TESTIMONY OF WILLIAM M. ACKER, JR.
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF ALABAMA
BEFORE THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
SEPTEMBER 28, 2010

It is a privilege to be able to share with you this morning some of the thoughts of a trial judge who has been grappling with ERISA for twenty-eight years. Appointed in 1982, I sweated over ERISA, and watched other courts sweat over it, until in 1998 I wrote the law review article that probably prompted this Committee to invite me. The article was entitled "Can the Courts Rescue ERISA?" A copy of that article is attached to my testimony as Exhibit "A". Although my old arguments are now somewhat dated, my answer to the question then was "NO", and since that time I have not changed my mind. The courts have not rescued ERISA. **If anything, they have dug the ERISA hole deeper**. I am not saying that the courts, including the Supreme Court, have not **tried** to make sense of ERISA, and to make it workable, but in truth, the situation is worse in 2010 than it was in 1998, and getting worse every day.

I hope that the Committee is not as interested in citations of authority to support my views as it is in the views themselves, acquired from experience as a trial judge confronted for twenty-eight years with a constantly changing ERISA.

I am assuming that except for Chairman Baucus, whose State has done away with the so-called "discretionary clause", for Senator Stabenow, whose State has done the same thing, and for Senator

Cornyn, whose State is in the process of doing it, if it has not already done so, and, who, as Texas Attorney General, was sued by Corporate Health Insurance in the case that became central to the "five-to-four" decision by the Supreme Court in *Rush Prudential v. Moran*, the other members of this Committee have no specialized knowledge about ERISA, or of the effect that the so-called "discretionary clause" (first given prominence by the Supreme Court in *Firestone v. Bruch*) has had on the ERISA courts and litigants as they plod along.

The Committee has already heard or will hear testimony from others who are my intellectual equals or my superiors, who support the continuation of the "discretionary clause", as central to ERISA benefits decision-making. I will try to explain why the "discretionary clause" is a disaster, both as a matter of economics and as a denial of "due process".

The Economic Effect of *Bruch*
"The Law of Unintended Consequences"

Bruch put the fox in the henhouse when it authorized ERISA plan administrators to operate under the now universally used provision (except for Michigan and Montana) that allows the plan administrator both to interpret the plan and to decide how to apply it to a particular disability claim. This concept not only is foreign to logic and common sense, but is unworkable and expensive. I am attaching as Exhibit "B" a copy of the initial order I routinely use in ERISA disability benefits cases. A look at it

from top to bottom will illustrate the complexity of court decision-making, something that only takes place after the already lengthy processing of the administrative claim, and after the claim has been denied upon final review by the plan administrator.

A driving force behind the idea of granting the insurer/plan administrator/plan sponsor almost unbridled discretion is the belief that the procedure will lessen costs and lessen the time spent on ERISA cases. This contention is the main argument in the *amici curiae* briefs filed in support of Standard Insurance Company's unsuccessful *certiorari* petition that sought to overturn the decision that confirmed Montana's right to eliminate the "discretionary clause".

It is, of course, true that in drafting legislation, Congress has an obligation to consider the economic impact, as well as the needs of society. This judge is willing to assume that Congress engaged in that debate before it enacted ERISA. The language it chose in 1974, if it had not, over time, been altered or obliterated by the courts, would provide for *de novo* consideration by a court of all denials of ERISA benefits. ERISA's Section 502(a)(1)(B) straightforwardly provides that any beneficiary of a plan governed by ERISA can bring a "**civil action...to recover benefits due him under the terms of his plan**". Rule 2 of the Federal Rules of Procedure provides: "There is one form of action—the **civil action**". This language recognizes nothing less

than an independent consideration by a court, a "trial on the merits". The procedure concocted by the courts in the years since 1974, now called "judicial review", based on an examination of the administrative record, while giving deference to the conflicted decision-maker who has already denied the claim, simply does not fit the scheme that Congress contemplated. Under *Bruch*, "judicial review", a phrase never used in ERISA, the burden of proof is on the plan beneficiary to prove to the court on a cold record that the denial decision was "arbitrary and capricious" or was "an abuse of discretion" (interchangeable terms used by federal courts). This burden is too great, and too time consuming.

I have found no empirical evidence to justify the argument that the costs of a trial *de novo* would be greater than the costs of so-called "judicial review". If the courts thought that they were reducing their load, they were dead wrong. I only wish that I could have brought enough steamer trunks to hold all of the trial and appellate court opinions written under the *Bruch* rule. It makes one's head swim to read the long, convoluted opinions rendered by trial and appellate courts, during the preparation of which the judges and their law clerks have labored and sometimes tossed a coin.

Before a plan beneficiary can even bring his claim to court, he will spend much energy, and probably attorneys' fees. Lawyers do not like to undertake these cases on a contingent fee basis,

because even if they win, the award of a fee is within the court's discretion. A claimant faces a structurally-conflicted decision-maker, whose self-interest not only bears on the way it looks at the claim, but provides every reason to prolong the review process. Once the case gets to court, using the *Bruch* "abuse of discretion" standard, a voluminous court opinion will eventually emerge. It will necessarily compare in detail the hearsay of opposing medical experts and vocational experts who opine on the income that can be realized from an alternative job that the plaintiff can perform, and then try to justify either an "abuse of discretion", or no "abuse of discretion". The trial judge, if he or she takes *Bruch* seriously, starts by being intimidated.

This problem was exacerbated by the Supreme Court in *Metropolitan Life v. Glenn*. In that case, the high court, which quickly acknowledged the existence of a structural conflict-of-interest, held that judges must consider the conflict-of-interest as a "**factor**" in determining whether or not there has been an "abuse of discretion". This new rule encourages plan administrators to create procedures that look like a blunting of their conflict-of-interest. It also increases the work of the trial court.

After the complaint has been filed, the court must first decide whether to limit its consideration to a review of the so-called administrative record, which may be a thousand pages, or to

allow limited discovery during which the plaintiff can seek evidence that may place more weight on the inherent conflict-of-interest. This judge does not criticize his fellow jurists, but sympathizes with them, for the head scratching they do as they decide a controversy under the instructions given in *Bruch* and *Glenn*.

Not only does *Bruch* tilt the scales against the beneficiary on questions of fact, but on the interpretation of the plan. Ordinarily, the interpretation of a contract is for a court or a jury. In one of my cases, *Oliver v. Coca Cola*, the Eleventh Circuit held that my opinion interpreting the plan to resolve an obvious ambiguity against the draftsman, was correct, but another panel of the Eleventh Circuit, in a separate case, held that the same plan was reasonably construed the other way by the Coco-Cola claims committee, meaning that Coca-Cola's claims committee did not abuse its discretion when it arrived at its favorable construction of the contract Coca-Cola had drafted. *Oliver* was remanded to me with instructions to remand it, in turn, to the Coca-Cola claims committee for its reconsideration. If the case had not been settled at that point, the courts would still be laboring over it.

What Shell is the Pea Under?

Another chore for the trial courts that needs to be removed arises from the fact that defendants don't often confess their liability, and plaintiffs don't know which entity to sue. The

funding source for the payment of monetary benefits is often obscure. I will give you an example from my personal experience. In *Florence Nightingale Nursing Service v. Blue Cross*, the only defendant named in the complaint was Blue Cross, but the truth was that the plan sponsor, who was the only obligor, was Integraph Corporation, the employer of the beneficiary. Integraph only hired Blue Cross to be its **claims administrator**. Blue Cross did not file a third-party complaint against Integraph. I accidentally flushed out the problem during a pretrial conference, and obtained the agreement of the plan sponsor and the claims administrator, who were represented by the same counsel, that if liability was found, one or the other would pay. If I had not ironed out this problem beforehand, and a judgment had not been entered against Blue Cross which was not a proper party, I do not know what would have happened.

The long and the short of it is that the "independent" consideration of an ERISA claim a contemplated by Congress would save judicial resources and clients' money. When Standard Insurance Company asserted in its petition for *certiorari* in the Montana case, that doing away with "discretionary clauses will lead to far more complex and costly litigation", it was not only wrong as a matter of fact, but was using a scare tactic.

If Congress doubts me, I recommend an experiment in which Congress will now reiterate what it said in 1974 (with no possible

misunderstanding this time) that *de novo* trials are the only appropriate procedure in ERISA cases, and wait to see the cases and judicial opinions that are produced. If I am proven wrong, I will gladly eat my words. At my age that may be a safe bet.

Justice Delayed Is Justice Denied

You have heard the cliche "justice delayed is justice denied". It has real application to ERISA. My friend and fellow district judge, Brock Hornby of the District of Maine, as recently as July 8, 2010, in *Kane v. SI Metro Services*, held that a plan beneficiary had plausibly demonstrated the futility of the final appeal to the plan administrator insisted upon by the administrator, and therefore could go directly to court to contest the lower level claim denial. As a judge, I have never been asked to go as far as Judge Hornby, although in the only case I ever argued before the Supreme Court of the United States, I did convince that Court to excuse my client's failure to exhaust remedies that were futile. If you have time, take a look at *Glover v. St. Louis & San Francisco Railroad* decided in 1969. I have had many ERISA benefits cases that, before they got to me, had bounced around the administrative process for years. By the time the matter gets to me, the beneficiary is not only administratively exhausted, but, unless he has died trying, his health has deteriorated to the point that a remand to the plan administrator for reconsideration is tempting. If the parties, to start with, understood that a denial

would shortly result in a trial on the merits, serious settlement negotiations would take place before access to the court is sought.

Plan administrators have often asked me to remand cases to them, asserting that they have uncovered something that now casts doubt on their administrative decision. Many courts remand under such circumstances. This procedure, of course, prolongs the agony. I do not remand such cases to the plan administrator unless ordered to do so by a higher court.

Until Congress grants relief, I will continue scrupulously to follow the directions given by the Supreme Court in *Bruch* and *Glenn*, that is, if there is a "discretionary clause".

Applicability of Rule 56

Attached as Exhibit "C", is an opinion I wrote on September 16, 2010, attempting to explain the impossibility of using Rule 56 as a vehicle for what Congress in 1974 described as a "civil action", but which has evolved into a "judicial review", sort of like a Social Security administrative review. If there is no real dispute of material fact, Rule 56 disposition is, of course, appropriate, but there is almost always a dispute of material fact. Competing doctors strangely see things differently, even in unsworn hearsay, and are subject to questions of credibility. If the employer/insurer/plan administrator is privileged to decide the truth of the "facts",and where those "facts" lead, as well as what the plan means, the decision is rarely for the beneficiary, that

is, unless it is a slam dunk, and not always then. It is difficult enough to read a thousand page administrative record, extensive briefs, and write an opinion that finds the decision-maker to have abused its discretion, or not to have abused its discretion, but Rule 56 does not fit this scenario. In footnote 4 of the Eighth Circuit's recent opinion in *Khoury v. Group Health Plan*, it worried over this problem, saying:

> Courts have struggled with the use of summary judgment to dispose of ERISA cases...We decline to decide the propriety of the use of summary judgment procedures in this case because the issue was not raised by the parties...If a district court rejects the ruling of the administrator, the district court would then have to independently weigh the evidence in the administrative record and render *de novo* factual determinations, contrary to the summary judgment standard of review.

The Eighth Circuit obviously had reservations about courts resolving factual disputes.

Super-Duper Preemption

In 1995, the Supreme Court of Alabama in *Weems v. Jefferson-Pilot Life*, held that Alabama courts have jurisdiction over ERISA cases, and that extra-contractual and punitive damages are recoverable because the Seventh Amendment gives the right to trial by jury. That decision still stands in Alabama, although the Alabama trial courts, unless a defendant first removes the case to federal court, dismiss an ERISA case without prejudice *sua sponte*. They are influenced by the federal courts that have suggested the complete "exclusivity" of federal courts over ERISA cases. I call

this "super-duper preemption". There is no language in ERISA, any more than in the Fair Labor Standards Act or in Title VII, that denies concurrent jurisdiction to the state courts. I do not blame the Alabama trial courts for doing what they do, although I have no reason to doubt that they can handle ERISA cases as well as I can, if not better. There is ambiguity as to whether ERISA creates this "super-duper preemption". The federal and state courts need to be on the same page on this question, and Congress should write that page in a clear hand.

Conclusion

I have covered some, if not all, of my pet peeves. ERISA jurisprudence will stay as messed up as it is, unless Congress reworks it. **The courts have not rescued ERISA**, and cannot be expected to do so. The most important legislative change that I implore you to make is to make it clear that when Congress says "civil action", as it did in 1974, it means what it said, "civil action" and not "judicial review".

Thank you for the opportunity to share these thoughts with you.

EXHIBIT "A"

CAN THE COURTS RESCUE ERISA?

HON. WILLIAM M. ACKER, JR.[+]

> [G]iven the acknowledged, underlying purpose of ERISA to protect employees and beneficiaries in employee benefit plans, this case represents the point at which the preemption tide should be stayed. A finding of preemption in this case not only fails to further any such protective policy, it conceivably offers an unscrupulous employer a method of avoiding employee benefit "burdens." An employer in this circuit can now hoodwink a long time employee and leave him stranded without any recourse whatsoever. This result stands the entire statutory scheme on its proverbial head.
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> . . . .
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> [T]he combination of the majority's holdings—that Sanson's state cause of action is preempted by ERISA even while ERISA denies him any alternative remedy—is disappointingly pernicious to the very goals and desires that motivated Congress to enact pension laws in the first place.[1]

Occasionally, a statute comes along that is so poorly contemplated by the draftspersons that it cannot be saved by judicial interpretation, innovation, or manipulation. It becomes a litigant's plaything and a judge's nightmare. ERISA falls into this category. In *Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield*[2] I started my opinion with these three sentences:

> A hyperbolic wag is reputed to have said that E.R.I.S.A. stands for "Everything Ridiculous Imagined Since Adam." This court does not take so dim a view of the Employee Retirement Income Security Act of 1974. Instead, this court is willing to believe that ERISA has lurking somewhere in it a redeeming feature.[3]

Since writing *Florence Nightingale*, I have changed my mind. ERISA is beyond redemption. No matter how hard the courts have tried, and they have not tried hard enough, they have not been able to elucidate ERISA in ways that will accomplish the

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[1] 966 F.2d 618, 623, 625 (11th Cir. 1992) (dissent of Judge Birch).

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

[3] *Id.* at 1457.

purposes Congress claimed to have in mind. For more than ten years, I have consistently and constantly criticized ERISA, and I feel no compunction in lifting passages from my prior opinions as I write this article. I cannot plagiarize myself.

Although ERISA contains many provisions worthy of critical comment, in my few allotted pages I will concentrate on the jurisprudence that deals with the relief, if any, obtainable by the employee-participant-beneficiary of an alleged ERISA plan when she or he claims to have been mistreated.

Since its passage, the Employee Retirement Income Security Act of 1974[4] has been the subject of multitudes of legal opinions and scholarly comments. The numbers of problems dealt with by courts, both in published and unpublished opinions, are impossible to count, but they run into the multiple thousands. Because ERISA invites dispute and frustration, judges are deluged with ERISA cases. A quick reading of my own many opinions (if a quick reading were possible) reveals why I have now arrived at the conclusion that ERISA cannot be rescued and made workable by the courts.

Congress enacted a badly flawed statute. ERISA's shortcomings are so myriad that the only possible judicial fix would be by the Supreme Court of the United States itself taking a much more active role than it has taken thus far in reconciling conflicts between the circuits and in filling in the congressionally created interstices by some consistent, fair and logical jurisprudence. Because I am not willing to be counted among those who advocate judicial activism as a substitute for legislative action, I would like to see the courts abdicate in favor of Congress. It will take courageous judges or justices to say: "This statute doesn't make sense, so we'll just remand the matter to Congress while the litigants wait until the legislative branch gets its act together."

Congress must take a completely new look at the public policy issues it thought it was solving when it abdicated to the courts a perceived societal problem. Congress claimed to be adopting a scheme designed to protect the interests of participants in and beneficiaries of employee benefit plans. Thousands of opinions have mouthed platitudes about the broad remedial purpose behind ERISA, but the implementation of that purpose, if that purpose was ever really intended by Congress (a matter of legitimate debate), is in shambles.

[4] 29 U.S.C. §§ 1001-1461 (1985 & Supp. I 1998).

THE DOCTRINE OF PREEMPTION

The subject that has spawned the largest number of judicial opinions is "preemption."[5] Some courts call it "super preemption." I call it "super-duper preemption." The Supreme Court itself has noted the tremendous amount of judicial effort expended as courts attempt to get a handle on this concept. In *De Buono v. NYSA-ILA Medical and Clinical Services Fund*[6] the Supreme Court expressed its chagrin as follows:

> The boundaries of ERISA's pre-emptive reach have been the focus of considerable attention from this Court. . . . [I]n the 16 years since we first took up the question, we have decided no fewer than 13 cases. The issue has also generated an avalanche of litigation in the lower courts. . . . [A] LEXIS search uncovered more than 2,800 opinions on ERISA pre-emption.[7]

Any discussion of the preemption doctrine starts with the fact that ERISA supersedes state laws "insofar as they may . . . *relate to* any [ERISA covered] employee benefit plan."[8] It is difficult to reconcile this broad preemptive language with ERISA's legislative history. This history suggests that the recipients of retirement and medical benefits were the objects of great concern.[9] Yet, as the statute is applied, the real beneficiaries of ERISA, if any, turn out to be the fiduciaries, the administrators, the employers and the insurers. Preemption has come to mean that once state remedies are eliminated, ERISA provides the only remedy, which is either a pallid remedy or no remedy. This is why I call it "super-duper."

Super-duper preemption has fostered several lines of inquiry in most ERISA benefits cases. The defendant-fiduciary-administrator-employer-insurer invariably wants ERISA to govern because of ERISA's severely limited or absent remedies for the plaintiff-employee-participant-beneficiary. The plaintiff, on the other hand, invariably wants to proceed under some state law theory that provides what ERISA was supposed to provide,

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[5] For an overview of ERISA preemption, see generally Jack F. Fuchs, *Federalizing State Law Tort and Contract Claims: The Scope of ERISA Preemption*, 39 FED. B. NEWS & J. 582 (1992); David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427 (1987); Leon E. Irish and Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REFORM 109 (1985); Jolee Ann Hancock, Comment, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 CUMB. L. REV. 383 (1995).

[6] 520 U.S. 806 (1997).

[7] *Id.* at 1749 n.1 (citations omitted).

[8] 29 U.S.C. § 1144(a) (1985 & Supp. I 1998) (emphasis added).

[9] *See* S. REP. NO. 93-127, at 18 (1973) ("It is intended that coverage . . . be construed liberally to provide the maximum of protection to working men and women covered by private retirement programs.").

namely a greater "degree of protection to working men and women covered by private retirement programs."[10] In this context, several questions inevitably arise for a putative plaintiff:

> 1. How direct must the connection to an ERISA plan be for my particular claim to "relate to" the plan and thus be preempted?
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> 2. Is there really an ERISA-governed plan to which my claim can "relate?" If so, who are the plan's fiduciaries or my other possible targets under ERISA?
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> 3. Does my complaint invoke a state law scheme designed to regulate insurance, thus exempting it from ERISA preemption by ERISA's so-called "savings clause?"[11]
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> 4. If my claim "relates to" an ERISA plan that is not subject to the "savings clause," what remedies, if any, does ERISA itself provide for me? If ERISA's precise language does not expressly provide an adequate remedy, can the "federal common law" of ERISA fill the void? As a plan beneficiary, am I entitled to a jury trial?

DOES THE CLAIM "RELATE TO" A PLAN?

In choosing the phrase "relate to," Congress may have intended to make ERISA preemption as broad as possible. Alternatively, Congress may have intended to give the courts unlimited discretion to decide when ERISA should provide the only remedy for a person aggrieved and when it should not. Legislative history, cited as usual in both directions, provides little help. As for the courts, a majority has found that relates to is as broad as the ocean, preempting everything. A sizeable minority, however, has required an ERISA plan to be *directly* affected in order for an ordinary state law claim to evaporate under super-duper preemption. Of course, some claims are so obviously related to an ERISA plan as to admit of no argument, regardless of how the term is defined. A great number of claims remain for which the ruling court's attitude toward ERISA determines the outcome on the preemption question.

The whimsical nature of this outcome can be illustrated not only by the marked difference in results among federal courts, but also by the varied results between federal and state courts.[12] The clash between state and federal courts should come as no surprise inasmuch as state courts are bound only by the Su-

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[10] *Id.*

[11] *See* 29 U.S.C. § 1144(b)(2)(A) (1985 & Supp. I 1998) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities . . . .").

[12] States have concurrent jurisdiction over claims for ERISA benefits. *See* 29 U.S.C. § 1132(e)(1) (1985 & Supp. I 1998).

preme Court's interpretation of federal law.[13] The ability to disagree with the ERISA decisions of lower federal courts has allowed state courts (predictably) to be more reluctant than their federal counterparts in eliminating traditional state remedies and jury trial.[14] Unfortunately, the Supreme Court has given neither federal courts nor state courts sufficient guidance to make ERISA law uniform in either forum.[15] State courts have had little opportunity to speak on the subject because cases filed in state courts are promptly removed to a federal forum before the state courts can speak.

A survey of cases indicates that the words "relate to" stretch and contract like a rubber band. Within the expanding phase of the rubber band stand hundreds of cases in which courts (mainly federal courts) have found that a claim relates to an ERISA plan and, therefore, is preempted by ERISA, despite the fact that ERISA either affords no remedy whatsoever or a woefully inadequate one.[16] Within the contracting phase of the

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[13] *See* United States v. Woods, 432 F.2d 1072, 1075 (7th Cir. 1970). As the United States Court of Appeals for the Seventh Circuit explained: "Finality of determination in respect to the laws of the United States rests in the Supreme Court of the United States. Until the Supreme Court of the United States has spoken, state courts are not precluded from exercising their own judgment upon questions of federal law." *Id.*

[14] *See generally* Weems v. Jefferson-Pilot Life Ins. Co., Inc., 663 So. 2d 905, 911-13 (Ala. 1995).

[15] In *The Prudential Insurance Co. of America v. National Park Medical Center*, 154 F.3d 812 (8th Cir. 1998), the Court of Appeals for the Eighth Circuit spoke for all lower courts by saying: "The precise scope of ERISA preemption of state law has left courts, including the Supreme Court, deeply troubled." *Id.* at 815.

[16] *See, e.g.*, Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003, 1010 (9th Cir. 1998) ("ERISA preempts state law claims, even if the result is that a claimant, relegated to asserting a claim only under ERISA, is left without a remedy. The focus is on ERISA. If it does not provide a remedy, none exists."); Franklin v. QHG, Inc., 127 F.3d 1024, 1029 (9th Cir. 1997) (holding ERISA preempts state law tort claims of fraud in the inducement where determination of fraud claim would have required construction of ERISA plan benefits); McCleod v. Oregon Lithoprint, Inc., 102 F.3d 376, 378 (9th Cir. 1996), *cert. denied*, 520 U.S. 1230 (1997) (holding that ERISA's civil enforcement scheme was exclusive, that ERISA preempted the state law claims, and that damages were unavailable despite fact that plaintiff was left with no adequate remedy); Tolton v. American Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) ("That ERISA does not provide the full range of remedies available under state law in no way undermines ERISA preemption."); Custer v. Pan Am Life Ins. Co., 12 F.3d 410, 418-19 (4th Cir. 1993) ("Custer's contention that the defendants may be nonfiduciaries or that ERISA provides no remedy against nonfiduciaries, leaving a gap, is, in our view, immaterial to the resolution of this issue. The Act's preemption clause does not place the analysis on whether remedies are provided by the Act, but rather on whether the action *relates* to any employee benefit plan."); Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992) ("While we are not unmindful of the fact that our interpretation of the pre-emption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, the lack of an ERISA remedy does not affect a pre-emption analysis."); Cromwell v. Equicor-Equitable HCA Corp.,

rubber band stands a growing minority of courts that has been unable to stomach the absence of any real remedy for a defrauded or otherwise abused beneficiary under ERISA.[17] Faced with this situation, these courts have found an insufficient relationship between the claim and an ERISA plan to trigger preemption, thus leaving state law remedies in place.[18] Alternatively, such courts have manufactured an ERISA common law remedy that virtually duplicates the preempted state law remedy.[19] I call

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944 F.2d 1272, 1276 (6th Cir. 1991) ("Nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without remedy.").

17 *See, e.g.*, Michigan Affiliated Healthcare Sys., Inc. v. CC Sys. Corp., 139 F.3d 546, 550 (6th Cir. 1998); Whitt v. Sherman Int'l Corp., 147 F.3d 1325, 1331-32 (11th Cir. 1998); O'Connor v. Unum Life Ins. Co. of Am., 146 F.3d 959, 962-64 (D.C. Cir. 1998); Wolf v. Reliance Standard Life Ins. Co., 71 F.3d 444 (1st Cir. 1995) (holding ERISA preemption waived as a defense); Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53 (4th Cir. 1995); Warner v. Ford Motor Co., 46 F.3d 531, 534 (6th Cir. 1995).

18 *See, e.g.*, Toumajian v. Frailey, 135 F.3d 648, 654 (9th Cir. 1998); Washington Physicians Serv. Ass'n v. Gregoire, 147 F.3d 1039, 1043 (9th Cir. 1998) ("A law does not 'relate to' an ERISA plan merely because it produces indirect economic effects that happen to influence the shopping choices that the benefit plan must make."); Morstein v. National Ins. Serv., Inc., 93 F.3d 715, 724 (11th Cir. 1996) (en banc) (holding that state law claims against an independent insurance agent and his agency for fraudulent inducement to purchase and negligence in processing an application for an ERISA-governed insurance plan are not preempted by ERISA because these claims "do not have a sufficient connection with the plan to 'relate to' the plan"); Forbus v. Sears Roebuck & Co., 30 F.3d 1402, 1407 (11th Cir. 1994) (holding that an Alabama fraud statute was not preempted by ERISA, when the statute at issue "does not require the establishment or maintenance of an ongoing plan, makes no reference to an ERISA plan, and functions irrespective of any such plan"); National Rehabilitation Hosp. v. Manpower Int'l, Inc., 3 F. Supp. 2d 1457, 1460 (D.D.C. 1998); McNatt v. Franklin Life Ins. Co., 998 F. Supp. 1253, 1254 (N.D. Ala. 1997); Levett v. American Heritage Life Ins. Co., 971 F. Supp. 1399, 1402 (M.D. Ala. 1997); Alacare Home Health Serv., Inc. v. Prudential Ins. Co., 957 F. Supp. 208, 209 (M.D. Ala. 1997); Gray v. New York Life Ins. Co., 879 F. Supp. 99 (N.D. Ala. 1995); Hensley v. Philadelphia Life Ins. Co., 878 F. Supp. 1465, 1466 (N.D. Ala. 1995) ("ERISA's super-preemption as a basis for federal question jurisdiction pursuant to 28 U.S.C. §§ 1441(b) and 1331 cannot be triggered simply by calling a particular insurance policy an ERISA plan and alleging that the plaintiff's claim relates to it."); Cook Wholesale of Medina, Inc. v. Connecticut Gen. Life Ins. Co., 898 F. Supp. 151, 153 (W.D.N.Y. 1995); Haley v. Trees of Brookwood, 838 F. Supp. 1553 (N.D. Ala. 1993) ("ERISA's superpreemption of state law claims does not render removable a state court complaint alleging that employer represented that insurance coverage would be continued under the Consolidated Omnibus Budget Reconciliation Act of 1988 (COBRA), knowing that there would be no such coverage and that the former employee would have no right to complain under COBRA."); Bryant v. Blue Cross & Blue Shield of Al., 751 F. Supp. 968 (N.D. Ala. 1990); McDonald v. Houston Brokerage, Inc., 928 S.W.2d 633, 638 (Tex. Ct. App. 1996).

19 *See* Cisneros v. Unum Life Ins. Co., 115 F.3d 669 (9th Cir. 1997), *withdrawn and superseded by* 134 F.3d 939, *cert denied*, 119 S. Ct. 1495 (1999). In the seminal preemption case of *Ingersoll-Rand v. McLendon*, the Supreme Court may have temporarily encouraged a belief among the federal courts that remedies similar (if not identical) to preempted state remedies could easily be fashioned with a principle of federal ERISA "common law." Ingersoll Rand Co. v. McLendon, 498 U.S. 133,

these not examples of judicial activism, but of justice. This judge has joined this new reluctance to make ERISA a black hole.[20]

The Supreme Court has recently indicated that the reach of the relates to language is not unlimited.[21] In *De Buono v. NYSA-ILA Medical and Clinical Services* the Supreme Court used the stated objectives of ERISA to limit the scope of "relates to."[22] At issue in *De Buono* was a New York state law that imposed a tax on gross receipts for certain health care services.[23] The court considered the actual operation of the state statute and concluded that the law at issue was one of a "myriad [of] state laws of general applicability that impose some burdens on the administration of ERISA plans, but nevertheless do not 'relate to' them."[24] The court acknowledged that the state law had a direct impact on the ERISA fund's decisions regarding coverage of health care services provided to its beneficiaries, but found this impact insufficient to bring the plan within ERISA preemption.[25] Specifically, the court stated that "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."[26] This statement represents a significant narrowing of the court's interpretation of ERISA preemption.

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145 (1990). This still-lingering idea derives from the Supreme Court's statement, made after unanimously finding the state claim at issue preempted, that "*the relief requested here is well within the power of federal courts to provide.*" *Id.* at 145 (emphasis added). Apparently, the Supreme Court did not mean what it said, because it has never repeated or encouraged other courts to follow the above-quoted expression. Some of the lower courts have also retreated from decisions that attempt to fashion an ERISA common law. *See Cisneros*, 134 F.3d at 947 (retreating from an earlier opinion issued in the same case in which the court incorporated the state law rule at issue into the federal common law of ERISA).

20 *See, e.g., McNatt*, 998 F. Supp. at 1253; *Gray*, 879 F. Supp. at 99; *Hensley*, 878 F. Supp. at 1465; *Haley*, 838 F. Supp. at 1553; *Bryant*, 751 F. Supp. at 968.

21 *See* De Buono v. NYSA-ILA Med. and Clinical Serv. Fund, 520 U.S. 806 (1997). *See generally* California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316 (1997); New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

22 De Buono v. NYSA-ILA Med. and Clinical Serv. Fund, 520 U.S. at 813-14 ("[W]e must go beyond the unhelpful text and the frustrating difficulty of defining [ERISA's] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." (citations omitted)).

23 *Id.* at 1749.

24 *Id.* at 1752 (citations omitted).

25 *See id.* at 1752-53.

26 *Id.* at 1753 (footnote omitted).

Wilson v. Zoellner[27] provides another recent example of a federal court flatly rejecting preemption under circumstances that most federal courts would have construed as sufficiently related to an ERISA plan to accomplish preemption. In *Wilson* the United States Court of Appeals for the Eighth Circuit found that because the state common law dealing with negligent misrepresentation was a law of general application, made no reference to, and functioned independently of ERISA, it did not relate to ERISA.[28] As the Eighth Circuit explained: "The law is clear that fraud claims against an insurance agent who solicits participation in an ERISA plan are not preempted under ERISA."[29]

Wilson's action against Zoellner would not have had any direct economic impact on the ERISA plan. A majority of courts would have found that Wilson's claim related to an ERISA plan and would have preempted his fraud claim against his insurance agent. Was the Eighth Circuit foolhardy or prophetic? In *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*[30] the Eighth Circuit demonstrated its internal schizophrenia by finding Arkansas's so-called "Patient Protection Act" preempted "by virtue of [its] making reference to and having a connection with ERISA plans . . . ."[31] At the same time the Eighth Circuit was retreating in *National Park Medical Center*, the Court of Appeals for the Ninth Circuit was advancing. In *Emard v. Hughes Aircraft Co.*[32] the Ninth Circuit decided that California's community property law, which clearly interfered with an ERISA plan's contractual obligation to pay benefits in a specific way, was not sufficiently related to the plan to be preempted. The most interesting thing about this obvious conflict between the Eighth and the Ninth Circuits is that they both rely on *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*[33] They simply read the Supreme Court differently.

The lower courts' resentment of ERISA's ambiguity and impracticality is palpable.

IS THE PLAN AN ERISA PLAN?

Many courts simply *assume* that ERISA provides the only

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[27]
[28] 114 F.3d 713 (8th Cir. 1997).
[29] *Id.* at 717 (citations omitted).
[30] *Id.* at 719.
[31] 154 F.3d 812 (8th Cir. 1998).
[32] *Id.* at 817.
[33] 153 F.3d 949 (9th Cir. 1998).
514 U.S. 645 (1995).

remedy for an employee complaining that he or she has been defrauded, or complaining that a benefits obligor has not met its obligation. This second assumption is based on the first assumption that there is an ERISA plan. Some judges, however—including this one—do not indulge the assumption that every scheme designed to provide employee medical, disability, or pension benefits is an ERISA plan. This judge requires litigants to prove that an ERISA plan *actually exists*, something that is not always easy to do.[34]

An extended question confronted by the would-be ERISA plaintiff is: "Who can I sue?" On this question, the courts again go in different directions. Some have difficulty finding a fiduciary or fiduciaries, even if a plan exists.[35] Others find that even a non-fiduciary can be sued under ERISA.[36] This creates chaos. For its part, the United States Court of Appeals for the Eleventh Circuit has held that the employer, not the insurer, is the only proper party defendant if the employer is the plan administrator.[37] A beneficiary's finding a target under ERISA has become a shell game.

WHEN DOES THE "SAVINGS CLAUSE" PROVIDE ESCAPE FROM ERISA?

Even if a claim admittedly relates to a proven ERISA-governed plan, the claim is "saved" from preemption if it is brought pursuant to a state law regulating insurance.[38] Courts of various jurisdictions have diversely interpreted ERISA's "savings clause." The confusion surrounding what is and is not saved from ERISA preemption can be illustrated by *Cisneros v. Unum Life Insurance Co.*[39]

In *Cisneros* the United States Court of Appeals for the Ninth Circuit found that a state law prohibiting an insurer from avoiding liability due to a beneficiary's late filing (unless the insurer

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[34] *See* Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118, 1120 n.2 (9th Cir. 1998) ("The burden of establishing the existence of an ERISA plan is on Paul Revere."); Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822 (N.D. Ala. 1988). *See generally* Kemp v. International Bus. Machines Corp., 109 F.3d 708 (11th Cir. 1997).

[35] *See* Santana v. Deluxe Corp., 920 F. Supp. 249 (D. Mass. 1996); Useden v. Acker, 721 F. Supp. 1233 (S.D. Fla. 1989), *aff'd*, 947 F.2d 1563 (11th Cir. 1991).

[36] *See, e.g.*, Herman v. South Carolina Nat'l Bank, 140 F.3d 1413, 1420 (11th Cir. 1998); LeBlanc v. Cahill, 153 F.3d 134 (4th Cir. 1998).

[37] *See* Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186 (11th Cir. 1997).

[38] *See* 29 U.S.C. § 1144(b)(2)(A) (1985 & Supp. I 1998). A self-insured plan does not constitute "insurance" for the purposes of the "savings clause." *See* 29 U.S.C. § 1144(b)(2)(B) (1985). No court appears to have considered the effect of a state insurance regulation on an employer's self-funded plan that is reinsured by an insurance company subject to regulation.

[39] *See generally* 115 F.3d 669 (9th Cir. 1997), *withdrawn and superseded by* 134 F.3d 939 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1495 (1999).

proved substantial prejudice from the delay) was saved from preemption because the state law constituted an insurance regulation.[40] The Ninth Circuit's first opinion went even further and found that this notice-prejudice concept was incorporated into the federal common law of ERISA.[41] On rehearing, the court retreated from this alternative justification for non-preemption.[42] In *Unum Life Ins. Co.* v. *Ward*[43] the Supreme Court reviewed the Ninth Circuit's *Cisneros* opinion and unanimously agreed that California's notice-prejudice rule was saved because it "regulate[d] insurance" and thus was not preempted. Inconsistently, I think, the Supreme Court simultaneously found that California's court-created rule, which made an employer the "agent of the insurer in performing the duties of administering group insurance policies," was nothing more than part of the general law of agency, did not "regulate insurance," and was therefore preempted. Why one of these two California rules regulated insurance and the other did not defies explanation.

The ultimate impact of the savings clause is yet to be determined. Any state legislature jealous of the traditional rights of action available to victims of fraudulent or abusive acts by insurers or their allies could enact a statutory scheme that expressly names regulation of the insurance industry as its purpose. Such a statutory scheme could justifiably incorporate traditional remedies for misrepresentation and other fiduciary abuses, such as claims for mental anguish and punitive damages, under carefully defined circumstances. Thus far, with the exception of Arkansas, no state legislature has been this gutsy. The Arkansas state legislature, however, has made the mistakes recognized by the Eighth Circuit in *Prudential Insurance Company v. National Park Medical Center*[44] by targeting only "health care providers" and having the audacity to mention ERISA while proscribing certain conduct.[45] When a state legislature awakens to the possibilities of the savings clause and enacts a statutory scheme that can survive judicial scrutiny, super-duper preemption, as a practical matter, will become less than super-duper.

WHAT REMEDIES DOES ERISA ITSELF PROVIDE?

Defendants' routine removal to a federal forum of every

[40] *Id.* at 675.
[41] *See id.*
[42] *See* Cisneros v. Unum Life Ins. Co., 134 F.3d 939, 947 (9th Cir. 1997), *cert. denied*, 119 S. Ct. 1495 (1999).
[43] 119 S. Ct. 1380 (1999).
[44] 154 F.3d 812 (8th Cir. 1998).
[45] *Id.* at 819.

case in which there is even the slightest possibility of successfully contending that the claim relates to an ERISA plan proves (if proof were needed) that ERISA's few express remedies are pitifully inadequate. Either Congress was hypocritical in stating ERISA's predominant purpose to be the protection of the rights of the beneficiaries of medical and retirement plans while simultaneously eliminating traditional remedies, or Congress was asleep at the switch.

In ERISA, Congress did not mention whether disputes were to be resolved by jury or by judge, leaving the courts to decide whether jury trials are available in ERISA cases. Most courts that have addressed the matter, including the Eleventh Circuit, have held that jury trials are not available under ERISA.[46] Congress apparently deliberately failed to address the availability of extra-contractual damages in ERISA controversies. A majority of courts that has addressed the issue, again including the Eleventh Circuit,[47] has limited an ERISA plaintiff to contractual damages, misdescribed as "restitution," which is a traditional equitable remedy.[48] This limitation prevents a prevailing ERISA plaintiff from recovering damages for mental anguish or for punishment of the malefactor, regardless of how much suffering a deliberately malicious fiduciary has caused by an intentional misrepresentation or by an inexcusable refusal to pay a valid claim.[49]

Although federal courts generally find extra-contractual damages and jury trials unavailable in ERISA actions, some state courts have reached different conclusions. The Supreme Court of Alabama, for example, allows recovery of extra-contractual and punitive damages, plus a jury trial, in ERISA cases.[50] Ala-

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[46] *See, e.g.*, Adams v. Cyprus Amax Minerals Co., 149 F.3d 1156, 1162 (10th Cir. 1998); Blake v. Unionmutual Stock Life Ins. Co. of Am., 906 F.2d 1525, 1526 (11th Cir. 1990); Bair v. General Motors Corp., 895 F.2d 1094, 1096 (6th Cir. 1990).

[47] *See, e.g., Blake*, 906 F.2d at 1525.

[48] *See generally* Drinkwater v. Metropolitan Life Ins. Co., 846 F.2d 821 (1st Cir. 1988); Hemelt v. United States, 951 F. Supp. 562 (D. Md. 1996), *aff'd*, 122 F.3d 204 (4th Cir. 1996); Rutledge v. American Gen. Life and Accident Ins. Co., 871 F. Supp. 272 (N.D. Miss. 1994).

[49] *See, e.g.*, Godfrey v. BellSouth Telecommunications, Inc., 89 F.3d 755, 761 (11th Cir. 1996); Sanson v. General Motors Corp., 966 F.2d 618 (11th Cir. 1992) (Birch, J., dissenting); McRae v. Seafarers' Welfare Plan, 920 F.2d 819, 821 (11th Cir. 1991).

[50] *See, e.g., Ex parte* Metropolitan Life Ins. Co., 679 So. 2d 686 (Ala. 1996) (Justice Houston, who had dissented from *Weems*'s holding that the Seventh Amendment guarantees an ERISA claim the right to a jury trial, joins majority in *Metropolitan Life* only because U.S. Supreme Court denied certiorari in *Weems*.); Weems v. Jefferson-Pilot Life Ins. Co., 663 So. 2d 905 (Ala. 1995); Haywood v. Russell Corp., 584 So. 2d 1291 (Ala. 1991).

bama is not the only state that deviates from the Eleventh Circuit's denial of extra-contractual damages, punitive damages and trial by jury.[51] In *Shaw v. Atlantic Coast Life Insurance Co.* the Court of Appeals of South Carolina, swimming upstream with Alabama, held that an ERISA claimant is entitled to a jury trial.[52]

Whether these state courts are correct or the Eleventh Circuit is correct regarding these ERISA issues depends on a definitive expression by the Supreme Court of the United States, or by Congress. One hopes that the Supreme Court will not ignore the Seventh Amendment jury trial issue in ERISA cases as it did in Title VII cases between 1964, the date of the enactment of the Civil Rights Act of 1964, and 1991, the date of when that Act was amended to provide for jury trial.[53] After twenty-six years Congress finally recognized the Seventh Amendment when the Supreme Court would not.

The federal courts have not obtained and will not obtain unanimity on the jury trial issue and the extra-contractual damages issue without Supreme Court direction. Before the Eleventh Circuit made clear its position that ERISA does not permit jury trials, the writer of this article held to the contrary.[54] Other federal judges have also occasionally held that the Seventh Amendment guarantees trial by jury in an ERISA case.[55] In *Adams v. Cyprus Amax Mineral Co.*, for example, a perspicacious district judge found an ERISA beneficiary entitled to a jury trial.[56] He was promptly reversed by the United States Court of Appeals for the Tenth Circuit.[57]

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[52] *See* Shaw v. Atlantic Coast Life Ins. Co., 470 S.E.2d 382 (S.C. Ct. App. 1996).

[53] *Id.* at 387.

[54] *See generally* 42 U.S.C.A. § 1981 (West 1984).

See Whitt v. Goodyear Tire & Rubber Co., 676 F. Supp. 1119 (N.D. Ala. 1987), *reconsideration denied sub nom.* Amos v. Blue Cross and Blue Shield of Al., 681 F. Supp. 1515 (N.D. Ala. 1988), *rev'd*, 868 F.2d 430 (11th Cir. 1989), *reh'g denied*, 875 F.2d 878 (11th Cir. 1989), *cert. denied*, 493 U.S. 855 (1989). The Supreme Court of Alabama followed the author of this article instead of the Eleventh Circuit. *See also* Blue Cross and Blue Shield of Ala. v. Lewis, 753 F. Supp. 345 (N.D. Ala. 1991); Rhodes v. Piggly Wiggly Ala. Distrib. Co., 741 F. Supp. 1542 (N.D. Ala. 1990).

[55] *See generally* U.S. CONST. amend. VII (The Seventh Amendment states: "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.").

[56] 954 F. Supp. 1470 (D. Colo. 1997).

[57] *See* 149 F.3d 1156 (10th Cir. 1998). The Tenth Circuit had earlier "decline[d] to reach this thorny issue [of ERISA jury trial]" after acknowledging that "ERISA does not specify whether cases arising under section 502 or section 510 are to be tried by a jury." Zimmerman v. Sloss Equip., Inc., 72 F.3d 822, 829-30 (10th Cir. 1995).

Even the Eleventh Circuit may be undergoing an opinion shift on the jury trial issue. In *Stewart v. KHD Deutz of America Corp.*[58] the Eleventh Circuit joined the Seventh Circuit in holding that "plaintiffs are entitled to a jury trial in hybrid LMRA/ERISA actions."[59] *Stewart* involved a claim for relief under both the Labor Management Relations Act (LMRA) and ERISA for defendant's failure to provide health benefit coverage in violation of collective bargaining agreements.[60] Though Eleventh Circuit precedent made clear that a jury trial is unavailable to plaintiffs in a pure ERISA claim,[61] the *Stewart* plaintiffs claimed a right to a jury trial under the LMRA, an issue of first impression for the Eleventh Circuit.[62] In granting plaintiffs a right to a jury trial, the court looked into the same question that it had considered when earlier it looked at ERISA, that is, whether the relief sought was "legal" or "equitable" in nature.[63] The court noted: "Monetary relief . . . is only presumed to be a legal remedy. A monetary award may be characterized as an equitable remedy if it is found to be 'incidental to or intertwined with injunctive relief.'"[64]

Arguing that the monetary relief sought in *Stewart* was equitable in nature, defendant understandably relied on the Eleventh Circuit's decision in *Blake v. Unionmutual Stock Life Insurance Co.*[65] In *Blake* the Eleventh Circuit characterized monetary relief in ERISA claims as equitable relief, thus precluding Seventh Amendment jury trial.[66] The *Stewart* Court rejected defendant's argument, finding that *Blake*'s classification of monetary damages in ERISA claims was "not determinative" of what constitutes monetary damages in LMRA-ERISA cases.[67] In my view, *Blake* suffered serious erosion in *Stewart*. The Eleventh Circuit could have easily applied *Blake* to prevent the *Stewart* plaintiffs from obtaining a jury trial.

Further erosion of the basis for denials of jury trials in ERISA cases has occurred at the Supreme Court level. Last year

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[58] 75 F.3d 1522 (11th Cir. 1996).
[59] *Id.* at 1528.
[60] *Id.* at 1524.
[61] *See* Blake v. Unionmutual Stock Life Ins. Co., 906 F.2d 1525, 1526 (11th Cir. 1990).
[62] *Stewart*, 75 F.3d at 1525.
[63] *Id.* at 1525-26.
[64] *Id.* at 1526 (citing Chauffeurs, Teamsters & Helpers Local No. 391 v. Terry, 494 U.S. 558, 571 (1990)).
[65] *Id.* at 1526-27; *see also Blake*, 906 F.2d at 1526.
[66] *Blake*, 906 F.2d at 1526.
[67] *Stewart*, 75 F.3d at 1527.

the Supreme Court in *Feltner v. Columbia Pictures Television, Inc.*[68] reiterated its recognition that the "'general rule' [is] that monetary relief is legal" and, therefore, a statutory cause of action for monetary relief carries with it the Seventh Amendment right to trial by jury.[69] The Court relied on this principle in holding that the Fair Labor Standards Act provides a right to trial by jury, despite the absence of any express authorization by Congress.[70] Other courts have reached similar decisions when construing statutes that, like ERISA, contain no express provision authorizing a jury trial.[71]

The combination of the bleeding wound *Blake* suffered in *Stewart* and the Supreme Court's statement in *Feltner* provides a more than sufficient reason for trial courts within the Eleventh Circuit to reopen the question of whether ERISA claims are triable by a jury. A recent statement by the Eleventh Circuit provides even further encouragement for reexamining the availabity of jury trials in ERISA cases.[72] In *Chambers v. Thompson* the Eleventh Circuit acknowledged an obligation to repudiate its prior holdings under circumstances such as here exist. The court stated: "We are bound to follow a prior panel or en banc holding, except where that holding has been overruled or undermined to the point of abrogation by a subsequent en banc or Supreme Court decision."[73]

Ironically, state and federal courts, sharing jurisdiction over most ERISA matters, split on issues that have not been addressed with sufficient particularity by the Supreme Court of the United States and that have not been clarified by Congress. As noted above, the Supreme Court sidestepped the jury trial issue in Title VII employment discrimination cases for twenty-six years and has likewise avoided the issue in ERISA cases since 1974. With the scholarly commentators divided[74] and the courts in

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[68] 523 U.S. 340 (1998).

[69] 118 S. Ct. at 1287.

[70] *See id.* at 1283-84.

[71] *See, e.g.*, Lorillard v. Pons, 434 U.S. 575, 580-81 (1978) (finding right to jury trial in Age Discrimination in Employment Act despite no express provision); Frizzell v. Southwest Motor Freight, 154 F.3d 641 (6th Cir. 1998) (finding right to jury trial in Family Medical Leave Act despite no express provision).

[72] *See* Chambers v. Thompson, 150 F.3d 1324, 1326 (11th Cir. 1998).

[73] *Thompson*, 150 F.3d at 1326.

[74] *See generally* Denise Drake Clemow and Lisa Hund Lattan, *ERISA Section 510 Claims: No Right to a Jury Trial Can Be Found*, 73 NEB. L. REV. 756 (1994); Michael McCabe, Jr., Comment, *The Right to a Jury Trial in Benefit Recovery Actions Brought Under ERISA Section 502(a)(1)(B)*, 20 U. BALT. L. REV. 479 (1991); Nancy L. Pirkey, Note, *The Availability of Jury Trials in ERISA Section 510 Actions: Expanding the Scope of the Seventh Amendment*, 27 VAL. U. L. REV. 139 (1992); Note, *The Right to Jury Trial in Enforcement Actions Under Section 502(a)(1)(B) of ERISA*, 96 HARV. L. REV.

disarray, the Supreme Court should now take a case in order to decide, at the very least, the jury trial issue. The court has already expressed its displeasure with ERISA, but more action is needed.

A new flexibility may also be developing in the once strict rule that denied plaintiffs traditional damage awards such as compensation for mental anguish and punitive damages for particularly egregious conduct on the part of an ERISA obligor. Although Eleventh Circuit decisions clearly prohibit an award of extra-contractual damages, *contract* damages have not yet been precluded. Alabama allows recovery for mental anguish for breach of contract under circumstances where such damages are foreseeable or within the contemplation of the parties.[75] In *McWilliams v. American Medical International, Inc.*[76] a judge of my court employed this concept and in an ERISA case awarded substantial contract damages for mental anguish.[77] That case is on appeal to the Eleventh Circuit. I do not predict the appellate outcome, but do point out that a contract requiring the payment of medical benefits, when breached by the obligor, virtually always causes some degree of mental anguish to a person who may desperately need medical attention, but cannot receive it. If damages for mental anguish can be recovered under a contract theory, the ERISA prohibition against extra-contractual damages (except punitive) may become passé.

THE SOLUTION, IF THERE IS ONE

On September 9, 1998, the Pension and Welfare Benefits Administration of the Department of Labor, which has certain ERISA rule-making power, issued proposed regulations that would require ERISA health benefit plan administrators to decide a claim for urgent care within 72 hours of receiving the claim and a non-urgent care claim within 15 days after the claim is filed.[78] The proposals would also require the prompt furnishing of pertinent information to the claimant. In my view, this will be applying a "band-aid" to the problem, even though it may reduce the defendant-employer-administrator-fiduciary's footdragging, previously done with impunity. After the comment period ends on November 9, 1998, these proposals, unless deep-sixed, will become final. Still, they fall far short of provid-

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737 (1983).

[75] *See* Sexton v. St. Clair Fed. Sav. Bank, 653 So. 2d 959, 960 (Ala. 1995).

[76] 960 F. Supp. 1547 (N.D. Ala. 1997).

[77] *McWilliams*, 960 F. Supp. at 1547.

[78] 63 Fed. Reg. 48, 391 (1998).

ing a solution to the problems inherent in the Congressional language, and unresolved by the Supreme Court.

The "Long Range Plan for the Federal Courts," adopted in December 1995, by the Committee on Long Range Planning of the Judicial Conference of the United States, contains the following recommendations:

> The jurisdiction of the federal courts to adjudicate routine claims for benefits under ERISA employee welfare benefits plans should be abolished, except when application or interpretation of federal statutory or regulatory requirements are at issue.
>
> Any new cooperative federal-state program to establish national standards for employee benefits (e.g., health care) should designate state courts as the primary forum for the review of benefit denial claims. However, any such program should include establishment of an administrative remedial process that must be exhausted before a state court action may be filed.[79]

In 1995, a publication entitled "Federal Practice Advisory"[80] proposed the following:

> Certain kinds of federal rights ought to be adjudicated only in the state courts, which have always had concurrent jurisdiction over suits involving workplace injuries under the Federal Employers' Liability Act and the Jones Act, as well as suits for employee benefits under the Employee Retirement Income Security Act (ERISA). Any new program establishing national guidelines for health care should make the state courts the primary forum for review of the denial of benefits.

I agree with these recommendations. They simply translate into a recommendation that ERISA be repealed. Congress is presently contemplating several possible corrective measures. If Congress is unwilling to recognize ERISA's abject failure, we will have a long wait for either ERISA's judicial or regulatory redemption. I will not be around to see it if it comes.

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[79] *Long Range Plan for the Federal Courts*, Dec. 1995 at 29 (published by Committee on Long Range Planning of the Judicial Conference of the United States).

[80] Issue No. 63, Jan. 16, 1995, p. 3.

EXHIBIT "B"

INITIAL ORDER IN ERISA BENEFITS CASES

The above-styled case appears to claim benefits and/or other relief under the Employee Retirement Income Security Act ("ERISA"). It therefore requires specialized treatment. Pursuant to Rule 26(f) and Rule 16, Federal Rules of Civil Procedure, the court will conduct a scheduling and status conference in chambers at ____ on _____, 201_. No less than seven (7) calendar days before said conference, each party shall file with chambers (not the Clerk) paper answers to the following questions involving subjects that will be more fully explored at the conference:

(1) If plaintiff has named more than one defendant, is a particular named defendant, or a third-party who is not a defendant, the entity liable for the ERISA violation or violations alleged if any such violation is found by the court? If so, name that entity.

(2) Does any defendant, if it has done so, plan to file a cross-claim or third-party action?

(3) Furnish a paper copy of the administrative record as it presently exists, including the plan document and the summary plan description. Are the parties in agreement about the accuracy and completeness of the administrative record as it presently exists? If the parties disagree about the accuracy or completeness of the current administrative record, what is the basis for disagreement?

(4) If the court should find any defendant liable under ERISA, do the parties agree as to the amount due, taking into consideration any offsets? If so, state that amount. If not, each party shall explain the amount it proposes in the event of a finding of liability.

(5) If the parties agree on the interest rate on benefits from the date of accrual, state the rate. If disputed, state the rate proposed by each party with its explanation.

(6) Does plaintiff seek benefits only pursuant to 29 U.S.C. § 1332(a)(1)(B), or does plaintiff seek relief pursuant to 29 U.S.C. § 1332(a)(3)?

(7) Should the case be decided on the administrative record alone? If not, what additional presently available evidence should be considered, and why?

(8) Will discovery beyond the administrative record be needed? If so, describe the nature of such evidence, and how the requesting party proposes to obtain it.

(9) What is the standard-of-review, and why?

(10) Does any defendant rely upon a discretionary clause in the plan? If so, does the clause meet the *Bruch* standard? If not, why not, including any contention by plaintiff that the summary plan description is deficient or inconsistent with the plan?

(11) Did any decision-maker whose decision is being contested, operate under a structural conflict-of-interest? If so, explain.

(12) Does any defendant claim insulation from liability by virtue of the existence of a trust or a totally disinterested decision-maker? If so, describe, including all documents by which decision-making authority is delegated. Furnish paper copies of all contracts or agreements by or between the plan sponsor, the claims administrator, the ultimate decision-maker, and the funding source.

(13) What entity or entities fund, whether directly or indirectly, any obligation to pay benefits?

(14) What, if any, control does the plan sponsor have over the benefits decision-making process, including any right to appoint any who participate in the decision-making process?

(15) Upon any appeal by the alleged beneficiary from an original denial of benefits, are the decision-makers the same as those who originally denied benefits? If different, explain the difference.

(16) If there is any alleged conflict-of-interest by any decision-maker, what steps have been taken, if any, to eliminate or

ameliorate that conflict?

(17) If any defendant interposes a defense of plaintiff's alleged failure to exhaust administrative remedies, what does that failure consist of?

(18) Is any defendant unwilling to waive all right to seek a remand of the dispute to the plan administrator or other decision-making entity? If not willing, why not?

(19) Does plaintiff claim that there is any procedural shortcoming by defendant or defendants that may affect liability, such as untimeliness of the denial decision (without limiting the scope of the question)? If so, describe.

(20) Has the Social Security Administration been involved in any way in the subject-matter of the case. If so, describe and give the result.

(21) Does plaintiff complain about any decision-maker's interpretation of plan language? If so, what is the difference in interpretation between the parties?

(22) Does plaintiff complain about any of the plan administrator's findings of fact (in contrast to conclusions reached upon such findings)? If so, in what respects?

(23) Does any party believe that the liability question cannot be finally disposed of on cross-motions upon a written record, whether or not supplemented beyond the present administrative record? If not, why not?

(24) Does any party dispute the right of the court, upon unsworn and uncross-examined written testimony, to make credibility determinations when material facts are in dispute? If so, explain.

(25) When will the case be ready for final disposition, whether upon cross-motions or upon bench trial?

(26) Does any party desire mediation?

DONE and ORDERED this ____ day of ____, 201_.

_____
UNITED STATES DISTRICT JUDGE

EXHIBIT "C"

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

TOMMY EDGAR, Plaintiff, v. DISABILITY REINSURANCE MANAGEMENT SERVICES, INC., et al., Defendants.	}	CIVIL ACTION NO. 09-AR-1562-S

MEMORANDUM OPINION AND ORDER

This court has previously held, and still believes, that Rule 56, F.R.Civ.P., was not designed for, and is only awkwardly used for, the resolution of disputes over entitlement to disability benefits under the Employee Retirement Security Act of 1974, 29 U.S.C. § § 1001, *et seq.* ("ERISA"). Nevertheless, the case law as it has evolved since 1974, despite the variants and contradictions introduced to the hodge-podge by the courts forced to deal with it, overlooks the plain language Congress used in ERISA. ERISA, properly understood, simply provides a trial *de novo* in all cases in which an application for benefits under an ERISA plan is finally turned down by the plan functionary. Section 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B)) straightforwardly says that any participant in a plan governed by ERISA can bring a **"civil action" "to recover benefits due him under the terms of his plan"**. (emphasis added). What is a "civil action", if not a lawsuit? The courts have substituted for the trial *de novo* unequivocally

mandated by Congress a procedure akin to, and borrowed from, the review of an administrative law judge's decision on a Social Security disability benefits claim. The words "judicial review" nowhere appear in ERISA. "Judicial review" is expressly provided for in a section of the Social Security Act, 42 U.S.C. § 405(g), which is itself entitled "**Judicial Review**". ERISA complaints and Social Security appeals are different animals.

The above-entitled case perfectly illustrates the problem inherent in an attempt to use Rule 56 as the device for resolving an ERISA controversy, especially when only one of the parties files a motion for summary judgment, and the parties do not agree to submit on the record. In the instant case, defendants, Disability Reinsurance Management Services, Inc. and Boston Mutual Life Insurance Co. ("defendants"), have jointly moved for summary judgment. Defendants are represented by the same counsel, and agree that they are to be treated as one. Siamese twins do not ask to be separated if they are happy together.

In the joint report of parties' planning meeting, the parties on October 8, 2009, expressed a stark difference of opinion as to the procedure under which their dispute must be resolved. The court, at the present instant, cannot resolve their **ultimate** dispute, but the court **must** resolve the difference of opinion as to **how to proceed** at this juncture. Defendants' position on October 8, 2009, was that "the Court's review of the claim decision is

limited to the administrative record and no discovery is appropriate beyond production of the administrative record with the possible exception of information relating to Plaintiff's income and other financial information that would be pertinent to Plaintiff's ongoing claim for benefits". On the other hand, plaintiff, Tommy Edgar ("plaintiff"), on October 8, 2009, took the position that limited discovery should be allowed and that the *de novo* standard of review applies. On October 9, 2009, the court entered its scheduling order, adopting the parties' joint suggestion of dates for early disclosure of expert witnesses. Plaintiff was to disclose experts by February 12, 2010, and defendants by March 12, 2010. Those dates have passed. What the purpose of disclosing experts was if a **trial** was not contemplated is not explained by defendants. Plaintiff has only implicitly and enigmatically attempted to explain it. The court ordered a discovery deadline of July 16, 2010, and a dispositive motion deadline of August 20, 2010. The lengthy time period between entry of the scheduling order and the deadline for completing discovery suggests that some discovery outside the administrative record was contemplated. Exactly what discovery has actually been undertaken is not known by the court, because there have been no objections to any discovery requests and no motions to compel.

Although the parties did not request a planning meeting with the court before the court entered its scheduling order, the court

eventually sensed what it should have sensed much earlier, namely, that the parties have diametrically opposing views about the so-called "standard of review". When the light dawned, the court ordered a conference on May 24, 2010, for the purpose of exploring and deciding upon the proper "standard of review". On June 8, 2010, defendants formally conceded that the "standard of review" is *de novo*. The reason for this concession may be that defendants' "discretionary clause", a provision now found in virtually every ERISA disability plan, and given overriding significance by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 (1989), is defective. Perhaps defendants' draftsman did not understand *Bruch*.

If defendants had admitted *ab initio* that the "standard-of-review" is *de novo*, and had convinced the court that the case must be decided on the administrative record alone, this case would have been decided much sooner, and with less expense. An early motion for partial summary judgment on the "standard of review", would have helped.

The joint report of parties filed on October 8, 2009, requested, *inter alia*, a "final pretrial conference with the Court 30 days before **trial**"; that "final lists of **trial** witnesses and experts under Rule 26(a)(3) must be filed by the parties 30 days before **trial**"; that "objections be filed within 10 days after a service of final list of trial evidence"; and that "the case should

be ready for trial by October 4, 2010" (emphasis added). The scheduling order entered on October 9, 2009, provided, *inter alia*: "All *in limine* motions based on *Daubert* must be filed prior to the final pre-trial conference." The court's reference to *Daubert* was without meaning unless a challenge by one party of the credentials and opinions of the opponent's experts was a future possibility. There can be no gate-keeping role for the court if an administrative record provides the only basis for decision.

The parties' planning report concluded with these revealing counter-expressions: "Defendants request a trial on briefs because this is an ERISA case and the Court's review is limited to the administrative record", whereas, "Plaintiff requests a bench trial and states that the trial is expected to last two days". Why would defendants even speak of a "**trial**"? The word "**trial**" does not fit an appellate review. Who ever heard of a "**trial**" in the Supreme Court, unless in a conflict between States? The "summary judgment" concept is not employed in appellate review any more than is a "trial". Defendants must have meant to be requesting oral argument on anticipated motions for summary judgment.

Defendants timely filed their Rule 56 motion, now under submission. Perfectly consistent with plaintiff's unwaivering position, he did not file a motion for summary judgment. Instead, he argues that there are disputes of material fact that preclude summary judgment, either for him or for defendants.

No citation is needed to support the long established acknowledgment by the federal courts, including the Supreme Court and the Eleventh Circuit, that on its face Rule 56 places upon the movant the burden of demonstrating that there are no disputes of material fact and that movant, on those facts, is entitled to judgment as a matter of law. The presentation of evidence by the non-movant, together with all reasonable inferences to be drawn therefrom, is to be treated as true for the purposes of deciding whether there is a genuine issue of material fact. It is not surprising that defendants' rendition of the evidence (lifted from the administrative record) is only supportive of, and consistent with, the conclusion, adverse to plaintiff, that was reached by the defendants' ERISA plan decision-makers. Defendants necessarily argue that upon a *de novo* consideration of the administrative record, they were **right** to deny plaintiff's claim for disability benefits. The evidence employed by the claim evaluators to reach their decision is elaborately described by defendants. There is no recognition by defendants of *contra proferentem*, a rule that applies to contract interpretation upon any *de novo* consideration of a contract. Defendants have no trouble in construing in their favor the contract they drafted. Defendants' evidence, of course, may prove ultimately successful at trial. It need not be repeated or analyzed here. Plaintiff's evidence proffered in opposition to defendants' Rule 56 motion is also detailed, but plaintiff

concentrates upon his argument that there **are** disputes of material fact, rendering Rule 56 inappropriate. This court agrees with plaintiff on this score.

The parties have not cited a single Eleventh Circuit or Supreme Court case, and this court has found none, making a persuasive argument that ERISA alters the routine way Rule 56 motions are to be treated and decided. It is somewhat strange that there is such a dearth of jurisprudence attempting to solve this procedural anomaly. There is some academic comment on the subject, but this court finds nothing to compare with the following thoughtful treatment of the problem by the Seventh Circuit in *Krolnik v. Prudential Ins. Co.*, 570 U.S. 841, 843 (7th Cir. 2009), a case that fits this case like a glove:

> *Firestone* holds that "*de novo* review" is the norm in litigation under ERISA. Cases such as this show that "*de novo* review" is a misleading phrase. The law Latin could be replaced by an English word, such as "independent." And the word "review" simply has to go. For what *Firestone* requires is not "review" of any kind; it is an independent *decision* rather than "review" that *Firestone* contemplates. The Court repeatedly wrote that litigation under ERISA by plan participants seeking benefits should be conducted just like contract litigation, for the plan and any insurance policy are contracts. 489 U.S. at 112-13, 109 S.Ct. 948. In a contract suit the judge does not "review" either party's decision. Instead, the court takes evidence (if there is a dispute about a material fact) and makes an independent decision about how the language of the contract applies to those facts.
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> That's well understood in insurance litigation under the diversity jurisdiction. If the plaintiff says that a fire at his home destroyed a valuable painting, and the insurer declines indemnity after finding that (a) there was no such painting, and (b) the fire was caused by

> arson, the federal judge won't ask what evidence the insurer considered. The court will decide for itself where the truth lies. A judge would not dream of forbidding the parties to take discovery, let alone of rejecting affidavits that did not depend on discovery. Evidence is essential if the court is to fulfill its fact-finding function. Just so in ERISA litigation. When review is deferential—when the plan's decision must be sustained unless arbitrary and capricious—*then* review is limited to the administrative record. See *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir.1999). Otherwise, however, the court decides on the record made in the litigation. And, if material evidence conflicts, then there must be a trial.

(emphasis in original). The Seventh Circuit denied rehearing and rehearing *en banc*.

What can a trial court do when there is a legitimate dispute of material fact in an ERISA benefits case in which the parties have not agreed to submit on the administrative record? The Seventh Circuit was entirely correct in *Krolnik* when it held that an ERISA benefits claim is nothing more or less than a claim for breach of contract. Rule 56 does not lend itself to making credibility determinations or decisions about ambiguous language when witnesses disagree about crucial facts, such as the conflicting medical findings in this case. At **trial**, the burden of proof will, of course, be on the plaintiff, as in any contract case, to prove by a preponderance of the evidence the terms of the contract, and that the contract was materially breached. The court assumes that plaintiff understands his obligation.

This court does not pretend to have the right, much less the ability, to decide a controversy based upon unsworn opinions and

unseen, uncross-examined witnesses. From experience as a trial lawyer and as a judge, this court knows that a trier-of-fact may find that the "light was green" on the basis of **one** sharp-eyed, disinterested witness, even though he is contradicted by **three** other witnesses, all of whom say the "light was red", when one of the three was drunk, one is the best friend of the injured party, and one is vision-impaired. **Believability** is something that cannot be fairly determined on a cold record that is made up of disputed renditions of the evidence upon which differing conclusions can reasonably be reached.

Defendants' final brief in response to plaintiff's brief spends little time trying to refute plaintiff's contention that Rule 56 is not the appropriate vehicle for a decision in this case. Instead, defendants reiterate the evidence and arguments that accompanied their Rule 56 motion, and upon which they may very well prevail at trial. Oral argument would be fruitless at this time. Material facts are in dispute, and defendants' denial of benefits is not to be accorded deference. The inevitable, structural conflict-of-interest recognized in *Metropolitan Life v. Glenn*, 552 U.S. 1161, 128 S.Ct. 1117 (2008), may be at play at trial, but it is not relevant now. Defendants' argument that Rule 56 disposition is mandatory under the present circumstances makes no sense. If the "standard of review" had been "abuse of discretion" or "arbitrary and capricious" (synonyms in the Eleventh Circuit), the

court would be bound by precedent (with which it respectfully disagrees), and would have had to decide this dispute without a trial on the merits, whether under Rule 56 or under the "made-up" procedure employed by some courts. A *de novo* standard requires an entirely different approach. This standard has been **statutorily** mandated by Michigan and Montana where "discretionary clauses" are forbidden. *See Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009), and *Standard Insurance Company v. Lindeen*, 584 F.3d 837 (9th Cir. 2009), *cert.den.* ____ U.S. ____, 130 S.Ct. 3275 (2010). Why Alabama has not followed Michigan and Montana is an academic question because the way to look at this dispute is anew.

For the foregoing reasons, defendants' motion for summary judgment is DENIED. This opinion would have required a fist full of pages if the court had been forced under the deferential standard to struggle to explain why the evidence does provide or does not provide a rational basis for defendants' denial decision. The fact that the standard here is *de novo*, or, as the Seventh Circuit says, "**independent**", locks in the requirement that the case be tried on the merits.

ERISA badly needs revision, but this court is not Congress and is neither authorized to rewrite ERISA nor to amend the Federal Rules of Civil Procedure.

The case is hereby SET for pretrial conference in Courtroom 4B, **at 9:30 a.m., September 30, 2010,** in accordance with the

attached pretrial instructions.

DONE this 17th day of September, 2010.

WILLIAM M. ACKER, JR.
UNITED STATES DISTRICT JUDGE