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FORTY YEARS OF ERISA JURISPRUDENCE: A LEGACY OF LIMITED PROTECTIONS BUT THE STEADY EROSION OF CONTRACT RIGHTS

Introduction

Forty years ago Congress passed the Employee Retirement Income Security Act of 1974 ("ERISA" or the "Act"). The Act was designed to encourage the creation of benefit plans and protect the benefits offered employees who worked in the private sector. Although the primary focus is the protection of pension benefits, the Act's application is broad, covering health, disability, and life insurance benefits offered to private-sector employees.[1] Health, disability and life insurance benefits are collectively referred to as welfare benefits within ERISA, and the Act provides that those who administer welfare benefit plans are subject to some of the same fiduciary responsibilities as administrators of pension plans. The Act included the creation of pension insurance administered by the Pension Benefit Guaranty Corporation, providing employees a government guaranty that upon retirement they would receive at least some, if not all, of their vested pension benefits if their employer could not meet its pension obligations.

Congress explained its purpose in enacting ERISA within the first section of the Act:

> It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing appropriate remedies, sanctions, and ready access to the Federal courts.[2]

ERISA's Current Legacy: Claimants Strive to Avoid the Act Enacted for Their Benefit.

Although the Act's purpose was to promote the creation of employee benefit plans and protect those benefits for employees, since ERISA's enactment most employees with pension or welfare benefit claims do whatever they can to escape the "protections" of the Act, while insurance carriers and employers that fund and administer the benefit plans push to have the claims governed by ERISA. Case law portraying an employee's struggle to have his or her pension or welfare benefit claim governed by ERISA is almost non-existent. Instead, ERISA benefit case law over the last forty years reveals a common theme: the employee's Sisyphean struggle to avoid ERISA.[3] The mountain of cases finding preemption is tall and imposing. The employee stands in the valley with her claim, her rock, using every ounce of physical energy and creative power to push her rock up and over the mountain, to free herself from the Act designed for her benefit. The fiduciary stands calmly upon the side of the mountain, seeking to return the rock to the valley where the protections of the Act lie, pressing the already heavy rock against the employee's skin, muscle, and bone, forcing it back downhill. Naturally, given the slope of the mountain and the application of pressure by the fiduciary, the rock almost always returns to the valley. The employee watches hopelessly as her heavy burden crashes back down the hill, seeing with despair that all of her toil was for nothing. She is confined to the valley. Many claimants, especially those who are already impaired when they began their quixotic ascent, remain beaten.

The primary reason for the seemingly endless repetition of this Sisyphean struggle is because ERISA decisions have guaranteed the underwriters of ERISA plans and policies deferential review provided their benefit plans contain a simple phrase or sentence that grants discretionary power to the plan fiduciary. The words can be as simple as "the plan fiduciary shall have full discretion to decide benefit claims." This simple phrase is held to protect them from the traditional "preponderance of the evidence" burden of proof applied in other breach of contract cases, the burden of proof that would have been applied before the enactment of ERISA, or the burden of proof commonly applied to those who work in the public sector or those who are lucky enough to have individual disability or life insurance policies. Other significant protections for those who fund ERISA benefit plans include the limitation of damages to lost benefits and the prohibition of live testimony, jury trials, and almost all

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discovery. The underwriters' medical experts are shielded from cross-examination. This is indeed a comfortable valley for the underwriters of ERISA benefit plans. In health and disability claims the written opinions of their consulting experts are more often than not the backbone of the denial and become the reason the court must sustain the decision when the abuse of discretion standard is applied.

There has been little backlash to the perversity that the Act designed to protect employees and their beneficiaries has ended up marginalizing their contract rights. Insurance carriers and employers, who have the greater power by virtue of their experience with benefit plans and their financial resources, have no incentive to rock the boat. Although there are a few outspoken critics, such as Judge William Acker in Alabama, federal courts remain content with the status quo. The alternative, a slew of pension, health, disability and life insurance benefit contract claims that must be decided in federal court with live testimony, juries, and a preponderance of the evidence standard, might substantially impede their efficiency.

The 1980s: Big Hair and the Destruction of the Flatlands

While MTV and its fans were caught up in the voices and big hair of Duran Duran and the Scorpions and Billy Idol, and U2 (yes, even Bono and the Edge had big hair back then), something less interesting but more complicated was going on with ERISA jurisprudence. Two seminal cases that started as state law claims for consequential and punitive damages as a result of the wrongful processing of disability claims became preemption cases when the insurance carriers sought to avoid the state law causes of action brought by the claimants: *Massachusetts Mutual Life Insurance Company v. Russell*[4] and *Pilot Life Insurance Company v. Dedeaux*.[5] The insurance carriers won both cases, i.e., ERISA was found to preempt the state law causes of action brought by the plaintiffs in both cases. The Supreme Court found that the preemption provision within ERISA, section 1144, was made deliberately broad to ensure enforcement of ERISA's comprehensive scheme, and that the claimants' request for consequential and punitive damages interfered with the Act's remedial provision, section 1132(a), which provided for a recovery of benefits for the claimants but did not provide for consequential or punitive damages.

In *Russell*, the Supreme Court said:

> The six carefully integrated civil enforcement provisions found in § 502(a)[6] of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.[7]

The word "flatland," as used here, refers to a landscape of parity between the parties when there is a dispute over a contract claim. The parties play on a level playing field. In this landscape, pension and health, disability, and life insurance coverage cases are decided in favor of the party that submits the greater weight of the evidence. But the levee broke in 1989 and the rushing current quickly destroyed the flatland and carved the valley where employees would be trapped with their benefit claims. In 1989 the U.S. Supreme Court decided *Firestone Tire & Rubber Company v. Bruch*.[8] At issue was the standard of review for ERISA cases, and at first blush it was a victory for employees, as the Court decided that de novo review was the proper standard of review for ERISA benefit cases.[9] The flatland seemed secure. However, in that decision the Court indicated that a discretionary standard of review, at least in regards to plan interpretation, could be achieved by simply making sure the policy granted interpretive authority to the insurance carrier or the administrator of a self-insured plan.[10]

Never has a lover been jilted in such a smooth and gentle manner. At first the Court focused on the importance of de novo review:

> ERISA was enacted "to protect the interests of employees and their beneficiaries in employee benefit plans" and "to protect contractually defined benefits." Adopting Firestone's reading of ERISA [having abuse of discretion review as the default standard] would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.[11]

But earlier in the opinion, the Court recites the Restatement (Second) of Trusts § 187 (1959): "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion."[12] This is where the levee broke and the flatland was destroyed.

The Mountain Grows, The Valley is Sustained

After *Firestone*, benefit plan scriveners were writing or refining clauses that would assure deferential review at the courthouse and claimants scurried to avoid ERISA's reach. In 2004, the Supreme Court decided a case created by Texas residents suing their health insurers for consequential damages under state law, specifically the Texas Health Care Liability Act.[13] The insurers sought the pleasant valley of ERISA. The Court found the claims were preempted by ERISA, describing the Act as a "comprehensive legislative scheme" with "broad preemption provisions."[14] Although the claimants suffered significant injuries, i.e., consequential damages, which they alleged were caused by wrongful denials

of coverage for necessary medical treatment, a finding of preemption left them with virtually no remedy, since ERISA's statutory remedial provision, section 1132, specifically allows a claim for benefits but does not expressly provide for a claim for consequential damages.[15] The Supreme Court reasoned that such specificity in the remedial provision, part of the Act's "comprehensive legislative scheme," meant that Congress intended to exclude consequential damage claims from wrongful denial of benefit claims.[16] The ERISA remedy that remained for the plaintiffs in the case (*Aetna* addressed two cases because of their factual similarity) was coverage for Vioxx instead of a generic drug for one plaintiff and additional night stays in the hospital for the other.[17] *Aetna* closed the door to consequential damage claims as a result of wrongful denial of coverage for benefits granted by an ERISA plan.

Metropolitan Life Insurance Co. v. Glenn

In 2008, the Supreme Court decided how to treat a conflict of interest, the most common one being an insurer who 1) must conduct the review of the denied claim as the claimant's fiduciary, as required by section 1133(2) of ERISA, but 2) is also the entity that must pay the claim if it decides to overturn the denial.[18] Clearly, one option was to decide that when there is evidence of a conflict of interest, the standard should change from deferential to de novo review. Given the hefty number of ERISA welfare benefit plans that are group insurance policies, this would mean that a large number of claims would receive de novo review. The Court rejected this option, noting that trust law, the framework to be used when construing ERISA claims, still applies a deferential standard of review when there is a conflicted trustee.[19] In protecting deferential review, the Court notes that research shows 1.9 million beneficiaries have health care claims denied each year.[20] The clear inference is that protecting deference is important because if all ERISA claim review denials made by insurance carriers required de novo consideration, the federal courts could not handle the load.

Conkright v. Frommert

In April of 2010, the Supreme Court decided *Conkright v. Frommert*, an ERISA pension case.[21] The issue in *Conkright* was whether or not an ERISA trustee with discretionary authority to approve or deny benefits (given by the plan) should have its discretionary authority taken away if the administrator's prior decision on the claim was ruled by the court to be an abuse of discretion.[22] The Supreme Court ruled against the employee and in favor of the plan trustee, holding that a trustee's discretionary authority should be preserved even if the trustee had previously abused its discretion when considering the claim.[23] ERISA deference is important enough to withstand a prior abuse of discretion because, in the words of Chief Justice Roberts, "ERISA represents a 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans."[24] Justice Roberts builds the following foundation for the Court's decision:

> "*Firestone deference . . . preserves the "careful balancing" on which ERISA is based.* Deference promotes efficiency by encouraging resolution of benefit disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review. Moreover, *Firestone* deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions. . . ."[25]

In the Fifth Circuit, Abuse of Discretion is Adopted for Factual Disputes: ERISA Claims are Transformed Into Administrative Law Claims.

The *Firestone* decision addressed whether deference should be afforded the plan fiduciary's interpretation of the benefit plan, but most ERISA welfare benefit cases revolve around factual disputes, primarily disputes over medical evidence, rather than plan interpretation. Two years after the *Firestone* decision, the Fifth Circuit was asked to decide whether a claimant was entitled to de novo review of an ERISA claim denial when the denial turned on fact-findings instead of plan interpretation. In *Pierre v. Connecticut General Life Insurance Company/Life Insurance Co. of North America*, the Fifth Circuit decided that the proper standard of review was abuse of discretion for the factual determinations of the plan fiduciary.[26] The court reasoned that in *Firestone*, the Supreme Court indicated that trust law was to be the guide in determining the rights and duties of a ERISA fiduciary who decides benefit claims, and under trust law a trustee has inherent discretion when it engages in fact-finding functions.[27] But the court gave the more compelling reason why de novo review should be avoided:

> There is a compelling practical reason why plan administrators are given wide discretionary powers in making factual determinations. We only need consider, for example, the number of claims that must be approved or denied under these plans. . . . The courts simply cannot supplant plan

administrators, through de novo review, as resolvers of mundane and routine fact disputes. Considerations of expediency therefore support deference to factual determinations made in the administration of the plan. Otherwise, federal trials are encouraged in the vast numbers of claims that are filed in the thousands of ERISA plans throughout this county. . . . We therefore conclude that a deferential standard for factual determinations is buttressed, if not compelled, by practical considerations.[28]

Thus, the court's role as fact finder was abdicated. When a denied ERISA benefit claim comes to court, the Fifth Circuit made it clear that it was no longer the court's role to decide whether or not there should be coverage or pension benefits should be paid. The court's limited role was to decide whether or not the plan administrator's decision to deny the claim was an abuse of discretion. For claimants governed by Fifth Circuit law, *Pierre* was the poison that seeped into the grass and the water of the valley. The final decision-maker on a benefit claim, whether it was an insurance carrier, third-party administrator, or employer, would be given the same deference as an administrative law judge, only to be overturned if there was not substantial evidence to support the decision. This compelled claimants to climb the mountain and escape ERISA, to find another valley where they could have a judge, or even a jury, decide whether or not the greater weight of the evidence indicated that their benefit claims should be paid.

Consider this situation: Ruby works as a courier. She is a single mother with two kids and lives paycheck to paycheck.[29] Ruby's physician has advised her that she should not return to work until she has back surgery and Ruby experiences too much pain to drive for any length of time. Her company provides short and long-term disability benefits to its employees by purchasing a group insurance policy from Big Bend National Insurance Company.[30] The company does nothing more than pay the premiums; the rest is left up to Big Bend, including the administration and payment of disability claims. Since the insurance policy is for the employees of the company, it is transformed into an ERISA plan, and therefore Big Bend is required to administer the disability claims in accordance with the claims regulations established by the U.S. Department of Labor for ERISA claims, as well as conduct a full and fair review of any denied claim as required by section 1133(2) of ERISA.

Sarah, a claims adjustor with Big Bend, denies Ruby's claim, citing insufficient evidence of disability. Ruby requests that Big Bend review the denial, often referred to as an appeal of the denial, and provides a narrative from her physician that concludes that Ruby remains disabled. In accordance with its statutory duty under section 1133(2), Big Bend conducts the mandated "full and fair" review of the denial. Practically speaking, this means that Sarah walks the claim file upstairs to Seth's office and puts it on his desk with Ruby's appeal clipped to the outside of the file. Seth is known as the senior appeals specialist and his office overlooks the beautiful desert landscape that surrounds Marfa, Texas. Seth hires medical consultant Dr. Marvin Payne, who lives in Portland, Oregon, and electronically submits the file and Ruby's appeal to Dr. Payne. Dr. Payne writes a report that concludes that Ruby is not disabled from being a courier. Seth receives the report and files it, giving Ruby written notice that the review is denied (as required by ERISA claims procedures), that it is Big Bend's final decision on the claim, and Ruby's only recourse is to file suit under section 502(a) of ERISA.[31]

Ruby files suit and loses in the district court. She appeals. The Fifth Circuit affirms the district court's decision, holding that Dr. Payne's report is substantial evidence to support Big Bend's final denial. Ruby takes her two kids and moves back to the one-bedroom house in Langtry where she grew up and her mother still lives, as they can no longer afford their house in Del Rio. She hears the dust hit the windows as she lies in bed, waiting for the pain to subside. She wonders why her life has taken such a turn.

Not far away, at least for Texans, after reading the Fifth Circuit opinion affirming his decision on Ruby's claim, Seth enjoys his view of the Chihuahuan desert. It feels good to have such power. You see, the courts have given him every bit as much power as any administrative law judge in Texas or the Commissioner of the Social Security Administration, whose factual findings and decision must be also be affirmed if there is substantial evidence to support them.[32] As he understands it, and he understands it correctly, "substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[33] His decisions will be affirmed even if they fall on the low end of a continuum of reasonableness.[34] Seth leans back and enjoys his coffee. Pretty good work if you can find it, he thinks to himself.

Notable Dissents

In 1983, the late Judge Joe J. Fisher of the federal district court in Beaumont, expressed his thoughts on ERISA's abuse of discretion standard of review:

> That holding [Fifth Circuit holding making abuse of discretion standard the default standard] perplexes this court. It allows an employer to breach his employees' compensation contract with impunity, so long as the employer does not do in an "arbitrary and capricious" manner. The administrator may be stupid, or simply ignorant, or ill-advised on the meaning of the contract. No matter. He may breach

> and breach again, yet the employee cannot enforce his rights.
>
> With the social security retirement system in a shambles and its bankruptcy imminent, private benefit plans offer most workers their only hope of security in old age or disability. To an older worker, his pension rights may be more valuable than his salary. He can enforce those valued rights, however, if and only if he can prove the contract's breach to be "arbitrary and capricious." *This is an absurd requirement.*
>
> The court believes that disputes over employment contracts—including pension and disability benefit plans—are most rationally, economically, and equitably resolved by the application of traditional contract principles. It is, after all, a contract that the court is being asked to interpret. [35]

The majority's decision had broad implications because of its view that the term "appropriate equitable relief" within section 1132(a)(3) precludes monetary damage claims.

Eight years later, Texas Supreme Court Judge Lloyd Doggett issued a concurring opinion in *Cathey v. Metropolitan Life Insurance Company*, which included the following passage regarding ERISA's shortcomings:

> Recognizing that *Ingersoll-Rand v. McClendon* and *Pilot Life Ins. Co. v. Dedeaux* control this case, I must concur with the court's opinion [that the employee's wife's health care claim was preempted by ERISA and therefore she could not bring state law claims against her insurer]. By its reading of ERISA's preemption clause, the United States Supreme Court has restricted the very rights of employees—to avoid the delay or denial of benefits—that Congress sought to protect. Through peculiar federal judicial interpretation, a statutory addition to workers' rights has been converted into a statutory removal of those rights. *The law has been reshaped into a form that achieves the converse of its original purpose.*[36]

In *Mertens v. Hewitt*, the Supreme Court, in a narrow five-four opinion, decided that the third remedial prong of ERISA, section 1132(a)(3), does not authorize damage claims against non-fiduciaries who knowingly aid a fiduciary in breaching its fiduciary duty.[37] The majority's decision had broad implications because of its view that the term "appropriate equitable relief" within section 1132(a)(3) precludes monetary damage claims. The dissent, authored by Judge White, joined by Chief Justice Rehnquist, Justice Stevens, and Justice O'Connor, emphasized that the majority's narrow construction of the term "equitable relief" stood at odds with congressional intent:

> Although the trust beneficiary historically had an equitable suit for damages against a fiduciary for breach of trust, as well as against a participating nonfiduciary, the majority today construes § 502(a)(3) as not affording such a remedy against any fiduciary or participating third party on the ground that damages are not "appropriate equitable relief." The majority's conclusion, as I see it, rests on transparently insufficient grounds. The text of the statute supports a reading of § 502(a)(3) that would permit a court to award compensatory monetary relief where necessary to make an ERISA beneficiary whole for a breach of trust. *Such a reading would accord with the established equitable remedies available under the common law of trusts, to which Congress has directed us in construing ERISA, and with Congress' primary goal in enacting the statute, the protection of beneficiaries' financial security against corrupt or inept plan management. Finally, such a reading would avoid the perverse and, in this case, entirely needless result of construing ERISA so as to deprive beneficiaries of remedies they enjoyed prior to the statute's enactment.* For these reasons, I respectfully dissent.[38]

The decision in *Mertens v. Hewitt* also assured ERISA claimants that they would have no incidental or consequential damage claims, even if they were not made whole by having their benefits restored.

In June 2014, ERISA's fortieth year, Judge Acker of the Northern District of Alabama wrote as follows:

> *Prologue*
>
> This court devoutly wishes that the Supreme Court of the United States had not blindly stumbled off on the wrong foot and in the wrong direction when it handed down *Firestone Tire & Rubber Co. v. Bruch*, the case in which it invented a strange quasi-administrative regime for court review of denials of ERISA benefit claims. It inexplicably substituted a procedure borrowed from administrative law for the clear congressional mandate that the filing of a "civil action" (a simple,

straight-forward, garden-variety suit for breach of contract) is the only means for challenging such denial decisions. In the *amicus curiae* brief filed by the Solicitor General in *Bruch*, he did his best to keep the Supreme Court from wandering off track and ignoring Congress. The Solicitor General, who was representing both Congress and the persons whom Congress intended to benefit from ERISA, failed to talk the Supreme Court out of its misguided step, a misstep that has led to a series of further judicial glosses, distillations, penumbras, and emanations, eventuating in the sad state of affairs now faced by ERISA claimants and by the courts who have to deal with ERISA benefit claims.

If Congress itself had enacted the weird scheme created by the *Bruch* court out of whole cloth, ERISA would have been promptly and successfully attacked for its patent unconstitutionality as a violation of "due process." A quick application of the universally recognized legal maxim, *nemo judex in causa sua*, would have kept any such statute off the statute books. Chief Justice Sir Edward Coke in *Dr. Bonham's Case*, 8 Co. Rep. 107a, 77 Eng. Rep. 638 (C.P. 1610), carved in granite for all time this fundamental jurisprudential principle when he said, using the vernacular: "No man should be a judge in his own case."

The justices of the Supreme Court, including some who decided *Bruch*, routinely recuse themselves when there is even the slightest hint of any possible self-interest by the recusing justice. And yet, today, clearly conflicted ERISA plan administrators and insurers, when granted by the plan document that they drafted full discretion to interpret their plans and to decide the ultimate issue of entitlement, are routinely allowed, even required, to rule on their own cases. Not surprisingly, this court has not found a single case in which an insurance company has recused itself in an ERISA case under the rule of *nemo judex in causa sua*. There is no scheme remotely like the one created by *Bruch* in the annals of Anglo-American jurisprudence. Chief Justice Coke is uncomfortable in his crypt. [39]

Conclusion

In the forty years since its enactment, ERISA has protected employees' pension benefits and provided the assurance, through the Act's creation of the Pension Benefit Guaranty Corporation and a guaranty fund, that an employee will receive at least some of the pension benefits that were promised him or her upon retirement.[40] However, claimants with ERISA benefit claims, i.e., claimants seeking pension, health, disability, or life insurance benefits, do whatever they can to escape the Act that was created for their benefit. The preemptive reach of ERISA is broad, however, so that an attempt to avoid ERISA is a Sisyphean struggle. Employees try to escape ERISA's long reach because the judicial decisions that have been made since ERISA's enactment hold that an abuse of discretion standard of review will be used by the federal court to review their claim, i.e., the insurer or plan administrator of a self-insured plan who decides the review of their claim will be given the same deference given to administrative law judges. The administrator's decision will only be overturned if there is not substantial evidence to support it or, if the claim turns upon plan interpretation, the administrator's interpretation of the plan is arbitrary. Damages will be limited to benefits that should have been paid, no matter the conduct of the plan administrator or the losses suffered by the claimant as a result of the wrongful denial of benefits. The claimant will not be given the chance to have a jury decide the issue, nor will she have the right to cross-examine experts or testify at the courthouse. Thus far, ERISA has not come close to providing the protections that Congress promised forty years ago.

1 Certain companies may offer other welfare benefits but health, disability, and life insurance benefits are the primary welfare benefits that are provided to employees.

2 29 U.S.C. § 1001(b). The reference to protecting interstate commerce is also explained within this first section of ERISA. In 29 U.S.C. § 1001(a), Congress notes that the "growth in size, scope, and numbers of employee benefit plans has been rapid and substantial" and for the protection of interstate commerce and the federal taxing powers it was necessary that "minimum standards be provided assuring the equitable character of such plans and their financial soundness."

3 This refers to King Sisyphus of Greek mythology, who, for his trickery, "the gods had condemned to ceaselessly rolling a rock to the top of a mountain, whence the stone would fall back of its own weight." Albert Camus, The Myth of Sisyphus and Other Essays 119–23 (Alfred A. Knopf, Inc., New York, translated from French by Justin O'Brien) (1955).

4 473 U.S. 134 (1985).

5 481 U.S. 41 (1987).

6 Section 502(a) of ERISA is now codified as § 1132(a).

7 *Russell*, 473 U.S. at 146.

8 489 U.S. 101 (1989).

9 *Id.* at 115.

10 *Id.* at 111. An ERISA plan administrator, as referred to here, is the administrator that decides the full and fair review of an employee's welfare benefit claim. If the benefit plan is insured, the plan administrator is almost always the insurer who also pays the benefits due, but in a self-insured plan, where the employer pays the benefits due, the plan administrator is typically a third-party administrator hired by the employer or a committee assigned by the employer.

11 *Id.* at 113–14 (citations omitted).

12 *Id.* at 111.

13 *See Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

14 *Id.* at 208.

15 *Id.* at 216–17.

16 *Id.*

17 *Id.* at 211.

18 *See Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

19 *Id.* at 115.

20 *Id.*

21 *Conkright v. Frommert*, 559 U.S. 506 (2010).

22 *Id.* at 509.

23 *Id.* at 521.

24 *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

25 *Conkright*, 559 U.S. *Id.* at 517 (emphasis added).

26 *Pierre v. Connecticut Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552, 1562 (5th Cir. 1991).

27 *Id.*

28 *Id.* at 1559 (citations omitted).

29 This is a fictional account meant to clarify the power that has been given those who decide ERISA claims.

30 The company name is invented to avoid picking on any particular insurance carrier. Prudential, Unum, MetLife, Standard, and the Hartford are all carriers who commonly underwrite group disability insurance policies that are ERISA plans.

31 Section 502(a) of ERISA is ERISA's remedial provision.

32 *See Perez v. Barnhart*, 415 F.3d 457, 461 (5th Cir. 2005) (substantial evidence supported finding by Commissioner of Social Security).

33 *Atkins v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, 694 F.3d 557, 566 (5th Cir. 2012).

34 *Id.*

35 *Hayden v. Texas-U.S. Chem. Co.*, 557 F. Supp. 382, 389–90 (E.D. Tex. 1983) (emphasis added).

36 805 S.W. 2d 387, 392 (Tex. 1991) (citations omitted) (emphasis added).

37 508 U.S. 248, 262 (1993).

38 *Id.* at 273–74 (emphasis added).

39 *Criss v. Union Sec. Ins. Co.*, 26 F. Supp. 3d 1161, 1162–63 (N.D. Ala. 2014) (emphasis added).

40 The Pension Benefit Guaranty Corporation and the guaranty fund are created in subchapter III of ERISA, 29 U.S.C. § 1301 et seq.