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Building the Magnetic Shield: Investigations of ERISA's Departure from its Original Purpose by Review of Disagreements between the Fifth Circuit and the U.S. Supreme Court

Introduction

These days, employees asserting individual claims for benefits find themselves in a remarkably hostile environment. The U.S. Supreme Court's interpretations of statutory provisions within the Employee Retirement Income Security Act of 1974 ("ERISA") have created a broad, protective shield for employers and insurers and have left the employee making a benefit claim holding a short, brittle sword. It was not meant to be this way. In 1974, when ERISA was enacted, Congress wrote that the new law's purpose was to protect the rights of participants and their beneficiaries to benefits promised by their employers. Today, however, most employees who become individual litigants try to evade the broad grasp of the Act passed for their protection. Ironically, they yearn for the salad days before 1974, when they could have asserted their property rights, their claims for pension benefits, health benefits, disability benefits, or life insurance benefits, on a level playing field.

To say that the Fifth Circuit and the U.S. Supreme Court have not seen eye-to-eye on some fundamental aspects of ERISA over the past thirty years understates the history of their discord. By chronicling where the two courts have disagreed, more specifically where the U.S. Supreme Court has overruled the Fifth Circuit or ruled contrary to Fifth Circuit precedent, these investigations record an abstract, zig-zagging jurisprudential history that demonstrates how unclear the statutory language of ERISA has turned out to be when applied to everyday life and how unhelpful it has been to the common woes of working men and women. Of the two courts, we will see that the Fifth Circuit has been more reluctant to abrogate individual property rights. This paper is also meant to be a didactic tool for ERISA practitioners, since an unusual number of the most significant ERISA cases that the Supreme Court has decided have traveled through the Fifth Circuit. Also, I mean to investigate how and where things went wrong, i.e., how individual property rights have been diminished by ERISA rather than fortified by it.

The Original Purpose

The Protection of the Property Rights of Employees and Their Beneficiaries

The original purpose of ERISA was to protect employees and their beneficiaries by protecting their rights to the benefits that employers had promised them. Congress explained its purpose 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."[1]

Nothing within the statutory text of ERISA indicates that prior to its enactment benefit plans were in peril because of excessive litigation by employees. To the contrary, ERISA's preamble indicated that the "growth in size, scope, and numbers of employee benefit plans has been rapid and substantial."[2] This burgeoning of benefit plans happened in the midst of employees prosecuting claims for wrongfully denied benefits in front of juries, under both common and statutory state law. Unlike the courts' later pronouncements and repeated justifications for limiting an employee's property rights, nowhere in ERISA's text did Congress indicate that an equal competing purpose in enacting ERISA was to protect employers and insurers from breach of contract and tort claims brought under a state's statutory or common law. This idea that ERISA was a delicate balancing act that was meant to protect equal but competing interests, the property rights of the employees pitted against the financial protection

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of employers and insurers, originated with the courts and remains a fundamental error.

ERISA's protection for employees included the creation of the Pension Benefit Guaranty Corporation ("PBGC"), a government agency that collects premiums from employers and, in case of an employer's default, will guaranty that an employee receive the pension benefits that she was promised.[3] From an employee's point of view, ERISA may have a thin appeal, but it has a broad embrace. Although most of it is designed for the protection of pension benefits,[4] ERISA also applies to all health insurance plans, life insurance plans, disability plans, severance plans, and any other group benefits that are offered by a private employer.[5] The Act was not a quick fix but instead was the culmination of a decade of legislative study, drafting, and discussion.[6]

ERISA's Preemption Clause

A Compromise with Employers and Insurers

ERISA's breadth and significance is created not only by its scope, written to include any employee benefit plan offered by a private employer, but by its broad preemption provision, meaning that all state laws that might be construed to govern employee benefit plans are generally superceded. If an employee's claim to benefits arises from an ERISA plan, she cannot pursue state law causes of action, such as breach of contract claims or claims of bad faith.[7] Notably, the state laws saved from ERISA preemption are laws that regulate insurance, banking, and securities – a preemption "savings" clause. The interplay between the broad preemption provision and the savings clause has been the source of more than one clash between the Fifth Circuit and the Supreme Court – disagreements that will be discussed in greater detail.[8] The ERISA shield is built in part from the Supreme Court's rulings on preemption, and I refer to the shield as having magnetic properties because of its preemptive power – literally pull – over the employee. In practice, the employee is pulled up against ERISA's preemptive shield.

Employees who have been denied plan benefits often file a lawsuit in state court to assert their property rights. The typical response by the defendant insurer or employer is to remove the case to federal court with the allegation that the state common laws and statutory laws are of no use to the employee because they are completely superceded, i.e., preempted, by ERISA. Since the preemption clause has been interpreted so broadly by the courts, the insurers and employers are generally right in asserting that the employee's claims are preempted by ERISA. The employee is compelled to either make her claims under ERISA statutory provisions or not make them at all.

When ERISA was sold to the general public, some members of Congress apparently either did not understand what they were selling or they were being disingenuous when they sold it. As quoted by the U.S. Supreme Court in *Shaw v. Delta Air Lines, Inc.*,[9] Congressman Dent said the following regarding ERISA's preemption clause:

> "Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation of Federal authority the sole power to regulate the field of employee benefit plans. *With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.*" (emphasis added) [10]

It was nonsense to assert that state and local regulation threatened participants' rights to benefits under their benefit plans. The preemption provision within ERISA was not designed to protect participants but was for the benefit of employers and insurers so that the creation of benefit plans by bigger companies would not be inhibited by the cost and complication of compliance with different state laws. The courts often point to this preemption compromise as proof that protection of employers and insurers was of *equal interest* to Congress when it passed ERISA. This misbrands the Act's purpose and its preemption clause. The notion that this was a "balancing act" gives the preemption clause too much weight. The preemption clause (with the savings clause, excluding from preemption state laws regulating banking, insurance, or securities) was a logical compromise, but the primary purpose of the Act was to strengthen the rights of employees and to provide protection for their promised benefits.

The Remedies for Individual Relief Offered by ERISA

In order to fulfill the promise of ERISA – the protection of the employee – it was essential that Congress create remedies for breaches of contract and negligent and bad conduct by those who controlled the benefit plans offered to employees. Congress attempted to accomplish this by replacing the remedial void created by the preemption clause with a remedial section within ERISA that was meant to be its backbone. Although ERISA's remedial statute has six prongs, there are only two that address an employee's right to obtain individual relief when his claim for benefits has either been denied or ignored. They are as follows:

"29 U.S.C. § 1132 (a)
A civil action may be brought-

(1) by a participant or beneficiary-

.....

(B) to recover benefits due to him under the terms of his plan,

to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i)to redress such violations, or (ii) to enforce any provisions of this subchapter or the terms of the plan...."

Two Reasons Why These Remedies Have Fallen Short of the Mark

There are two principle reasons why these remedies have not fortified the rights of employees.

First, the remedial provisions (along with the claim regulations established later by the U.S. Department of Labor) written for individuals lacked specificity, leaving the courts to determine critical issues, such as the right to a jury trial, the right to prove one's case with live testimony, the right to consequential or punitive damages as additional equitable relief, the right to discovery and cross-examination of witnesses, the right to de novo review by the courts, and the right to relief and sanctions for violations of the claim regulations established by the Department of Labor; and

Second, the U.S. Supreme Court has interpreted the remedial provisions very narrowly, and when doing so has misbranded ERISA as a congressional balancing act. This balancing act myth distorts the intent of Congress and veils the existential undercurrent – individual employees have lost substantial rights as a result of this Act passed for their benefit.

The U.S. Supreme Court Redesigns ERISA as a Congressional Balancing Act

1. Interpreting the Preemption Clause: *Pilot Life Ins. Co. v. Dedeaux*

The Fifth Circuit Preserves State Law Causes of Action Against Insurance Carriers for Breach of Contract and Breach of Fiduciary Duty

In 1975, a year after ERISA was passed, Mississippian Everate Dedeaux injured his back at work and sought permanent disability benefits under a disability policy that he had acquired as a benefit of his employment. The policy was underwritten by Pilot Life Insurance Company. Pilot Life paid him for two years, then repeatedly reinstated then terminated his disability benefits. Dedeaux filed suit against Pilot Life, seeking damages under Mississippi common law for breach of contract, breach of fiduciary duty, and fraud. In response, Pilot Life asserted that his claims could not be brought under Mississippi common law because they were preempted by ERISA. The District Court agreed with Pilot Life and Dedeaux appealed the case to the Fifth Circuit Court of Appeals. By decision handed down in September of 1985, the Fifth Circuit reversed the judgment for Pilot Life, relying upon a case that had been decided by the U.S. Supreme Court earlier that summer, *Metro. Life Ins. Co. v. Mass. Travelers Ins. Co.*[11] In *Metropolitan*, the Supreme Court had ruled that a Massachusetts statute requiring specific mental health care provisions within all health insurance policies written in the state was not preempted by ERISA because of the preemption's savings clause, which excluded from preemption state laws that regulated insurance.[12] The Fifth Circuit applied similar reasoning in allowing Mr. Dedeaux to proceed with his state law claims of breach of contract, breach of fiduciary duty, and fraud.

The Fifth Circuit indicated that they saw nothing within the preemption clause or the remedial statute of ERISA that showed an intent by Congress to prevent Mr. Dedeaux from proceeding with the state law claims that he favored. The panel wrote as follows:

> ".. And given the repeated reaffirmance and application of the forty year old McCarran-Ferguson Act, which in essence states that insurance matters are areas of state concern absent a clear congressional statement to the contrary, clear and precise words by Congress would be required to disgorge states of their long-held ability to proscribe and create a cause of action for an insurer's failure to pay insurance benefits. We are left with the unavoidable conclusion that state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to, or coequal with any cause of action available under ERISA. (emphasis added) (cite omitted)."[13]

2. The U.S. Supreme Court's Decision in *Pilot Life*: Claims Against the Insurance Carrier Are Preempted by ERISA

Pilot Life, desperately wanting to pull Mr. Dedeaux against ERISA's magnetic shield and avoid the unpleasant outcomes that breach of contract, breach of fiduciary duty, and fraud

claims can bring to an insurer, sought, and was granted, review by the Supreme Court. The Supreme Court's reversal of the Fifth Circuit resulted in the crumbling of hope that the most obvious employee benefit claim, a common law claim for breach of the insuring agreement when the benefit plan was a group insurance policy, could be preserved. To understand the Supreme Court's reversal in *Pilot Life*, however, it is important to understand a case that the Supreme Court decided two years earlier.

In 1985, the same year that the Fifth Circuit ruled that Mr. Dedeaux's common law claims against his insurer were preserved, the Supreme Court had decided *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). Like Mr. Dedeaux, Mrs. Russell was a disabled person angry with her insurance company. Unlike Mr. Dedeaux, Mrs. Russell chose to utilize ERISA, believing she found a jewel within ERISA's remedial scheme, namely breach of fiduciary duty. Although she was paid the benefits due her under the contract, Russell sued Massachusetts Mutual for delaying her disability benefit payments, alleging the interruption of benefits forced her "disabled husband to cash out her retirement savings which, in turn, aggravated the psychological condition that caused (her) back ailment."[14] She sought extra-contractual and punitive damages under the ERISA remedial provisions.

The primary problem with Mrs. Russell's claim, as the Supreme Court explained with unanimity, was that ERISA's remedial scheme limits breach of fiduciary duty claims[15] to claims that protect the entire plan against the breach – for example, a misappropriation of trust funds held by the plan to pay the employees' pension benefits or health benefits. This second remedial prong of ERISA doesn't allow individual relief. However, instead of confining the opinion to the interplay between the remedial prong that Mrs. Russell sued under, section 1132(a)(2), and the Act's breach of fiduciary duty provision, section 1109, to make clear that section 1132(a)(2) limits participants to suits on behalf of the plan, the Court expanded its focus to the entire remedial scheme of ERISA, all six prongs, and declared them both carefully crafted (inferring lucidity), and comprehensive.[16] This idea that the remedial scheme of ERISA is both clear and comprehensive is the foundation for the balancing act myth that would be formulated in Pilot Life, which has been repeatedly used as a justification for narrowing the property rights of employees and their beneficiaries.[17]

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In *Pilot Life*, decided two years after Russell, Justice O'Connor, writing for a unanimous Court, emphasized that Dedeaux's causes of action for breach of contract, fraud, and breach of fiduciary duty could be brought not only against insurance companies but against a wide array of other defendants. Reversing the Fifth Circuit, the Supreme Court held that Dedeaux's claims weren't saved from ERISA preemption.[18]

In *Pilot Life*, the Supreme Court indicated that in view of the complicated and comprehensive architecture of ERISA's remedial scheme (as declared in the *Russell* opinion), it could be inferred that ERISA was really a delicate balancing act, and the protection of employers who offer benefit plans or insurers who underwrite them *was as important* to Congress as the protection of the property rights of employees. Justice O'Connor wrote as follows:

> *"In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted...provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." Russell., supra, at 146. 105 S.Ct., at 3092."*[19] (Emphasis added).

We will return to *Pilot Life* and its progeny, as this myth that ERISA was a balancing act is used repeatedly to justify a limitation on the property rights of employees, and was used by the Supreme Court as recently as April of 2010 as justification for keeping *Firestone* deference sacrosanct within the ERISA scheme.[20] However, first we will investigate other cases that demonstrate how the sharpest legal minds can have remarkably disparate interpretations of statutory provisions within ERISA as well as the intended framework for deciding claims. This can only lead to the conclusion that although Congress may have meant well, ERISA's application to real

life disputes has been anything but clear and comprehensive. These myths of clarity, comprehensiveness, and balance, established in *Russell* and *Pilot Life*, and the logical constructs built on top of it in cases like *Conkright*, have served as tyrants to real life experience.

Other Notable Disagreements Between the Fifth Circuit and the U.S. Supreme Court Over ERISA

1. The Standard of Judicial Review of a Denial of Benefits Under an ERISA Plan

Fifth Circuit Adopts the Abuse of Discretion Standard of Review as the Default Standard

From a worker's perspective, a scarlet letter was placed on ERISA claims not long after the statute was enacted (1974) when the Fifth Circuit, in harmony with a majority of other federal circuits, emphasized that a claim decision by the plan trustee (the final decision-maker on a benefit claim, who in ERISA parlance is a plan fiduciary) was to be upheld unless it was arbitrary and capricious.[21] At this point there was no requirement that the benefit plan expressly grants discretion to the trustee. The majority of other circuit courts were in agreement.[22] The reasoning was based on trust law.[23] Analogous to other trust arrangements, an ERISA trustee's decision to distribute trust assets, i.e. employee benefits, or to withhold them, was not to be interfered with unless it was arbitrary and capricious.[24]

These holdings branded a scarlet letter on ERISA contracts because the decision to pay or not pay employee benefits from a plan would not be overturned unless the trustee committed an abuse of the discretion. No longer would a judgment in favor of the party who provided the fact finder the greater weight of the credible evidence be considered the right result.

2. The U.S. Supreme Court Adopts the De Novo Standard of Review as the Default Standard but Offers a Safe Haven to Insurers and Employers

In 1989, in *Firestone Tire & Rubber Co. v. Bruch*,[25] the U.S. Supreme Court disagreed with the Fifth Circuit and other circuits that had declared the abuse of discretion standard as the default standard of review for ERISA benefit claims. The Court held that an ERISA fiduciary's decision should be reviewed by the court *de novo*.[26] The Court noted that prior to ERISA's enactment in 1974, benefit contract decisions were reviewed *de novo* and reasoned that it would be incongruous to adopt an abuse of discretion standard after ERISA was passed, since such a standard would "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted."[27] The Court also found that a default abuse of discretion standard was inconsistent with basic trust law.[28]

The irony of *Firestone* is that the decision has become an integral part of the magnetic shield that employers and insurers use to attract, then fend off, individual benefit claims. In *Firestone*, the Court ruled that although the proper default standard was a *de novo* standard, if an ERISA benefit plan – viewed as a standard trust document – granted the fiduciary discretion to decide claims, the standard of review is ramped up to abuse of discretion. As anyone experienced with ERISA litigation knows, a plan that does not grant the plan trustee discretion to decide claims is a rare document. At first blush, *Firestone* seems to have preserved an employee's right to a level playing field, a right that is consistent with congressional intent. However, since almost all ERISA benefit plans grant discretion to the employer or insurer that renders the final decision on the claim, *Firestone* has been an essential tool to advance the collectivist theory that by providing insurers and employers shields of deference the courts are actively protecting the "public interest in encouraging the formation of benefit plans." In *Firestone*, the Court held that a trustee who has been granted discretion is "not subject to control by the court except to prevent an abuse by the trustee of his discretion."[29]

By 1989, the year *Firestone* was decided, the pattern was already established – proof that ERISA was failing to protect the employees that it intended to protect. Employers and insurers were running towards ERISA for protection and collaring resistant claimants and bringing them along for the short ride. But, *Firestone* deference, as Judge Roberts refers to it in the 2010 decision *Conkright*, solidified the protections offered employers and insurers. Because most benefit plans grant discretion to the employer or insurer that renders the final decision on a claim, *Firestone* endorsed the slanted playing field, guaranteeing the contradiction that most benefit claims were less likely to succeed as a result of ERISA.

ERISA Preemption

1. The Fifth Circuit Preserves Individual Health Care Claims Against Insurers: *Roark v. Humana, Inc.*

In 2002, the Fifth Circuit decided *Roark v. Humana, Inc.*[30] This case arose out of a number of health care claims where employees or their beneficiaries sued their HMOs under Texas state law for negligence under the Texas Health Care Liability Act ("THCLA"). They alleged their doctors recommended a certain treatment that their HMOs negligently refused to cover. As typically happens, the HMOs removed the cases to federal court, running for ERISA's magnetic shield. The health care cases were consolidated.

The Fifth Circuit found two claims that survived ERISA preemption, the claims of Calad and Davila. Calad alleged that she was discharged too early after a hysterectomy and suffered complications as a result of the early discharge by the HMO (CIGNA) that insured her and her husband. Davila alleged permanent harm as a result of his HMO (Aetna) not agreeing to pay for Vioxx to treat his arthritis pain but instead agreeing to a cheaper substitute (Naprosyn) that caused a near heart attack and internal bleeding. The Fifth Circuit relied upon a previous decision, *Pegram v. Hedrick*,[31] where the Supreme Court found that a claimant could not bring a breach of fiduciary duty claim under ERISA provision 1132(a)(2) against her doctor and her HMO, since those were not benefit claims but rather "mixed eligibility and treatment" claims that did not fit within ERISA's remedial scheme. Quoting *Pegram*, the Fifth Circuit wrote that "there is no ERISA preemption without clear manifestation of congressional purpose," and "it was unimaginable that Congress intended ERISA to create a federal common law of medical malpractice."[32]

The Fifth Circuit's method of resolving the preemption issue was to go through the remedial provisions of 1132 and see whether the state law duplicates or "falls within the scope of an ERISA 502(a) remedy."[33] If it did, it would be preempted. First, it reviewed the 1132(a)(2) provision and relying upon *Pegram v. Hedrick*,[34] found that Calad and Davila's claims fell outside 1132(a)(2).

There is no ERISA preemption without clear manifestation of congressional purpose... it was unimaginable that Congress intended ERISA to create a federal common law of medical malpractice.

The Fifth Circuit then looked at the most commonly used remedial section, 1132(a)(1)(B), designed for individuals seeking plan benefits, to see if the plaintiffs' claims duplicated a claim for benefits. The Fifth Circuit decided that Calad and Davila's claims fell outside 1132(a)(1)(B) as well, because they were tort claims, not breach of contract claims, and ERISA remedial provision 1132(a)(1)(B) did not specifically preempt tort claims. Presumably, the Fifth Circuit was guided by the practical implications of finding preemption under 1132(a)(1)(B). If ERISA preemption had been found, Ruby Calad, claiming she suffered severe medical complications because of early discharge from the hospital, would only be entitled to the value of a longer stay in the hospital, but would not be entitled to claim her real damages, the harm she suffered as a result of her early discharge. Likewise, ERISA preemption would strip Juan Davila of his right to claim consequential damages as a result of Aetna's decision to only approve Naprosyn instead of the more expensive drug Vioxx. His only remedy under ERISA benefits provision 1132(a)(1)(B) would be the cost difference between Napropsyn and Vioxx. The facts of both cases exposed the silent undercurrent: ERISA did not protect people from many real life deprivations. The remedy offered by ERISA in both cases fell ridiculously short of reasonable relief for the deprivations that were suffered.

2. The U.S. Supreme Court Reverses in *Aetna v. Davila*: Avoiding the Existential Undercurrent with the Myth of a "Careful Balancing of Interests"

Setting aside the contradiction of its decision with ERISA's stated purpose of offering protection to employees, the U.S. Supreme Court reversed the Fifth Circuit and found preemption. It focused on the 1132(a)(1)(B) prong, finding that no matter that Calad and Davila cast their claims as tort claims, the events that triggered their claims were the same – breaches of plan requirements, i.e., ERISA breaches of contract. Davila's only claim against Aetna was that it refused to pay for his Vioxx prescription, and Aetna's only duty towards Davila was as a claims administrator for the plan. Calad's only claim against CIGNA was CIGNA's refusal to pay for more nights in the hospital. CIGNA's only duty to Calad was in its role as claims administrator for Calad's health plan.[35] To avoid the existential undercurrent, i.e., the real-life deprivations created by the decision, the Supreme Court offered the distracting myth created in Pilot Life:

> "The limited remedies available under ERISA are an inherent part of the "careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans. (cite omitted)"[36]

Not everyone was willing to stay above the existential undercurrent. The injustice that resulted from the Court's holding was lamented by Justices Ginsburg and Breyer in their concurring opinion in *Aetna*:

> "I also join the "rising judicial chorus urging that Congress and (this) Court revisit what is an unjust and increasingly tangled ERISA regime." (cite omitted).
>
> Because the Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the "equitable relief"

allowable under § 502(a)(3)," a "regulatory vacuum" exists: "Virtually all state law remedies are preempted but very few federal substitutes are provided (cite omitted)."

A series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief..."[38]

State HMO Acts Allowing Claimants Independent Medical Reviews

1. In *Corporate Health Insurance Inc. et al. v. The Texas Department of Insurance*, the Fifth Circuit Finds Independent Medical Reviews Preempted

ERISA battles involving individual benefit claims (as opposed to class action claims) usually arrive at the greatest stage, the U.S. Supreme Court, for the same reason: the claimant wants to avoid ERISA and the insurance company or employer seeks to pull the claimant against the ERISA shield, then fend off her claim. The repeated struggle between insurer or employer on the one hand and the employee, or those acting on her behalf, on the other, was also the back story for the U.S. Supreme Court's decision in 2002, *Rush Prudential HMO Inc. v. Moran*.[39]

In 2000, the Fifth Circuit decided *Corp. Health Ins. Inc. et al. v. Tex. Dep't. of Ins.*[40] In the case, various HMOs run by Aetna asserted that a Texas law that had just been passed, Senate Bill 386, was preempted by ERISA. Senate Bill 386 was a statutory act regulating HMOs and had a liability provision that allowed an insured to sue an HMO for damages if the HMO failed to exercise ordinary care in making a health care treatment decision. In addition, the bill had a provision that offered insureds an independent medical review when the HMO denied coverage on the basis that the treatment was not medically necessary. When such a circumstance occurred, the HMO was bound to the medical decision of the independent reviewer. Although the Fifth Circuit found that many of the provisions were not preempted, it ruled that the independent review mechanism that could bind the ERISA fiduciary was preempted since it was an alternative mechanism for participants to obtain benefits – therefore, the state law conflicted with prong 1132(a)(1)(B), meant to be the exclusive mechanism for obtaining benefits under an ERISA plan.[41]

2. The U.S. Supreme Court Holds that Independent Medical Reviews are Not Preempted: *Rush Prudential HMO, Inc. v. Moran*

In *Rush Prudential HMO, Inc. v. Moran*,[42] the Supreme Court disagreed. In looking at the independent review mechanism established by the new Texas law, as well as a similar statute in Illinois, the Court decided that since the benefit claim was not enlarged, that is, the claimant requesting the independent medical review could get nothing more than the health treatment that she requested, it is not preempted. It contrasted the claimant's limited remedy with the remedies that were found to be preempted, namely punitive damages and emotional distress damages sought in *Pilot Life* and consequential damages sought in *Russell*.[43]

Preemption of Wrongful Discharge Claims:

When an ERISA plan gives a plan fiduciary discretion to decide benefits, the high hurdle, the abuse of discretion standard of review, is placed on the track and disabled employees... must try and jump over it.

Along the same vein of preemption analysis, the concern that a remedy will contrast with ERISA's limited enforcement scheme, in *Ingersoll-Rand Company v. McClendon*,[44] the U.S. Supreme Court overturned a Texas Supreme Court opinion that found an employee's claim for wrongful termination survived preemption. McClendon's claim was based upon the allegation that he was terminated so that his employer, Ingersoll-Rand, could avoid paying him vested pension benefits (McClendon had worked for Ingersoll-Rand for nine years and eight months – he was fired four months before his pension vested). The Texas Supreme Court found the claim survived preemption because the employee sought lost wages, recovery for mental anguish damages, and punitive damages, not pension plan benefits. The U.S. Supreme Court said no, these remedies allowed by the Texas Supreme Court impermissibly supplant the remedies allowed under section 1132 for violations of section 1140, which is meant to protect an employee from being terminated so that the employer can avoid paying promised benefits.[45] In explaining why it had snuffed out McClendon's state law claims, the Court again quoted the "careful balancing" myth of *Pilot Life*.[46]

Differing Views of the Anti-Alienation Clause:

Kennedy v. Plan Administrator for DuPont Savings and Investment Plan.

The Fifth Circuit Decision in *Kennedy*: ERISA's Anti-alienation Clause Doesn't Allow a Waiver of Benefits

In *Kennedy v. Plan Adm'r for DuPont Savings & Inv. Plan*,[47] the issue was whether Liv, an ex-wife who had waived an interest in the pension benefits of her ex-husband William, in a divorce decree should still be paid those benefits if the plan requirements for changing the beneficiary had not been followed. The benefits would be paid to the estate, if not to the ex-wife. The Fifth Circuit awarded the benefits to the ex-wife, reasoning that her waiver in the divorce decree was an unlawful assignment of the pension benefits to the estate, made unlawful by ERISA's anti-alienation provision, 29 U.S.C. § 1056(d)(1).[48]

The U.S. Supreme Court's Decision in *Kennedy*: Waiver Invalid because the Plan Documents Control

The U.S. Supreme Court did not reverse the Fifth Circuit, but found for the ex-wife for a different reason. The Court criticized the Fifth Circuit's broad reading of the anti-alienation clause, noting that a spouse's waiver of survivor benefits is clearly allowed and is not considered an assignment or alienation of those benefits.[49] The Supreme Court focused on the plan requirements. DuPont, as plan trustee, is required to follow the plan and should not be obligated to review extraneous documents, such as divorce decrees, to determine the beneficiaries. Since Liv was still listed as the plan beneficiary, the benefits should be paid to her, despite her waiver of that interest in an earlier divorce decree.

Differing Views on the the Anti-Cutback Rule:

Central Laborers' Pension Fund v. Heinz

1. The Fifth Circuit Decision in *Spacek v. Maritime Ass'n* Allowing the Expansion of Non-compete Provisions as Applied to Former Employees

One of the most important ERISA statutory rules that applies to pension benefits is the anti-cutback rule, 29 U.S.C. § 1054(g). This rule protects employees from amendments to pension benefits that "cut-back" property rights, i.e., vested benefits.

For the same reasons that non-compete clauses are often found in employment agreements, pension plans often contain provisions that attempt to keep retired employees from working for competitors. In *Spacek v. Mar. Ass'n*,[50] the Fifth Circuit found that an amendment to a pension plan that expanded the non-compete provisions for an individual working in the longshoring industry, made after the employee's (Spacek's) retirement and causing his accrued benefits to be suspended, was not a violation of the anti-cutback rule because it was an amendment that caused a suspension of benefits, not a reduction or cut-back, of vested benefits.[51]

2. The U.S. Supreme Court Abrogates *Spacek*: *Central Laborer's Pension Fund v. Heinz*

Six years later, the U.S. Supreme Court addressed the same issue in *Cent. Laborers' Pension Fund v. Heinz*.[52] Certiorari was granted because a split in the circuits was created when the Seventh Circuit disagreed with the Fifth Circuit's holding in *Spacek*. The Seventh Circuit held that a suspension of accrued pension benefits caused by a pension plan amendment made after the employee retired violated the anti-cutback rule.[53] The Supreme Court affirmed the Seventh Circuit holding and abrogated Spacek, taking the view that a suspension of benefits makes them less valuable and, therefore, is a condition narrowing property rights, violating the anti-cutback rule.[54]

The Conflict of Interest of an ERISA Fiduciary Conducting the Mandatory Review of a Denied Benefit Claim

When an ERISA plan gives a plan fiduciary discretion to decide benefits, the high hurdle, the abuse of discretion standard of review, is placed on the track and disabled employees and other contestants must try and jump over it. Using trust law as their compass, the federal courts have wrestled with how this standard of review is affected when a trustee has a conflict of interest. Trust law developed around relationships that were much different than the relationships created by ERISA benefit plans. Pre-ERISA trustees were usually disinterested individuals who were dealing with issues involving the protection and limited distribution of family wealth. The lawyer or banker or trust department who acted as trustee was commonly paid a fee to invest, protect, or distribute someone else's money. In contrast, when an employer or insurer is an ERISA trustee, i.e., fiduciary, they are deciding whether or not to pay *their* money to someone else. The trust laws and decisions before ERISA did not address these circumstances adequately, and so the courts have struggled to describe and sometimes circumscribe this new figure, made powerful and enigmatic because he is automatically cloaked with deference regardless of his character.

1. The Fifth Circuit's Decision in *MacLachlan v. Exxon-Mobil Corp.*: An Employer Fiduciary Who Decides Benefit Claims is not Necessarily Conflicted

The courts have been fairly uniform in their agreement that an insurer trustee faces a conflict of interest, and most courts, including the Fifth Circuit prior to the Supreme Court's decision in *Metro. Life Ins. Co. v. Glenn*,[55] treated

this conflict, often called a structural conflict, as reducing the level of deference owed the trustee (the Fifth Circuit has vaguely described this tempering of deference as a "modicum less" deference than normal).[56] However, the Fifth Circuit did not find the same need to temper deference when an employer rather than an insurer acted as plan trustee and made the final decision on a benefit claim. The Fifth Circuit wrote as follows about an employer's conflict of interest:

> "The district court assumed there is a conflict of interest because Mobil interprets and administers its own plan, leaving open the possibility that it would limit claims to reduce its liability. The court need not have made that assumption. The mere fact that benefit claims are decided by a paid human resources administrator who works for the defendant corporation does not, without more, suffice to create an inherent conflict of interest. Were that enough, there would be a near-presumption of a conflict of interest in every case in which an employer both offers a plan and pays someone to administer it, making a full application of the abuse of discretion standard the exception, not the rule.
>
> *Vega* did not profess to create such a presumption, and we do not read it to have created one for cases of this sort. Rather, this court's decisions, following Vega, that have found an apparent conflict of interest are ones in which a claim was denied by an insurance company that did not employ the claimant, but instead was contractually obligated to make payments under the employer's plan (cites omitted).
>
> This is a significant distinction, because corporations that pay generous levels of benefits to their workers do so for self-interested reasons: Such benefits are one part of the total package of compensation that employers use to attract and retain capable workers. It is therefore less than patently obvious that employers would systematically benefit from a denial of meritorious claims."[57]

2. The Supreme Court Decides *Metropolitan Life Ins. v. Glenn*

Five years later the U.S. Supreme Court took a less noble view of an employer trustee. When asked to decide how an insurer's conflict of interest should be treated when it was given discretion in the plan, in *Metropolitan Life Ins. v. Glenn*,[58] the U.S. Supreme Court said the following about a employer trustee who is given discretion:

> "The first question asks whether the fact that a plan administrator both evaluates claims for benefits and pays benefits creates the kind of "conflict of interest" to which Firestone's fourth principle refers.[59] In our view, it does.
>
> That answer is clear where it is the employer that both funds the plan and evaluates the claims. In such a circumstance, "every dollar provided in benefits is a dollar spent by....the employer: and every dollar saved...is a dollar in the (employer's) pocket. *Bruch v. Firestone Tire and Rubber Co.*"[60]

Contrary to the Fifth Circuit's view as expressed in *MacLachlan*, the U.S. Supreme Court believed that insurer's conflict to be less obvious than an employer's conflict, but either one has a conflict of interest that must be considered by the courts when engaging in an abuse of discretion analysis.

The Myth of the Balancing Act: The Supreme Court Fluctuates

The Supreme Court's reliance upon the balancing act myth has been circumstantial. Sometimes descriptions of congressional intent that seem incongruous are contained within the same opinion, as in *Varity Corp. v. Howe*,[61] In *Varity*, Justice Breyer, writing for the majority, describes the law of trusts as a starting point, but then says that courts "may have to take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place."[62] However, the Court then backed away from the balancing act myth when finding that the employees' claim for benefits fits within ERISA's remedial scheme as appropriate equitable relief under 29 U.S.C. § 1132(a)(3), reasoning that since ERISA's "basic purposes" are to protect the interests of participants and beneficiaries, it is "hard to imagine why Congress would want to immunize breaches of fiduciary obligation that harm individuals by denying injured beneficiaries a remedy."[63]

In finding that ERISA does not authorize damage claims against non-fiduciaries who knowingly aid a fiduciary in breaching its fiduciary duty, Justice Scalia writes that there is a "tension between the *primary* (ERISA) goal of benefitting employees and the *subsidiary* goal of containing pension costs (cites omitted)(emphasis added)."[64] Unlike the balancing act myth, which characterizes the enactment of ERISA as an attempt to satisfy equal, competing interests, Justice Scalia accurately describes the protection of employers and insurers from

excessive costs as a *subsidiary* goal in passing ERISA. In the *Mertens* dissent, Justice White, joined by Justice Renquist, Justice Stevens, and Justice O'Connor, describes the "protection of beneficiaries' financial security against corrupt or inept plan management" as the primary goal of Congress, and describes the majority opinion as achieving the "perverse" result of "construing ERISA so as to deprive beneficiaries of remedies they enjoyed prior to the statute's enactment."[65]

In *Firestone*, the Court justified an employee's right to *de novo* review by referring to congressional intent in passing ERISA:

> "ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans," (cite omitted) and "to protect contractually defined benefits."(cite omitted). "Adopting Firestone's reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.."[66]

Yet ultimately, because the decision stresses deference when discretion is granted to the fiduciary in the plan document, the practical result of *Firestone* runs contrary to its reasoning. Paradoxically, *Firestone* deference achieves what it warns against, affording "less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted."[67]

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.

In *Aetna Health Inc. v. Davila*,[68] the Supreme Court decided in favor of the health insurance carriers and against the employees, who were trying to avoid the magnetic pull of the ERISA shield and bring claims under Texas state statutory law. In justifying its decision, Justice Thomas, writing for the majority, returned to the myth of the balancing act:

> "The limited remedies available under ERISA are an inherent part of the "careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans. *Pilot Life*, supra, at 55.."[69]

After *Firestone*, the next Supreme Court case addressing the judicial standard of review of benefit claims was *Metro. Life Ins. Co. v. Glenn*.[70] *Glenn* puts on display one of the fundamental differences between an ERISA benefit plan and a common trust document, namely, awarding ERISA plan benefits generally causes financial pain to the fiduciary, as the benefit money comes out of the trustee's pocket. The issue in *Glenn* was how the Court should weigh this conflict of interest that occurs with most ERISA fiduciaries (in the *Glenn* case, Metlife) when the fiduciary is to be given the benefit of the doubt, i.e., the abuse of discretion standard applies. The Court decided that this conflict must be given some weight when a benefit decision is under judicial review. The majority justified its decision by saying "as to all three taken together (the arguments raised by MetLife) we find them outweighed by "Congress' desire to offer employees enhanced protection for their benefits." (citing *Varity* 116 S.Ct. at 1065)."[71]

These fluctuating descriptions of congressional intent show the Court trying to pin down something that is fuzzy and slippery rather than clear and comprehensive. Also, these varying descriptions of congressional intent show a surprising comfort with the contradiction.

ERISA's Failure to Protect Individual Property Rights Gains Recognition in the Courts

In 1983, Judge Joe J. Fisher of the federal district court in Beaumont, relaxed his judicial demeanor and in one of his opinions published his honest thoughts on the abuse of discretion standard (Judge Fisher was writing about Fifth Circuit authority requiring him to decide an ERISA benefits claim under an abuse of discretion standard; *Firestone* had not been decided):

> "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* (emphasis added).

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..."[72]

Eight years later, Judge Doggett, in a concurring opinion for the Texas Supreme Court styled *Cathey v. Metro. Life Ins. Co.*[73] wrote as follows regarding ERISA's shortcomings:

"...Recognizing that *Ingersoll-Rand v. McClendon* (cite omitted) and *Pilot Life Ins. Co. v. Dedeaux* (cite omitted) 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...* (emphasis added)."[74]

It is critical to remember that this myth of a balancing act is a judicial construct. Congress never said ERISA was a balancing act.

In *Mertens v. Hewitt*,[75] the U.S. Supreme Court, in a narrow five-four opinion, decided that the third remedial prong of ERISA, 1132(a)(3), does not authorize damage claims against non-fiduciaries who knowingly aid a fiduciary in breaching its fiduciary duty. The majority's decision had broad implications because of its view that the term "appropriate equitable relief" within 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 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 when 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."[76] (emphasis added).

In *Great-West Life & Annuity Ins. Co. v. Knudson*,[77] the majority opinion denied relief to an insurer seeking subrogation under a plan under 1132(a)(3), the prong providing for appropriate equitable relief. In her dissent, Justice Ginsburg criticized this additional narrowing of the remedial prongs of ERISA as follows:

"Today's results... yields results that are demonstrably at odds with Congress' goals in enacting ERISA. Because in my view Congress cannot plausibly be said to have "carefully crafted" such confusion, ...I dissent."[78]

The New Expansion of the "Balancing Act" Myth: Conkright v. Frommert

In April of 2010, the Supreme Court decided *Conkright v. Frommert*, an ERISA pension case and one of the foundations for the holding was that the interests of employers (and by extension insurers and third-party plan administrators) were as important to Congress when it enacted ERISA as the interests

of employees. *Conkright* embraces the balancing act myth from *Pilot Life* and takes another step away from Congressional intent as originally expressed when ERISA was passed."[79]

The issue in *Conkright* was whether 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. 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. 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. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 215 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987))."[80] Expanding on the collectivist leanings of *Pilot Life*, Justice Roberts builds the following foundation for the Court's decision:

> "*Firestone deference.....preserves the "careful balancing" on which ERISA is based* (emphasis added). 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....."[81]

It is critical to remember that this myth of a balancing act is a judicial construct. Congress never said ERISA was a balancing act. Since the Act's stated purpose was to provide more protection to employees we can reasonably conclude that it was not. Compromises were made, such as a broad preemption clause, and these compromises can fairly be described, as Justice Scalia described them, as being motivated by subsidiary goals of containing costs, but ERISA's primary goal was to offer more protection to the employee. The inference that there was an equal, unstated interest to protect employers and insurers is based upon the fallacy that ERISA's remedial provisions were both clear and comprehensive. The *Conkright* decision dresses *Firestone* deference in silk clothes. These words that convey order-efficiency, predictability, and uniformity-may be beautiful threads, lofty and distracting, but they still adorn a fallacy, the notion that ERISA was enacted as much to protect employers and insurers as it was to protect the property rights of employees. *Conkright* goes so far as to say that ERISA *represents* a careful balancing of competing interests (emphasis added).[82] This judicial theory is far removed from Congress's stated purpose in enacting ERISA.

Potential Disagreements on the Near Horizon

1. Standard of Review of Factual Determinations of a Fiduciary

Although this has not been specifically addressed by the U.S. Supreme Court, the Fifth Circuit's view that factual determinations by a plan trustee should always be given deference is an isolated view and should be jettisoned.

In a Byzantine decision that further tangled an already complicated area of litigation, the Fifth Circuit decided in *Pierre v. Conn. Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, that despite the Supreme Court's decision in *Firestone* requiring *de novo* review of a fiduciary's interpretation of plan terms when there is no discretionary clause in the plan, ERISA trustees should always be granted discretion in regards to their factual determinations.[83] This is an isolated decision. Every other circuit has construed *Firestone* more broadly, believing that it stands for the proposition that absent a discretionary clause, both factual determinations and plan interpretations are subject to *de novo* review.[84]

The Fifth Circuit's unnatural division of a trustee's decision into "factual determinations" and "plan interpretations" is logically flawed. Because ERISA trustees deal in real cases and controversies, as opposed to advisory opinions, their decisions are always mixed decisions, involving the flesh and blood of the underlying facts and then application of those facts to the plan terms. A *de novo* review as required by *Firestone* is a *de novo* review of the decision to approve or deny benefits.[85] Since approving or denying benefits is always a mixed decision, applying facts and interpreting the plan in light of those facts, it can only logically follow that a *de novo* review must allow the court to look at the facts and apply them to the plan without deferring to the trustee. Deferring to factual determinations but not deferring to plan language impossibly complicates the matter. In some cases, such as disability cases, the focus is on the facts (in a disability case, the focus is usually on medical information). In other cases, such as pension cases, the greater focus may be on plan interpretation. In either event, however, the decision being reviewed is always a mixed decision and, therefore, should warrant a *de novo* review on the rare occasion that a plan does not grant discretion to the fiduciary.

2. Time Requirements for Deciding Claims

ERISA provides that the U.S. Department of Labor (DOL) shall establish the regulations that will govern ERISA claims. Another area of disagreement between the Fifth Circuit and the Supreme Court might concern the DOL's time requirements for deciding claims. Although an individual's property rights are already firmly diminished by ERISA doctrines deference to insurance carriers and employers, as well as taking away the right to live testimony, discovery and cross-examination, losing the right to a jury trial, no right to consequential damages, i.e. being made whole – another palpable harm is when the courts refuse to meaningfully enforce the deadlines for deciding claims.

The time requirements set by the DOL for a final decision on claims depends upon the type of claim. A fiduciary trustee is required to complete the review of a denied disability claim and decide it within forty-five days, with a forty-five day extension for special circumstances.[86] In regards to these time requirements and other claim regulations, set as *minimum requirements* for plan trustees who render the final decision on claims,[87] the DOL states as follows:

> "29 CFR § 2560.503-1(l) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim."

This provision became effective in 2002. It replaced a provision indicating that a claim would be "deemed denied" if it had not been decided within the time requirements set by the DOL. The majority of federal circuit courts, in agreement with the DOL, have ruled that if a trustee with discretion fails to decide a disability claim within the time requirements set by the DOL, it loses it discretion and the court should decide the case the old fashion way (pre-ERISA way), in favor of the party whose position is supported by the greater weight of the evidence.[88] The Fifth Circuit has not decided a case since the 2002 amendment. However, under the "deemed denied" provision the Fifth Circuit has allowed the fiduciary to retain discretion even though the fiduciary's decision was untimely.[89] If the Fifth Circuit splits with the majority of circuits when construing the 2002 amendment, the U.S. Supreme Court may address the issue. If a failure to follow time requirements falls only into the already cluttered realm of ERISA esoterica, (the ERISA doctrine of substantial compliance – meaning that an employer or insurer does not need to fully comply with the DOL's minimum requirements for claim regulations, just substantially comply – often renders the DOL claim regulations esoteric) a claimant's individual rights are diminished further and the Act strays even further from its stated purpose.

3. Restricting or Eliminating the Use of the Wildbur Two Step

Another potential disagreement between the Fifth Circuit and the U.S. Supreme Court is the Fifth Circuit's use of a formula, the *Wildbur* two step, that in most cases distorts the abuse of discretion analysis and improperly minimizes or forecloses the weighing of additional important factors that may be critical to an adequate review of a fiduciary's decision.

The formula is as follows:

Wildbur's First Step

> "1) whether the administrator has given the plan a uniform construction;
> 2) whether the interpretation is consistent with a fair reading of the plan: and
> 3) any unanticipated costs resulting from different interpretations of the plan."[90]

If the court determines that the administrator's interpretation is incorrect, the court then determines whether the administrator abused its discretion by applying the following three factors:

Wildbur's Second Step

> "1) the internal consistency of the plan under the administrator's interpretation:
> 2) any relevant regulations formulated by the appropriate administrative agencies; and
> 3) the factual background of the determination and any inferences of lack of good faith."[91]

The first step was adopted from a pension case five years after ERISA was enacted.[92] The case had to do with a plan provision suspending or forfeiting pension benefits for pensioners who had worked in the trucking industry and who had returned to work as truck drivers. The Court found that the trustees of the fund had given the plan a uniform construction, as they had suspended benefits to 238 other pensioners who had returned to work as truck drivers.[93] Also, suspending Bay-

les benefits when he went back to work as a trucker was found to be a fair reading of the plan.[94] Finally, the court found that the unanticipated cost would exceed $750,000.00 annually if participants who went back to work as truckers could still collect benefits from the fund.

The second three factors originated three years later with *Dennard v. Richards Group, Inc.*[95] In *Dennard*, the court was required to analyze a fiduciary's interpretation of complicated provisions of a profit-sharing plan in order to establish whether the fiduciary acted reasonably (not arbitrarily and capriciously) in denying Dennard interest on his profit sharing account. The court applied the three factors of *Bayles*, but said that along with these factors, which established the "legally" correct meaning, the court also viewed as "probative of the good faith of a trustee or administrator the following factors: (1) the internal consistency of the plan under the administrator's interpretation; (2) any relevant regulations formulated by the appropriate administrative agencies; and (3) the factual background of the determination and any inferences of lack of good faith."[96]

The first three factors established in *Bayles* and the second three factors from *Dennard* were consolidated and became the complicated formula used by the Fifth Circuit for determining arbitrary and capricious conduct in most ERISA cases. Both *Bayles* and *Dennard* were pension plan interpretation cases in which the facts were essentially undisputed. Application of these six factors to a different category of claims, a disability case, for example, which usually turns upon medical treatment and opinions and evidence of functional capacity, makes little sense. Plan uniformity is generally not an issue because each person's health condition is unique. A fair reading of the plan is sometimes involved, but more often than not there is agreement on the plan terms. The third factor in the first step, whether any unexpected costs would result, is usually irrelevant. Instead, the relevant factors are whether the person can perform the functions of his job, or sometimes any job, which turns upon the medical evidence and evidence of functional capacity, as well as the conflict of interest of the fiduciary and the manner in which the claim was processed. Many decisions, especially disability decisions, become needlessly opaque because of the court's application of the *Wildbur* formula.

The second three factors, meant to aid the court in evaluating whether the fiduciary acted in good faith, can be utilized when procedural errors have been committed by the fiduciary, such as a delay in deciding the claim. These second three factors are usually more relevant than the first three, since a violation of procedural requirements, coupled with thin evidence may indicate an abuse of discretion. By inference, the Fifth Circuit has recognized the limited usefulness of the *Wildbur* two step, but little attempt has been made to confine its use. For example, the disability case *Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan*,[97] the court just examined the record for substantial evidence without mentioning the *Wildbur* formula.[98] On the other hand, the court still engages in the *Wildbur* formula in disability cases that turn on the facts.[99] There is little hint beforehand which track the courts will take, which causes a real dilemma for the claimant or the fiduciary when the time comes to write dispositive motions.

Many decisions, especially disability decisions, become needlessly opaque because of the court's application of the Wildbur *formula.*

This rigid formula should not withstand scrutiny if brought before the U.S. Supreme Court because it can unfairly distort the abuse of discretion analysis. More often than not, the *Wildbur* formula either does not apply or fits poorly. Even though the formula does not apply, meaningless factors, such as uniformity or unanticipated costs, are often still considered and sometimes used as a tally against the claimant. Inapplicable factors shouldn't be used as support for denying relief.

The U.S. Supreme Court's reasoning in *Glenn* means that courts are required to be flexible in reviewing decisions for abuse of discretion, and the Court warns against the easy use of formulas. Commenting on the use of formulas as a method of taking into account the conflict of interest of an insurer-fiduciary, in the *Glenn* decision the Supreme Court followed a prior decision, *Universal Camera Corp. v. NRLB*,[100] a case that was a judicial review of an agency's factual finding, and quoted the decision as follows:

> "In explaining how a reviewing court should take account of the agency's reversal of its own examiner's factual findings, this Court did not lay down a detailed set of instructions. It simply held that the reviewing judge should take account of that circumstance as a factor in determining the ultimate adequacy of the record's support for the agency's own factual conclusion. In so holding, the Court noted that it had not enunciated a precise standard. But it warned against creating formu-

las that will "falsify the actual process of judging" or serve as "instruments of futile casuistry." The Court added that there are no talismanic words that can avoid the process of judgment." It concluded then, as we do now, that the want of certainty in judicial standards partly reflects the intractability of any formula to furnish definiteness of content for all the impalpable factors involved in judicial review. (Cites omitted)"[101]

CONCLUSION

ERISA stands at odds with the reason for its creation. The Act has abridged individual property rights rather than strengthened them. The Supreme Court's interpretation of the preemption clause, as well as its interpretation of the remedial provisions intended to provide individual relief, have created a magnetic shield that protects employers and insurers from remedies that were available before ERISA's enactment. Individual claimants are constantly seeking ways around ERISA and insurers and employers seek its shelter, hoping to mire individuals in its complexity and its promise of very limited relief. This perverse result, that ERISA has achieved the opposite of its intended purpose,[102] has been veiled to some extent by the myth that grew out of a disagreement between the Fifth Circuit and the U.S. Supreme Court, the misbranding of ERISA is a tightrope walk, a balancing act, where the protection of employers and insurers was as important to Congress when it passed ERISA as the property rights of the individual. ERISA was never meant to be a balancing act. The many disagreements that are investigated here show that the decisions of the Fifth Circuit, most notably the *Pilot Life* and *Aetna* decisions, have been more closely aligned with the ERISA's raison d'etre. This lengthy history of disagreement also proves that ERISA is neither clear nor comprehensive. The myth that ERISA was a congressional balancing act, derived from a false notion of clarity and comprehensiveness, may be an attractive myth, but its usefulness is primarily that it is a cool, rational distraction from the existential undercurrent: sick and disabled employees have lost the level playing field that was theirs before 1974, and for many wrongs they are left without a remedy. In these investigations we see that reason has often been a tyrant to the Act's original purpose, offering lofty distractions to veil its shortcomings. When we take Congress at its word – that ERISA was intended to protect the interests of participants in employee benefit plans and their beneficiaries – we see that in regards to individual benefit claims, ERISA has fallen well short of the mark.

1. 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."

2. *Id.*

3. ERISA is divided into three Subchapters: Subchapter I: the Protection of Employee Benefit Rights: Subchapter II: Jurisdiction, Administration, Enforcement; Joint Pension Task Force, Etc.; Subchapter III Plan Termination Insurance. It is Subchapter III, 29 U.S.C. § 1301 et eq., that creates that PBGC. There are statutory limits to the benefits that are guaranteed by the PBGC.

4. The formation of ERISA can be traced back to 1963, when Studebaker defaulted on its pension promises to thousands of auto workers and the United Auto Workers sought legislative reform on their behalf which culminated in ERISA's plan termination insurance program. LANGBEIN, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in *Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1365 (2003)

5. Benefit plans of public sector employees are exempt from ERISA. 29 U.S.C. § 1003(b)(1)

6. *Mertens v. Hewitt*, 508 U.S. 248, 251 (1993)

7. 29 U.S.C. § 1144 is the preemption provision, providing that ERISA supersedes all state laws with limited exceptions, the most notable of which are state laws regulating banking, insurance, or securities.

8. *Id.*

9. 463 U.S. 85, 103 S. Ct. 2890 (1983)

10. 120 Cong. Rec. 29197 (1974), taken from *Shaw v. Delta Air Lines*, supra. 463 U.S. at 99.

11. *Metro. Life Ins. Co. v. Mass. Travelers Ins. Co.*, 471 U.S. 724 (1985).

12. *Id.* at 740-741.

13. *Dedeaux v. Pilot Life*, 770 F.2d at 1316-1317.

14. *Id.* at 137.

15. 29 U.S.C. §1109 establishes the fiduciary duty of ERISA plan administrators; 29 U.S.C. § 1132(a)(2) allows a cause of action for breach of that duty.

16. *Id.* at 146.

17. This idea that the ERISA remedial scheme is comprehensive, almost architecturally profound, and therefore does not leave room for any damages beyond past benefits due has been coined the "Specificity Myth" by GEORGE FLINT, JR., ERISA: Extracontractual Damages Mandated for Benefit Claims Actions, 36 ARIZ. L. REV. 611, 638 (1994) and Flint's criticism is echoed by LANGBEIN, supra, at p. 1342.

18. *Pilot Life*, 481 U.S. at 50-51.

19. *Id.* at 54.

20. *Conkright v. Frommert*, _____U.S._____, 130 S.Ct. 1640 (2010).

21. *Paris v. Profit Sharing Plan for Emp. of Howard B. Wolf, Inc.*, 637 F.2d 357 (5th Cir. 1981). *Dennard v. The Richards Group Inc.*, 681 F.2d 306 (5th Cir. 1982)

22. *See, e.g., Riley v. MEBA Pension Trust*, 570 F.2d 406, 410 (2nd Cir. 1977); *Rehmar v. Smith*, 555 F.2d 1362, 1371 (9th Cir. 1976).

23. *Dennard*, 681 F.2d at 313

24. *Paris*, 637 F.2d at 362.

25. 489 U.S. 101 (1989).

26. *Id.* at 115.

27. *Firestone*, 489 U.S. at 114.

28. *Id.* at 113-114.

29. *Id.* at 111, quoting Restatement (Second) of Trusts § 187 (1959).

30. 307 F.3d 298 (5th Cir. 2002).

31. 530 U.S. 211 (2000).

32. *Roark*, 307 F.3d at 308.

33. *Roark*, 307 F.3d at 305. Here the Court cited *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

34. 530 U.S. 211 (2000).

35. *Davila*, 542 U.S. at 211.

36. *Id.* at 215.

37. Remedial prong 1132(a)(3).

38. *Id.* at 222.

39. 536 U.S. 355 (2002).

40. 215 F.3d 526 (5th Cir. 2000).

41. *Corp. Health*, 215 F.3d at 539.

42. 536 U.S. 355 (2002).

43. *Rush Prudential*, 536 U.S. at 380.

44. 498 U.S. 133 (1990).

45. *Ingersoll-Rand Co.*, 498 U.S. at 141-142.

46. *Id.* at 144.

47. 129 S.Ct. 865 (2009).

48. *Kennedy v. Plan Adm'r for the Dupont Sav. & Inv. Plan*, 497 F.3d 426, (5th Cir. 2007).

49. *Kennedy*, 129 S.Ct. at 872.

50. 134 F.3d 283 (5th Cir. 1998).

51. *Spacek*, 134 F.3d at 288-289.

52. 1541 U.S. 739 (2004).

53. *Cent. Laborers' Pension Fund v. Heinz*, 303 F.3d 802 (7th Cir. 2002).

54. *Cent. Laborers' Pension Fund*, 541 U.S. at 745-746.

55. 554 U.S. 105 (2008).

56. *Lain v. UNUM Life Ins. Co. of Am.*, 279 F.3d 337, 343 (5th Cir. 2002) (quoting *Vega*, 188 F.3d at 301)

57. *MacLachlan v. ExxonMobil Corp.*, 350 F.3d 472, 479, n. 8. (5th Cir. 2003)

58. 554 U.S. 105 (2008).

59. *Firestone's* fourth principle refers to the RESTATEMENT (SECOND) OF TRUSTS, § 187. Comment d, which is quoted in the *Firestone* case and reiterated in *Glenn* as follows: "If a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there was an abuse of discretion." *Glenn*, 128 S.Ct. at 2348.

60. Glenn, 554 U.S. at 112.

61. 516 U.S. 489 (1996).

62. *Varity*, 516 U.S. at 497.

63. *Id.* at 513.

64. *Mertens v. Hewitt*, 508 U.S. 248, 262-263 (1993).

65. *Mertens*, 508 U.S. at 274.

66. *Firestone*, 489 U.S. at 113-114.

67. *Id.* at 114.

68. 542 U.S. 200 (2004).

69. *Davila*, 542 U.S. at 215.

70. 128 S. Ct. 2343 (2008).

71. *Glenn*, 554 U.S. at 114.

72. *E.D. Hayden v. Texas-U.S. Chemical Co.*, 557 F. Supp. 382, 389-390 (E.D. Tex. 1983).

73. 805 S.W. 2d 387 (Tex. 1991).

74. *Id.* at 392.

75. 508 U.S. 248 (1993).

76. *Mertens*, 508 U.S. at 273-274

77. 534 U.S. 204 (2002).

78. *Id.* at 234.

79. *Conkright v. Frommert*, _____U.S._____, 130 S.Ct. 1640 (2010).

80. *Id.* at 1649. Underlying this theory that benefit plans need to be protected from state laws is the inferred threat that benefit plans will diminish or even disappear if the employers and insurers are not provided this protection. This theory, like much of the rational constructs that overlay ERISA's text, lacks empirical data to support it. Teachers in the public school systems throughout the country are still offered benefit plans that are underwritten by prominent insurers and are affordable. These benefit plans are government plans excluded from ERISA. If public school teachers are denied benefits by an insurer, they retain the full range of state laws to challenge the benefit decision.

81. *Id.*

82. *Id.* at 1651.

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

84. For this footnote identifying decisions in the other circuits that stand contrary to *Pierre*, I am indebted to Kevin Tarrant, who handled the *AIG v. Dutka* case for the plaintiff and retained the tenacity to seek certiorari from the Supreme Court. These cases are taken from his Petition for a writ of certiorari: *Bellino, et el. v. Schlumberger Tech., Inc.*, 944 F.2d 26, 27-29 (1st Cir. 1991); *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 250-251 (2nd Cir. 1999); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183-1184 (3rd Cir. 1991); *Reinking v. Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1213-1214 (4th Cir. 1990); *Rowan v. Unum Life Ins. Co. Of Am.*, 119 F.3d 433 (6th Cir. 1997); *Ramsey v. Hercules Inc. & Provident Life & Accident Ins. Co.*, 77 F.3d 199, 203 *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1095-1096 (9th Cir. 1999); *Ray v. Unum Life Ins. Co. of Am., a Maine Corp.*, 314 F.3d 482 (10th Cir. 2002); and *Shaw v. Conn. Gen. Life Ins. Co.*, 353 F.3d 1276, 1286 (11th Cir. 2003).-205 (7r th Cir. 1996); *Riedl v. Gen. Am. Life Ins. Co.*, 248 F.3d 753, 756 (8th Cir. 2001).

85. Again, *Firestone's* requirement of *de novo* review is mostly esoteric, as practitioners are generally dealing with plans that grant deference.

86. 29 CFR § 2560.503-1(i)(3).

87. A claims administrator may only serve the plan as a claims administrator if he or she makes initial decision(s) on the claim but not the final decision on a claim. However, a claims administrator is also a plan fiduciary when he or she makes the final decision on a claim. This is dictated by 29 U.S.C. § 1133(2), which requires that a participant have the opportunity for a full and fair review of a denied claim by "the appropriate named fiduciary" of the plan.

88. *Jebian v. Hewlett-Packard Co.*, 310 F.3d 1173 (9th Cir. 2002); *John F. Gritzer v. CBS Inc.*, 725 F.3d 291 (3rd Cir. 2002); *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98 (2nd Cir. 2005); *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003). According to the Department of Labor, the wording of the ERISA claim regulation that applies to claims that are not decided in a timely manner was changed to "clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference." Pension and Welfare Benefits Administration, 65 Fed. Reg. 70246-01, 70255 (Nov. 21, 2000).

89. *S. Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101 (5th Cir. 1993).

90. *Wildbur v. Arco Chem. Co.*, 974 F.2d 631, 638 (5th Cir. 1992).

91. *Id.*

92. *Bayles v. Cent. States, Se. and Sw. Area Pension Fund*, 602 F.2d 97 (5th Cir. 1979).

93. *Bayles*, 602 F.2d at 99.

94. *Id.*

95. 681 F.2d 306 (5th Cir. 1982).

96. *Dennard*, 681 F.2d at 314.

97. 493 F.3d 533 (5th Cir. 2007).

98. Another example of a disability case where *Wildbur* is not applied is *Holland v. Int'l Paper Co. Ret. Plan*, 576 F.3d 240 (5th Cir. 2009).

99. See, for e.g., *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262 (5th Cir. 2004).

100. 340 U.S. 474 (1951).

101. *Glenn*, 128 S. Ct. at 2352 (2008).

102. The phrase is lifted from Justice Doggett's concurrence in *Cathey v. Metro. Life Ins. Co.*, 805 S.W. 2d 387, 392 (Tex. 1991).