blue Cross and Blue Shield of Texas*, 729 F Supp 49 (ND Tex 1990) (Texas law of bad faith, breach of duty of good faith and fair dealing).
 58. 119 S Ct 1380 (1999).
 59. 21 Employee Benefits Cas 2941 (CD Cal 1997).
 60. 627 F2d 820 (7th Cir 1980). Also see *Sullivan v LTV Aerospace and Defense Co.*, 82 F3d 1251 (2d Cir 1996) and *Morgan v Ameritech*, 26 F Supp 2d 1087 (CD Ill 1998) (court collects cases pro and con regarding jury trial right - decision that there is no right to jury trial).
 61. *Stanton v Larry Fowler Trucking, Inc.*, 52 F3d 723 (8th Cir 1995); *Smith v CMTA-IAM Pension Trust*, 746 F2d 587 (9th Cir 1984).
 62. 728 F2d 820, 828 (7th Cir 1984).
 63. *Id* at 828; also see *Armistead v Vernitron Corp.*, 944 F2d 1287 (6th Cir 1991); *Nachwalter v Christie*, 805 F2d 956 (11th Cir 1986); *Eddy v Colonial Life Ins. Co.*, 59 F3d 201 (DC Cir 1995).
 64. *Maune v IBEW Local No. 1, Health and Welfare Fund*, 83 F3d 959 (8th Cir 1996); *Little v Cox's Supermarkets*, 71 F3d 637 (7th Cir 1995).
 65. 112 S Ct 2638 (1992).