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The editors welcome unsolicited lead articles written by practicing attorney, judges, professors, or other qualified individuals. Manuscript length should be approximately 15-30 typed, double-spaced pages. Endnotes should conform to the Sixteenth Edition of A Uniform System of Citation, published by the Harvard Law Review Association.

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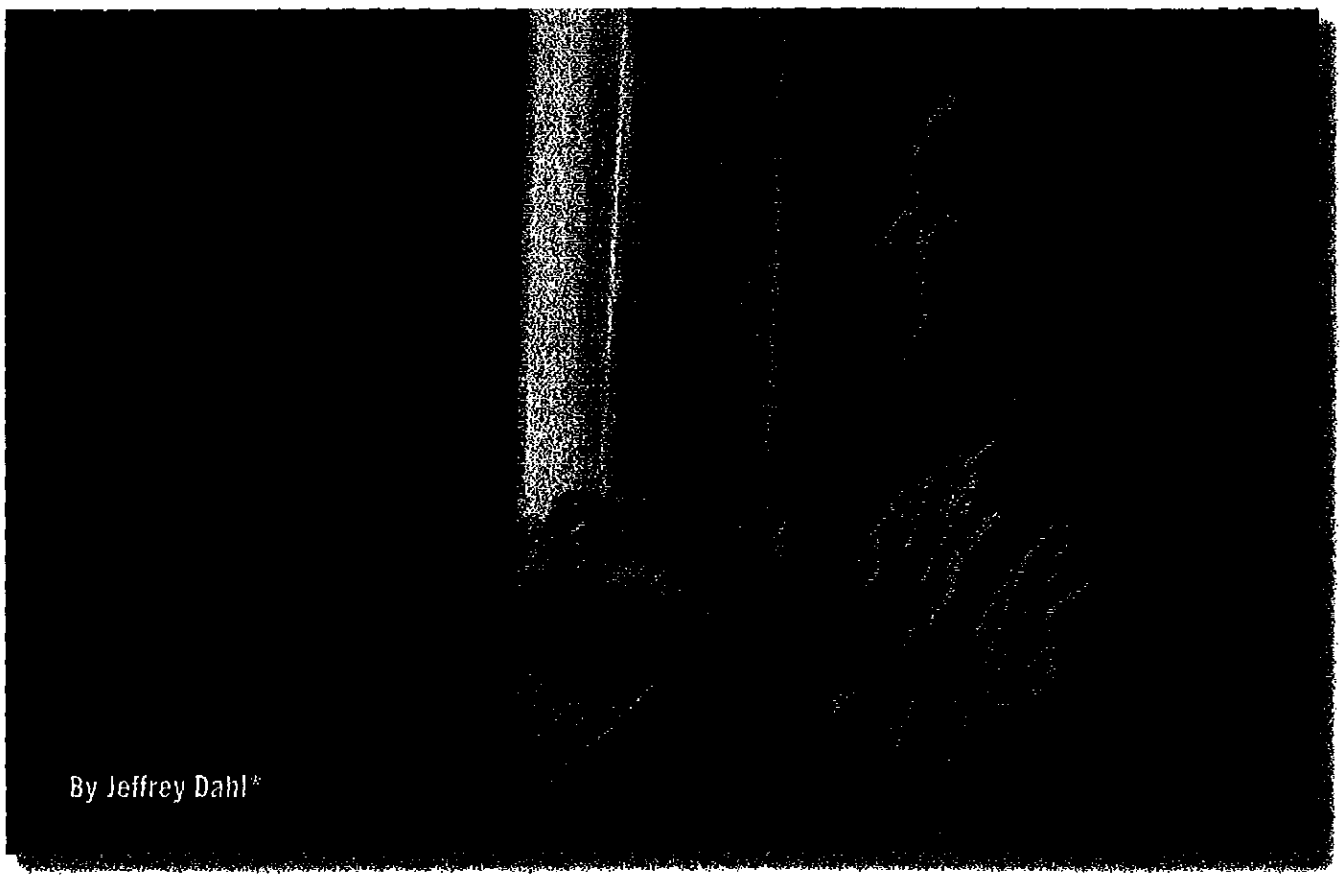
Articles

Recent Developments

. . . there is no set of maxims more important for a historian than this: that the actual cause of a thing's origin and its eventual uses, the manner of its incorporation into a system of purposes, are worlds apart; that everything that exists, no matter what its origin, is periodically reinterpreted by those in power in terms of fresh intentions; that all processes in the organic world are processes of outstripping and overcoming, and that, in turn, all outstripping and overcoming means reinterpretation, rearrangement, in the course of which the earlier meaning and purpose are necessarily either obscured or lost . . .

–Friedrich Nietzsche[1]

Exiled to ERISA's Stark Terrain



By Jeffrey Dahl*

My Revelation and Maria's Sorrow

The First Meeting

My first meeting with an ERISA disability claimant, who is often struggling to make ends meet after experiencing a loss of income due to serious illness or injury, is invariably a depressing one. As if her troubles weren't piled high enough, I bear more bad news. So that the claimant has a clear understanding of the hurdles and barriers that she faces, I disclose the following to her:

1) Regardless of how well the claimant and her treating physicians have documented her illness with the ERISA claims administrator, she has a good chance of being denied benefits, probably because the debilitating symptoms of her illness are not prone to objective measurement or because of the ERISA plan's narrow definition of total disability plan.[2]

2) The claims administrator will get the presumption that it made the right decision. To prevail at the courthouse it will not be enough to prove that she is disabled – we have to eviscerate their evidence. We have to prove that the administrator had very little or no reasonable evidence to support its decision that she did not meet the definition of disability within the plan.

3) There is no right to a jury trial.

4) The claimant and her family members, close friends, fellow employees, and treating physicians will never get to testify in court concerning her illness.

5) The conduct of the administrator and the economic harm and mental suffering that may have been caused by an arbitrary decision to deny her disability benefits are irrelevant – if we are wildly successful (hit a home run) at the courthouse nine months to a year and a half from now, we will get the past benefits that are due along with attorneys' fees.

6) The court has wide discretion in deciding whether to award attorneys' fees. If they are not awarded, the contingency fee will be taken out of the past benefits that are owed to her.

7) If we win, and if there is no appeal, she will be paid the past benefits due and then she will be back on the disability plan, which may result in another lawsuit down the road as a result of another denial of benefits.

8) If there is an appeal of a judgment in her favor, we will have to organize our own party in New Orleans because it will be no party trying to uphold the judgment at the Fifth Circuit Court of Appeals.[3]

The hopeful look, that expectation of justice, vanishes, replaced by looks of defeat and resignation, feelings that have grown all too familiar. My client's spouse might anxiously protest, "My wife took this job because of the generous benefits they offered. They promised to pay 60% of her income if she couldn't do her job because she got sick. What will we do for the next year? The next month? She's our breadwinner. We've maxed out our credit cards, we're four months behind on our mortgage, one child needs physical therapy, another needs special tutoring. *No one ever told us that it would be so difficult to get our benefits!*"

"I know," I respond sympathetically. "No one is required to give you these details when they sell you the disability insurance or try to make the job more attractive by describing the benefits that are offered. Unless you are weird enough to have acquired a background in ERISA law, the benefit that you thought you were getting is far from the benefit that you received."

Naturally, they expected that the disability benefits offered through work would offer the safety net that they needed. Nobody told them about the canyon into which they might fall – the quiet airspace between the inability to work due to illness or injury and the approval for disability benefits under an ERISA disability plan. In this canyon you may meet more women than men, probably because women suffer from "subjective" illnesses such as fibromyalgia more than men. In this silent canyon you might meet Linda Ellis of *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262 (5th Cir. 2004), Valerie Corry of *Corry v. Liberty Life Assurance Co. of Boston*, 499 F.3d 389(5th Cir. 2007), Andrea Pylant of *Pylant v. Hartford Life and Accident Ins. Co.*, 497 F.3d 536 (5th Cir. 2007), Susan Gothard of *Gothard v. Metro. Life Ins. Co.*, 491 F.3d 246 (5th Cir. 2007), or Linda Chandler of *Chandler v. Hartford Life*, 178 F. App'x. 365 (5th Cir. 2006), to name a few.

Let me back up and describe the journey.

The Purpose of ERISA

The Employee Retirement Income Security Act of 1974 ("ERISA")[4] was created for the protection of employees, called "participants" in the ERISA lexicon, their families, and their beneficiaries. Congress articulated the purpose of its passage in 29 U.S.C. 1001(b):

> 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 for appropriate remedies, sanctions, and ready access to the Federal courts.

My first ERISA client, Maria, found little solace in the irony that the intricate network of provisions within the Act designed to protect her and her family had become a substantial shield to the fiduciary that denied her claim.

Stark Terrain: Limitations on Remedies, Limitations on Evidence, and the Deferential Standard of Review

1. Limited Remedies

Maria was the family breadwinner. She had worked for the same employer for 24 years and worked her way up the corporate ladder until she was struck by chronic pain and fatigue, which her doctors eventually diagnosed as fibromyalgia and chronic pain syndrome. The fibromyalgia and chronic pain triggered severe depression, and the symptoms from the combination of these illnesses grew more frequent and more severe. She continued working for a couple of years despite her doctor's recommendations that she stop. She attended therapy sessions after work when she felt up to it and she slept all weekend in order to conserve her energy for the coming workweek. But after a string of absences, days when she could not pull herself out of bed, she decided to heed the advice of her husband and her physicians to take a leave of absence and apply for disability benefits.

She submitted her physicians' progress notes to her disability plan claims administrator. These notes clearly described the severity of her illnesses. Maria and her family were shocked when the claims administrator of her self-insured disability plan denied her claim.[5] Maria and her husband Henry worked together to appeal her claim supplying the administrator with

letters from her family doctor, her rheumatologist, and her psychiatrist, all of whom documented the severity of her illness and warned that any attempt by her to return to work would be detrimental to her treatment and any potential for recovery. As a rule, Marla and her husband mistrusted lawyers, and anyway it seemed to be an unnecessary expense as anyone with common sense would be able to see that Maria was disabled after review of her medical records. The administrator denied her appeal despite the unequivocal evidence that they submitted. Maria and Henry were devastated. Then Maria received a call and a follow-up letter from her supervisor, telling her that since the appeal of her disability claim had been denied she was required to report for work the following Monday morning. Since she couldn't keep up with the housework, or even her daily hygiene, she wondered how on earth her employer could think that she was able to return to work. Her failure to report to work that Monday resulted in her termination.

In order to make ends meet, they pulled out all of their retirement savings and sold their house at a discount to capture what little equity they had acquired. They moved into a small apartment with their two high-school aged children. Maria's depression grew so severe that she had to be hospitalized. COBRA premiums, uncovered medical expenses, and other unexpected costs, along with the day-to-day living expenses, quickly ate up their nest egg. They were reduced to running up credit card debt that they didn't know how they would repay. It wasn't long before their only option was bankruptcy. This killed them inside because they had always prided themselves in their self-sufficiency and ability to pay all of their debts. The world now revolving without them, they came to my office and brought Maria's claim file for me to review.

I reviewed her claim file and couldn't believe that her claim had been denied. I thought to myself, "Dude,[6] there was no valid reason to deny this claim. They can't get away with relying on these bogus medical consultants who never even saw Maria. How could this type of disease, chronic pain, and fatigue be measured by someone a thousand miles away? How absurd! She was treated with nothing but suspicion by the claims administrator, who hired someone to conduct video surveillance on her twice! They figured that she could work because they caught her going to the pharmacy, the therapist, and the hairdresser in the same day. Totally bogus, dude, totally bogus." I was fired up for some justice.

I prepared my state court petition. It was a train carrying powerful freight, with cars labeled breach of fiduciary duty, bad faith, statutory insurance claims under § 541 of the Texas Insurance Code (including claims for attorneys' fees), negligence, breach of contract, and fraud – each car stuffed with significant damage numbers for Maria and her family, whose lives had been turned upside down as a result of no income stream (i.e. as a result of the claim administrator's denial). Then I studied the law. I discovered that the drafting of that fine, powerful petition, that veritable tour de force, was a waste of my time.

In *Pilot Life v. Dedeaux*, the insured, a resident of Mississippi, brought claims of tortious breach of contract, breach of fiduciary duties, and fraud in the inducement against his insurer as a result of being denied long-term disability benefits.[7] The U.S. Supreme Court found all of the plaintiff's causes of action were preempted. Maintaining a utilitarian approach, Justice O'Connor wrote as follows:

> (t)he Solicitor General for the United States as amicus curiae, argues that Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) (29 U.S.C. 1132(a)) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress. . . . We agree. . . .
>
> 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 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'(quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).[8]

I began to study ERISA with the zeal of a boy waiting in line to get his flu shot. I learned that the architecture of ERISA is detailed and comprehensive, a congressional masterpiece that was the result of ten years of study, and then I became sure that the "reticulated" provisions within ERISA must hold the Act's promise of providing protection to Maria and her family.[9] During that ten years of study, Congress must surely have foreseen bad consequences, such as the ones that befell Maria and her family as a result of the claims administrator's denial.

I thought that I would find an avenue for Maria's consequential damages by making a breach of fiduciary duty claim under 29 U.S.C. § 1109, a reasonable thought considering that 1109 is captioned "Liability for Breach of Fiduciary Duty." Then I discovered that Doris Russell's counsel tried this and failed. In *Mass. Mut. Life Ins. Co. v. Russell*, the U.S. Supreme Court ruled that the claimant, Russell, could not bring her claim for extra-contractual and punitive damages against her group disability insurer (an ERISA plan) under § 1109, and that she was limited to bringing a benefits claim under 29 U.S.C. § 1132(a).[10]

Finding little comfort in the law, I laid in bed and read the journal of the Danish philosopher Soren Kierkegaard. I needed someone who shared my view of life's imperfections. I read aloud to my wife:

> All of existence intimidates me, from the tiniest fly to the enigmas of incarnation; as a whole it is inexplicable, my own self most of all; all of existence is pestiferous, my own self most of all....[11]
>
> I prefer talking with old persons of the female sex who peddle family gossip; next, with the insane-and last, with very sensible people.[12]
>
> Being trampled to death by geese is a slow way of dying, and letting oneself be torn and worn to death by envy also is a long-drawn-out process....[13]

"Arrgghhh," she moaned, her face in the pillow, and somehow, without looking, she thrust her palm within an inch of my nose. I understood this subtlety and flicked off the light and listened to the silence, wondering how it would feel to have geese stomping on me and marveling at my wife's power to change the world with a raise of the eyebrows or, in this case, the uncoiling of a cobra-quick arm and hand. She was indeed an urban Zen master.

Maria needed answers, however, so after a week or so, I regained the energy to return to § 1132(a) with the hope that I would uncover ERISA's subtle power. One of those provisions

must be meant to make Maria and her family whole. After all, it was reasonable to reckon that in passing a law to protect the property rights of employees a group as well-schooled as the U.S. Congress didn't inadvertently circumscribe those rights. I reviewed § 1132(a) in detail and some case law that interpreting it.

Review of § 1132(a)(1)(A)

"(a) Person empowered to bring a civil action
A civil action may be brought-
(1) by a participant or beneficiary-
(A) for the relief provided for in subsection (c) of this section..."

I was led to § 1132(c). "Wow!" I thought. This provision allowed me to bring suit for the administrator's failure to mail the claim file and the disability plan within 30 days after receipt of Maria's written request and obtain penalty damages of $100.00 per day for every day after the expiration of 30 days. Remembering that it took nine months for the administrator to deliver Maria her file, the adrenaline started to flow. I found a couple of district court cases that have enforced the provision and I embraced the analysis of § 1132(c) as set forth by of Judge Hittner in *Lee v. Benefit Plans Adm'r of Armco, Inc.*:

> Moreover, the Court finds nothing in the plain language of the statute to support a holding that an Administrator is not liable unless its act of withholding information was deliberate. Rather, it appears that when Congress specifically included the language "fails or refuses" it contemplated strict liability for acts reasonably within the Administrator's control....[14]

There was no Fifth Circuit case directly on point, but I feared the discussion of § 1132(c) as set forth in *Paris v. Profit Sharing Plan for Emps. of Howard B. Wolf, Inc.*, upholding a district court's refusal to award damages under § 1132(c) because there was no showing of prejudice as a result of the administrator's failure to comply with the time requirements of § 1132 (c).[15]

I caught myself. These penalty provisions may be helpful, but they were merely a band-aid that would be dwarfed by the gaping wound.

Review of § 1132(a)(1)(B)

I proceeded to section 1132(a)(1)(B):

(a) Person empowered to bring a civil action
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.

I found that this was the standard provision under which benefit claims are brought. It allows for recovery of wrongfully denied benefits or a judgment regarding a right to future benefits under the plan. Again, I read that this limited remedy, to the exclusion of all state law remedies, is interpreted by the court as "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."[16]

Review of § 1132(a)(2)

"(a) Person empowered to bring a civil action
A civil action may be brought...
(2) by the Secretary,[17] or by a participant, beneficiary, or fiduciary for appropriate relief under Section 1109 of this title."

I returned to § 1109(a) to refresh my memory:

> (a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary, which have been made through the use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

As previously mentioned, the U.S. Supreme Court made it clear in *Mass. Mut. Life Ins. Co. v. Russell* that suit for a violation of breach of fiduciary duty under § 1109 brought through the remedial provision § 1132(a)(2) is reserved for claims made by participants or beneficiaries on behalf of the plan, and § 1132(a)(2) and its compadre § 1109 cannot be used by a claimant seeking individual relief.[18]

Disappointed that the exquisite provisions of § 1109 were not meant for Maria, I moved on to the final remedial provision that offered any hope, § 1132(a)(3).[19]

Review of § 1132(a)(3)

(a) Person empowered to bring a civil action
A civil action may be brought...

(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 violation or (ii) to enforce any provisions of this subchapter or the terms of the plan.

I was euphoric. My attention was fixed on the phrase "other appropriate equitable relief to redress such violation." What court would not award Maria her consequential damages under this provision? The court would hold that since her benefits claim under § 1132(a)(1)(b) limits recovery to her past due disability benefits, the "other equitable relief" language of §1132(a)(3) provided the instrument for making her whole. More specifically, I was sure that § 1132(a)(3) would allow her to recover economic damages, such as her health care costs that would have been covered under the group health plan,[20] reimbursement for COBRA premiums that she paid, costs of her ruined credit, the further appreciation that would have occurred on her house, reimbursement of her tax penalty for early withdrawal of her retirement benefits, and also might provide an avenue for her to recover for her mental suffering as a result of the administrator's knowing conduct in wrongfully denying her claim.

Then I read *Varity Corp. v. Howe*, the leading U.S. Supreme Court case on individual relief under § 1132(a)(3). In a frenzy, I underlined, highlighted, and circled the following language from the opinion:

> Four of that section's (1132, in the opinion referred to as 502) six subsections focus upon specific areas, i.e.,

> the first (wrongful denial of benefits and information), the second (fiduciary obligations related to the plan's financial integrity), the fourth (tax registration), and the sixth (civil penalties). The language of the other two subsections, the third and fifth, creates two "catchalls," providing "appropriate equitable relief" for "any" statutory violation. This structure suggests that these "catchall" provisions act as a safety net, offering appropriate equitable relief for injuries caused by violations that 502 (1132) does elsewhere not adequately remedy.[21] (emphasis added).

"Exactly," I exclaimed aloud, alarming our cat. "This is Maria's safety net!" I read on and another phrase in the opinion caught my eye. "Thus, we would expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'"[22] (emphasis added; cite omitted).

"This is totally righteous," I said to myself. Our case clearly fit into the "catchall" provisions of § 1132(a)(3).

Then came Dark Monday. I anointed it Dark Monday because that was the night that I read *Great-West Life & Annuity Ins. Co. v. Knudson*[23] and *Sereboff v. Mid Atl. Med. Servs., Inc.*,[24] two fairly recent opinions issued by the U.S. Supreme Court regarding § 1132(a)(3), and realized that Maria's claims for any damages beyond her past due benefits were pipe dreams. Maria's consequential damage claims were for money damages, and any claim for money damages was not a claim seeking "equitable relief" but rather "legal relief", and therefore not viable under § 1132(a)(3).[25]

Then I uncovered the Fifth Circuit's take on *Varity Corp. v. Howe*, set forth in *Rohrer v. Raytheon Eng'rs & Constructors, Inc.*[26] and *Tolson v. Avondale Indus., Inc.*[27] and read various district court cases following them, and realized that we wouldn't even get out of the gate. *Tolson* and its progeny had developed a bright line rule that a claim for benefits under § 1132(a)(1)(b) is inconsistent with a claim for equitable relief under § 1132(a)(3), and the two claims, even if pled in the alternative, can't be brought in the same lawsuit.[28]

I was apoplectic and could not speak. I went to bed. Dim Tuesday (the following day), my wife, who was more irritated than perplexed by my recent distraction and melancholy, was pleased to see me snuggled up in bed reading to all three children. With a fond smile, she paused in the doorway to listen:

> I would now like to tell you, gentlemen, ("and ladies," I interjected for my daughter) whether you do or do not wish to hear it, why I never managed to become even an insect. I'll tell you solemnly that I wanted many times to become an insect. But I was not deemed worthy even of that. I swear to you, gentlemen, that to be overly conscious is a sickness, a real, thorough sickness. For man's everyday use, ordinary human consciousness would be more than enough; that is, a half, a quarter of the portion that falls to the lot of developed man....[29]

"What's gotten into you!" she exclaimed, interrupting our children's introduction to lofty self-pity.

"ERISA," I responded cryptically. I was replaced in that Nirvana, that warm reading spot between our children, who were then wide awake and fascinated that I was reading them forbidden literature.

"But it's a classic," I feebly protested as I shuffled out of the room, looking for the cold spot in our home that was equivalent to the end of the bench. As I found it, I heard my four-year old exclaim, "That was kind of cool, Mommy, that story about Daddy becoming an insect. Can we hear it tomorrow?" Celebrating with the panache of an accountant who finds one more tax deduction, I made a fist along my knee and pumped it a couple of times. From a distance, I was sustained.

I read on, finding a particular passage apropos:

> "For pity's sake," they'll shout at you, "you can't rebel: it's two times two is four! Nature doesn't ask your permission; it doesn't care about your wishes or whether you like its laws or not. You're obliged to accept it as it is, and consequently all its results as well. And so a wall is indeed a wall . . . etc. etc." My God, but what do I care about the laws of nature and arithmetic if for some reason these laws and two times two is four is not to my liking? To be sure, I won't break through such a wall with my forehead if I really have not got strength enough to do it, but neither will I be reconciled with it simply because I have a stone wall here and have not got strength enough.[30]

2. Limitations on Evidence

I needed to face the music. No matter the conduct of the administrator or what happened to Maria as a consequence of no income stream, all we had was a benefits claim. I talked with Maria and her family and gave them the unpleasant news about the limitations on their remedies. I fought the urge to read them Dostoevsky.

That night I laid in bed and stared at the ceiling fan. The analogies descended from the circling blades, one after another. I was experiencing a Viagra commercial in reverse. My powerful freight train had been reduced to a rusty handcar. My marsh, harboring a variety of life, had been reduced to a slender, vulnerable reed that stood within it. Maria had been exiled to a wasteland, a jurisprudential Siberia. My once finely carved tribal warrior had been whittled away to a shapeless wooden stick, the point of which could never be sharpened. I was being sent to battle with a dull stick. I winced. My impotence was palpable, and I expected it would be tolerated with a mixture of sympathy and impatience by the judge and opposing counsel as I, bereft of any witnesses to the truth of Maria's illness, waved my stick in the quiet courtroom air and like Atticus Finch pleaded for justice for Maria. The trial might even be perceived as satire.

Focused on what remained of Maria's benefits case, I read a few Fifth Circuit opinions and understood that the evidence was limited, with few exceptions, to the claim file.[31] The few exceptions that had been recognized either (1) related to cases in which the administrator's interpretation of the plan was at issue, or (2) concerned claims in which medical terminology needed to be explained (without elaboration that would stray into additional opinions regarding the claimant's condition).[32] The exceptions were irrelevant to Maria's case. There would be no live testimony. She and Henry would never get to tell their story at the courthouse. There would be no jury trial.[33]

3. Standard of Review

I explored under what standard the administrator's decision would be reviewed by the court. Maria's case was a challenge to the factual findings of the administrator, as opposed to a claim that the administrator incorrectly interpreted the disability plan. As I surveyed the uninviting horizon, I learned that the Fifth Circuit stood solitary in its opinion that when the administrator's factual findings were being contested, the administrator's decision was automatically given deference and would be reviewed under an abuse of discretion standard.

The seminal case regarding the standard of review is the U.S. Supreme Court decision *Firestone Tire and Rubber Co. v. Bruch*, decided in 1989.[34] In Bruch, contrary to the plan administrator's (Firestone) urgings, the Court ruled that a "denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility of benefits or to construe the terms of the plan."[35] The Court reasoned that, in the absence of deference granted to the trustee in the trust document, trusts have typically been construed by the courts in the same manner that other contracts have been construed, without giving deference to either party's interpretation.[36] Two years later, in 1991, the Fifth Circuit decided *Pierre v. Conn. Gen. Life Ins. Co. / Life Ins. Co. of N. Am.*[37] The Fifth Circuit interpreted Bruch narrowly, deciding that it was limited to plan interpretation issues, and held that under established principles of trust law, an administrator's factual determinations were owed a deferential review, regardless of the language within the plan document.[38] I couldn't find another circuit that followed *Pierre*, but instead found that the Third Circuit, and Fourth Circuit, Sixth Circuit, and Seventh Circuit had all held that, absent plan language permitting deference to the administrator's fact findings, factual determinations by administrators were subject to *de novo* review.[39]

Not surprisingly, Maria's disability plan provided that the administrator had discretion to interpret the terms of the plan. I told Maria and her family, who now visited my office with such trepidation that they visibly shook, that her case would be reviewed under an abuse of discretion standard. She was fed up with me because I had not been advocating for her but instead I was just another messenger of darkness.

"You mean to tell me that Dr. Diamond, that supposed doctor sitting in Rhode Island who reviewed my medical records and wrote that ridiculous opinion, that doctor who would not know me if he walked into this room, that doctor who no doubt has a steady income stream from the claims administrator, can write an opinion that I am not disabled from his desk in Rhode Island and that will be enough for them to win the case? He doesn't even have to see me?"

I nodded, warily surveying the conference table for sharp objects that could be hurled at me. Henry, a struggling artist and furniture maker who had been the stay-at-home dad for the children since their birth, and who had become Maria's caretaker, was livid.

"Well, we need you to do something. We need you to fly up to Rhode Island and take that a..hole's deposition. He doesn't know anything about Maria's day-to-day life. You ought to live with her. It's more than heartbreaking seeing how her life has changed. This Dr. Diamond probably hasn't seen a live patient in ten years. He was probably drunk when he wrote his sorry report. I bet he just cut and pasted it from a previous one he had written. I can picture him in a nice, big house with a nice car, all paid for by screwing strangers like Maria."

Ready to throw the conference table on its side and take cover behind it, I had to advise them further. "I doubt the court will let us take his deposition. In all probability he will be shielded from any attempts we make to learn anything about him."

There was silence at the other side of the table. Although I wanted to compare Maria's circumstance to Kafka's Joseph K., who "for without having done anything wrong (he) was arrested one fine morning,"[40] I needed something more concrete, something that would confirm that my description of this absurd circumstance was accurate. I read Maria and her family a short excerpt from an opinion written by Judge Higginbotham from the Fifth Circuit, in which the district court's finding of abuse of discretion by the administrator was reversed:

> . . . Accordingly, this court has held that an administrator does not abuse its discretion when it relies on the medical opinion of a consulting physician whose opinion conflicts with the claimant's treating physician (cite omitted). This is so even if the consulting physician only reviews medical records and never physically examines the claimant, *as taxing to credibility though it may be* (emphasis added).[41]

They left hurt and dismayed, their only solace being that I was working on a contingency fee (given their financial condition, there was no other option) and therefore, to a very limited degree, sharing their pain. It occurred to them to call me everyday and talk as long as possible, just to return an ounce of punishment for the pounds of it that I had inflicted upon them.

That night my wife found me in our recliner, wearing the beer-stained torn robe that I had been given while still in high school, the faithful one that had seen me through college and law school, the same one that I had thrown away when starting my new life but then at 3 a.m. sat up in a sweat, knowing that I was discarding too much, that I was losing part of my soul, and therefore the one, with flashlight in mouth, that I had retrieved from the dumpster. The robe was tied with my old, faithful belt because I had lost the sash somewhere in the boarding house where I lived during law school. I had given it to my boarding house friend, the one with the t.v., to tie up his three-legged table so that we could put his black and white t.v. on it. I was wearing my fur-lined hunting boots and having a cheap, stiff scotch as I read Hemingway to the cat:

"...You have youth, confidence, and a job," the older waiter said. "You have everything."

"And what do you lack?"

"Everything but work."

"You have everything that I have."

"No. I have never had confidence and I am not young."

"Come on. Stop talking nonsense and lock up."

"I am of those who like to stay late at the café," the older waiter said. "With all those who do not want to go to bed. With all those who need a light for the night."

"I want to go home and into bed."

"We are of two different kinds," the older waiter said. He was now dressed to go home. "It is not only a question of youth and confidence although those things are very beautiful. Each night I am reluctant to close up because there may be some one who needs the café."

"You mean to tell me that Dr. Diamond, that supposed doctor sitting in Rhode Island who reviewed my medical records and wrote that ridiculous opinion, that doctor who would not know me if he walked into this room, that doctor who no doubt has a steady income stream from the claims administrator, can write an opinion that I am not disabled from his desk in Rhode Island and that will be enough for them to win the case?

"Hombre, there are bodegas open all night long."

"You do not understand. This is a clean and pleasant café. It is well lighted.

The light is very good and also, now, there are the shadows of the leaves."

"Good night," said the young waiter.

"Good night," the other said. . . .[42]

My wife scratched the top of my head affectionately as I scratched the cat's head, then she retreated into our bedroom. She was not sure what to say. I was left to read to the cat. She purred with pleasure as I continued to read to her. That is what Maria needed, I thought, and what I was supposed to provide for her, a clean, well-lighted place where she could come and find some shelter.

Claims Procedure: A Full and Fair Review Under 29 U.S.C. § 1133

After reviewing Maria's claim file, and then other claim files of Texas workers, I determined that their rights to a "full and fair" review had been successfully short-circuited by claims administrators over and over again without fear of retribution.[43] But were the administrators to blame? After all, their primary duty and loyalty was to the stockholders of the company. Why wouldn't they eviscerate the process to the degree that the courts would permit? The full and fair review requirement hindered the cost efficiencies of processing claims and therefore, when considering a large quantity of claims, added significant expense in servicing claims that would be passed on to the employer or perhaps an insurance carrier.[44] In contrast, there was certainly no requirement that one's homeowner's insurance carrier review the claim twice, with the second review being conducted by someone other than the person who initially decided the claim.[45] From a traditional insurance carrier's perspective, a perspective no doubt shared by many employers, the "full and fair review" requirement was a classic example of unnecessary government interference.[46]

Backing up, the full and fair review requirement of any ERISA claim is found at 29 U.S.C. § 1133 and is as follows:

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

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

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

The "full and fair" review is critical to the claimant because it is generally the last de novo review. Once the final review is decided, the presumption that the fiduciary made the right decision (i.e. the allowance of wide discretion) is locked into place.

Section 1135 gives the Secretary of Labor the power to prescribe such regulations as are deemed necessary or appropriate to carry out the provisions of ERISA. With that authority, the Secretary prescribed minimum claim procedures that can be found in the Code of Federal Regulations at 29 C.F.R. § 2560.503-1. Included within the regulations are time requirements imposed on administrators in responding to claims and appeals as well as requirements concerning the content of the denial notices, both at the initial claims stage as well as the "full and fair" review stage, or appeals stage, mandated by § 1133(2).

The first denial to the claimant must be in writing and must include the following:

1) the specific reason or reasons for the denial;
2) reference to the plan provisions on which the determination is based;
3) a description of additional information necessary for the claimant to perfect her claim;
4) a description of the plans review procedures; and
5) if any guidelines or protocol were relied upon, a statement that guidelines or protocol were relied upon and will be provided if requested.[47]

The requirement that the administrator provide adequate notice of its reasons for denial, coupled with the claimant's right to receive the claim file upon request,[48] are fundamental to the claimant's right to a full and fair review of her claim. The claimant's right to the file is fundamental because, *before she has filed her appeal*, she can review the contents of the file and ensure it includes all the information that she submitted. With her claim file and first denial in hand she is given the opportunity to correct patent mistakes made by the administrator or perhaps even by her medical providers, review the claim log entries of the adjustor to see if they accurately reflect events about which she may have personal knowledge (e.g. telephone conversations between her and the claims administrator) and most importantly, it allows her to respond to evidence acquired by the administrator, typically reports from medical and vocational consultants who were hired by the administrator. A primary purpose of this administrative due process is so that the disputed claim might be fully fleshed out and correctly decided without the need for court intervention, or, for that matter, even a lawyer's intervention.[49] The review process, this prompt "fleshing out" of the claim, has been best described as a "meaningful dialogue between the ERISA plan administrator and their beneficiaries" about which there is nothing extraordinary or surprising, but rather is "how civilized people communicate with each other regarding important matters."[50]

Someone will experience the financial pain of compliance with this government regulation, this "full and fair review" requirement. It may be the corporation with a self-funded plan, it may be a third-party administrator that gets paid a flat fee for deciding claim appeals, or it may be the insurer of an insured plan. Regardless of who it is, the longer the dialogue between the beneficiary and the administrator, the higher the cost to administer the claim. In order to keep costs down, the employer or the insurer is motivated to develop a review process that is efficient and of short duration, yet perceived as substantially compliant with the requirements of a "full and fair" review of a denied claim.[51]

The Review of Maria's Claim

Maria's claim exhibits her administrator's desire to short-circuit the review requirement of § 1133(2) and also demonstrates the incredible latitude that it thinks the courts will permit. Upon receipt of Maria's appeal letter, the administrator sent the letter and the claim file upstairs to the appeals department, where an "appeals specialist" was assigned to decide the appeal.[52] The appeals specialist, a woman named Jennifer who was sitting at a desk in Chicago with Maria's claim file stacked in front of her, promptly called Maria and introduced herself. She told Maria that per ERISA law she (Jennifer) would have 45 days to decide her appeal, and indicated that once the determination was made,

it would be final. If Maria was dissatisfied with the decision, she could then sue under ERISA law. Maria told me that as she listened to Jennifer recite her script, she felt that collapsing hollowness return, a fresh awareness that nothing good would come from her appeal. She was silent as Jennifer continued.

"The time period that we are reviewing is from March 20th to the present. If you would like to submit additional medical information in support of your appeal we will be happy to review it. If you want to submit additional information, tell me and I will suspend the 45-day period until you tell me that all of your information has been submitted. *Once you tell me that you have submitted all of your medical information, the next step will be to send all of your information to one or more independent medical consultants, we call them IPAs, independent physician advisors.* I will send them all of your medical documents and they will send me a report. Once I receive their information, I will make a decision on your claim. If your appeal is denied, then there is no additional appeal. *We will not consider any additional information that you submit after I decide your appeal.*"

Maria quietly wept at the other end of the line and then whispered goodbye.

Jennifer received the letters from Maria's physicians and confirmed with Maria that no more documents would be submitted. She put them in Maria's claim file and had two copies made, overnighting one to Dr. Steel, a psychiatric consultant from Iowa who she often used, and the other copy was sent to Dr. Diamond in Rhode Island, a retired rheumatologist who often reviewed her fibromyalgia / chronic fatigue claims.[53] Both provided reports to Jennifer indicating their conclusions that there was insufficient objective evidence of disability and therefore Maria was capable of performing sedentary work. Jennifer promptly sent out a denial letter to Maria, advising her that her appeal had been denied and that the decision was final. In the denial letter, Jennifer quoted the definition of disability within the plan and in giving the reasons for denial repeated paragraphs almost verbatim from the conclusion sections of the reports from Dr. Steel and Dr. Diamond. The letter closed by advising Maria once again that the decision was final, and that the only recourse that remained was to bring suit under § 502(a) of ERISA.

The review process was gamed here because the administrator put its heavy hitters, the impenetrable Dr. Diamond and Dr. Steel, at the end of the claims process. This is an efficient process. The heavy hitters, who cost money, were meant to close the door on Maria's claim, not invite dialogue concerning her medical condition. Imagine having a lawsuit in which, in order to prevail; all you had to do was provide some evidence that your client made the right decision. Even if 75% of the reasonable evidence went the other way, imagine no pesky jury members, and further, imagine that during the trial you would be allowed to put on your expensive experts last in this "battle of experts",[54] and they would be free to testify without fear of a deposition or cross-examination. Imagine the battlefield upon which this "battle of experts" occurs. It is eerily modern. The treating physicians run through an open field while the consultants watch from a remote, undisclosed location, waiting for the signal to try and obliterate them with the push of a button.

What administrators typically don't tell claimants, and what Maria wasn't told, is that claimants are allowed to provide rebuttal testimony to door-closing experts. Not only was this information kept from Maria, but in fact she was told the opposite by the appeals specialist Jennifer – she was told that her claim was closed and that no further evidence would be considered. Fortunately, the law allows claimants further dialogue, even though the administrator tells them otherwise. This tolerance for a continued dialogue between claimant and administrator was established in *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 300 (5th Cir. 1999) (en banc), in which the Fifth Circuit held that "the administrative record (i.e. the evidence at trial) consisted of relevant information made available to the administrator prior to the complainant's filing a lawsuit and in a manner that gives the administrator a fair opportunity to consider it."[55] Although some claimants may hire a lawyer after their appeal is denied, many do not. Many give up, left adrift in that silent canyon with the false notion that further dialogue with the claims administrator, that administrator who is a fiduciary charged with acting with the utmost loyalty and honesty to them, is not permitted.[56]

Many give up, left adrift in that silent canyon with the false notion that further dialogue with the claims administrator, that administrator who is a fiduciary charged with acting with the utmost loyalty and honesty to them, is not permitted.

The Moral of *Wade v. Hewlett-Packard:* "You Shoulda Got Your Lawyer Yesterday"

A case that unfortunately illustrates Nietzsche's maxim too well, that is, that the original purpose of things gets lost by reinterpretation by those with fresh intentions who are in power, is one recently decided by the Fifth Circuit, *Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan.*[57] In that case, the panel reviewed an appeal process that involved two appeals, one to the same third-party administrator that initially denied the claim and the second and final appeal to a benefit committee within Compaq, Wade's employer.[58] In that case, the administrator that first denied the claim did not send a denial letter nor did it share the consulting physician's opinion that it relied upon in denying the claim. It merely called Wade on the telephone and told him that he had been denied. Wade appealed the decision, and at the second level of consideration (his first appeal), the administrator affirmed the denial of benefits and gave as the reason that "the clinical information does not meet ValueOptions' Short-term disability criteria."[59] The opinion notes that the second denial, like the first, was below compliance with the minimum claim regulations established by the Secretary of Labor, as the second denial did not "reference the Plan criteria, explain why his information failed to meet the criteria, advise him of the appeal time-line, or detail the information Wade should submit to perfect his appeal."[60] Wade's second appeal was denied by Elaine Boddome, who apparently has such qualities that she is sometimes fairly described as a committee, who advised Wade in writing that his second appeal was denied because his "documentation did not substantiate a claim for short-term disability."[61]

Again we are reminded of Kafka's Joseph K., who without having done anything wrong was arrested one fine morning and then spent the remainder of his days obediently waiting for an opaque bureaucracy to decide his fate. In *Wade*, the Fifth Circuit found that this one-way communication by the administrator substantially complied with the full and fair review requirements of § 1133, finding that "although the Plan's claims processing at the first two levels of review did not comply with Section 1133, the final level of review, and the most relevant one, substantially complied and intended to correct the disputed procedural and technical errors below."[62] Somehow, the court characterized

this review of Wade's claim as a "meaningful dialogue between beneficiary and administrator despite technical errors. (cite omitted)."[63]

The court's decision in *Wade* obliterates the purpose of § 1133 and the regulations because § 1133 and the regulations are meant to promote meaningful dialogue during the claims process, not facilitate an administrator's ability to shirk its simple duties throughout the claims process and then give full disclosure at the end. Full and fair review means "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision."[64] The court, either unwittingly or purposefully, erodes its decision in *Schadler v. Anthem Life Ins. Co.* 147 F.3d 388, 393-94, in which it aptly described the purpose of the required notice for the initial denial as set out in 29 C.F.R. § 2560.503-1(g)[65] as "necessary so that plan beneficiaries 'can adequately prepare . . . for any further administrative review, as well as an appeal to the federal courts.'"(cite omitted). What good does it do Wade, or the medical providers who might aid him by writing a rebuttal remarks or have Wade undergo additional testing to satisfy the administrator, to get a denial at the end of two appeals that finally gives Wade notice of the reasons for denial and refers to the plan provisions that are relied upon? Presumably, like Maria's administrator, Wade was also told in the committee's letter that his claim was closed, that no further evidence would be considered, and that the only recourse that remained was to file suit under § 502(a). Wade may have been lucky enough to find a lawyer who would help him with his appeal, and Wade may have been lucky enough to find a lawyer who knew enough about ERISA to know the rule established in Vega, that additional evidence is permitted despite the administrator's stated refusal to consider it, but the majority of claimants probably aren't so lucky.

More fundamentally, decisions like *Wade* are inimical to the raison d'etre for ERISA's claims procedures. The plan disclosure and claims procedure requirements of ERISA were meant to level the playing field by compelling employers to simplify the explanation of benefits and the claims process so that a layperson, the average employee, could understand what she was getting, how she might make a claim for benefits, if such a claim became necessary, and how she might appeal that claim. Recognizing that those disabled from working, or in search of health care benefits or pension benefits, do not typically have a cache of money lying around from which they can pay a lawyer, Congress compelled employers to provide a summary of benefits in such a way that the average person would understand it.[66] Notice of the initial adverse benefit determination (i.e. denial) is to contain the important details in plain, unambiguous language: the reasons for denial (both the plan provisions relied upon as well as a concise description of the evidence of lack of evidence relied upon), what might be submitted by the claimant to perfect the claim (i.e. have the denial overturned) and the ability to appeal the decision and time for the appeal.[67] The purpose is plain. There is to be no mystery here, no lying behind the log or taking advantage of an asymmetry of information. Rather, there is to be a current of plain dialogue during the claims process, rather than after the claims process, which is meant to be navigable without a guide.

Disclosure Requirements: Free Markets Require Full and Accurate Disclosure

Maria and I didn't talk much after we filed our summary judgment briefs and responses and anxiously awaited the judge's decision. Reason was of little use now, so we resorted to our imaginations. We were walking side by side across a different terrain, a terrain in which all of the inexorable and inhuman mechanisms that seemed to run the world had taken a back seat to a Kantian ethic, where all men and women were treated as ends in themselves, rather than a means to an end.[68] Standing on this rarified terrain, we imagined the information that would have been conspicuously disclosed to Maria by the administrator when it distributed the Summary Plan Description ("SPD") of her disability benefit plan. The first page of the SPD might have read as follows:

> THE DISABILITY PLAN YOU ARE BEING OFFERED HAS SIGNIFICANT LIMITATIONS THAT ARE DESCRIBED BELOW.
>
> JUST BECAUSE YOU AND YOUR TREATING PHYSICIAN(S) BELIEVE THAT YOU ARE UNABLE TO WORK DUE TO ILLNESS OR INJURY, DOES NOT MEAN WE WILL PAY DISABILITY BENEFITS UNDER THIS PLAN. IN CONSIDERING YOUR CLAIM, WE WILL PROBABLY ENGAGE MEDICAL CONSULTANTS WHO WILL REVIEW YOUR MEDICAL RECORDS BUT NEVER MEET YOU, AND IF THEY DISAGREE WITH YOUR PHYSICIAN(S) AND BELIEVE THAT YOU ARE STILL ABLE TO WORK, WE CAN DENY YOU DISABILITY BENEFITS UNDER THIS PLAN. IT WILL NOT SIMPLY BE PRESUMED THAT WHAT YOUR TREATING PHYSICIAN(S) ARE SAYING IS ACCURATE.
>
> THIS PLAN HAS GIVEN US THE DISCRETION TO DECIDE WHETHER OR NOT YOU ARE ENTITLED TO BENEFITS. IF YOU SHOULD FILE SUIT, TO WIN IN COURT WE ONLY HAVE TO PROVE THAT THERE WAS SOME REASONABLE EVIDENCE TO DENY YOUR CLAIM. THEREFORE, EVEN THOUGH THE MAJORITY OF THE MEDICAL EVIDENCE MAY INDICATE THAT YOU ARE DISABLED, YOU MAY STILL LOSE IN COURT. THE OPINIONS OF OUR CONSULTANTS WHO WILL NEVER MEET YOU WILL STAND ON EQUAL FOOTING WITH THE OPINIONS OF YOUR TREATING PHYSICIANS. IF YOU CHOOSE TO GO TO COURT, MORE OFTEN THAN NOT WE WIN THESE CASES BASED UPON THE OPINIONS OF OUR MEDICAL CONSULTANTS.
>
> MANY OF THE MEDICAL CONSULTANTS WHO MAY BE HIRED TO DECIDE YOUR CASE LIVE AND WORK NORTH OF THE MASON-DIXON LINE. THAT IS PROBABLY ALL THAT YOU WILL BE PERMITTED TO LEARN ABOUT THEM.
> ALSO, IN CONSIDERING WHETHER YOU CAN NO LONGER PERFORM YOUR JOB, WE WILL REVIEW WHETHER OR NOT YOU CAN PERFORM YOUR JOB AS IT IS DESCRIBED IN THE DICTIONARY OF OCCUPATIONAL TITLES RATHER THAN REVIEW THE ACTUAL REQUIREMENTS OF YOUR JOB.
>
> IN REGARDS TO THE DEFINITION OF TOTAL

DISABILITY, IF YOU CAN PERFORM AT LEAST ONE OF THE MATERIAL AND SUBSTANTIAL DUTIES OF YOUR OCCUPATION, YOU WILL NOT QUALIFY FOR BENEFITS UNDER THIS PLAN. THAT IS TO SAY, IN ORDER TO QUALIFY FOR TOTAL DISABILITY BENEFITS YOU MUST BE REDUCED TO A STATE OF ABJECT HELPLESSNESS.

NEITHER YOU NOR YOUR PHYSICIAN(S) WILL BE ALLOWED TO TESTIFY IN COURT, AS THE DECISION BY THE JUDGE WILL BE BASED UPON THE RECORDS SUBMITTED TO THE CLAIMS ADMINISTRATOR.

YOU WILL NOT BE ALLOWED A JURY TRIAL.

IF YOU DO PREVAIL AT THE COURTHOUSE, THE ONLY REMEDY TO WHICH YOU WILL BE ENTITLED WILL BE THE AWARD OF BENEFITS THAT WE SHOULD HAVE PAID IN THE FIRST PLACE.[70]

BY THE WAY, WHEN THE "APPEALS SPECIALIST" OR "ERISA SPECIALIST" WHO WORKS FOR THE CLAIMS ADMINISTRATOR FOR THIS PLAN TELLS YOU THAT YOU CAN'T RESPOND TO THEIR EXPERT CONSULTANTS BECAUSE YOUR CLAIM IS CLOSED, DON'T BELIEVE THEM. IT IS NOT THE LAW.

This information, unfairly cloistered within the federal courtroom and lawyers' offices, should not be considered esoteric, as these are the hinges upon which so many benefit claims and meager settlements turn.

Everyone sleeps as I lay below the ceiling fan. The fan's breeze and the sound of my wife's even breathing as she sleeps is my comfort. Is this really such a fantasy? Although we cannot thrive on that Kantian terrain because it asks too much of us, it asks that we always do the right thing out of a sense of duty regardless of the consequences, doing the right thing as a means to an end is common behavior. To be perceived as good in the community has value-it may allow us to have more friends, to attain more power or personal wealth, it may help our image or it may just help us sleep at night. In a corporate setting, being perceived as good is often profitable.

This lack of disclosure regarding ERISA benefit plans has closed markets. Free markets depend upon accurate and full disclosure, e.g. S.E.C. regulations, financial reporting, Enron, etc. If complete disclosure is made, employers and disability carriers could offer a number of plans and the beneficiaries could make an informed choice. The portfolio of choices offered employees might be as follows: (1) no benefits; (2) an ERISA group plan giving discretion to the administrator to decide benefits and a definition of total disability that allows for non-coverage if the claimant can perform at least one of his material and substantial duties (the Bronze Plan, also referred to as the *Ellis* plan); (3) a non-discretionary ERISA group plan that would allow the claimant *de novo* review at the courthouse and provide a broader definition of disability (the Silver Plan); (4) a non-discretionary ERISA group plan that defers to the credible opinions of treating physicians and provides for a broader definition of disability (the Gold Plan); and (5) an individual non-ERISA policy which provides a broad definition of disability and under which all state law remedies are preserved (the Platinum Plan-offered by only outside vendors). Underwriters and insurance agents would be given an opportunity for Power Point presentations to peddle multiple products to a group of employees. The limitations of the current Bronze Plan would become a selling point for the Silver Plan, a more expensive plan that provides more coverage and adds to the carrier's bottom line. Why not? The invisible hand might lift everyone up.

My Revelation and Maria's Sorrow

Not surprisingly, Maria and I lost the case. The opinions of the stranger from Rhode Island, the rheumatologist Dr. Diamond, won the day. The court determined that his written report, perhaps, as Henry suggested, written with an expensive Cabernet at hand and hammered-out before dinner, was some reasonable evidence that Maria was not disabled. "No objective evidence of disability," he proclaimed. For months afterwards that powerful ghost harassed me, appearing before dawn in the parking garage with a hubristic smile, only to disappear before I could confront him and ask him about his life and tell him about Maria. Sometimes I saw him on the San Antonio River, clever as a shrimp,[70] expertly piloting a sleek craft through the river's narrow curves, but upon my approach he and his boat would vanish into the fog.

I thought it cowardly and unproductive to blame others and I knew that I needed to move on. Ghosts sometimes disappear in spring, and so it was with the ghost of Dr. Diamond. He disappeared as the mountain laurel bloomed and in time for our annual spring trip to North Padre. Still bruised from our defeat, I grabbed a book from the despair section of my small library and stuck it in my gym bag, sliding it underneath my clothes as if smuggling a flask of whiskey. It must have been the sun that soaked it out of me, the children's laughter as we chased down Frisbees and footballs and waves and we built amorphous things which in the children's eyes were perfect castles...it must have been when my wife and I drank a beer and then another while walking along the beach during the late afternoon, watching our children zig and zag with the incoming waves on thin legs, their unrestrained laughter spiraling upwards-they were frenetic sandpipers turned to silhouette by an angular sun. It must have been all of that and more. That night I curled up with my book after all of the other dominoes had fallen:

> The gods had condemned Sisyphus to ceaselessly rolling a rock to the top of a mountain, whence the stone would fall back of its own weight. They had thought with some reason that there is no more dreadful punishment than futile and hopeless labor. . . . It is during that return, that pause, that Sisyphus interests me. A face that toils so close to stones is already stone itself! I see that man going back down with a heavy yet measured step toward the torment of which he will never know the end. That hour like a breathing-space which returns as surely as his suffering, that is the hour of consciousness. At each of those moments when he leaves the heights and gradually sinks towards the lairs of the gods, he is superior to his fate. He is stronger than his rock . . . . I leave Sisyphus at the foot of the mountain! One always finds one's burden again. But Sisyphus teaches the higher fidelity that negates the gods and raises rocks. He too concludes that all is well. This universe henceforth without a master seems to him neither sterile nor futile. Each atom of that stone, each mineral flake of that night-filled mountain, in itself forms a world. The struggle toward the heights is enough to fill a man's heart. One must imagine Sisyphus happy. . . .[71]

We all had our many stones, and one of mine was ERISA. This conclusion seemed right for me, that to be fulfilled we needed an acute awareness of all that surrounded us during our labors. We needed a fidelity to the world around us. Rather than pack myself in a few boxes, "I am this" or "Tomorrow I will be that," I needed to empty those boxes and let the journey itself fill my heart. This intuition did not emanate from a conviction that the world had no master, however. I found another idea more concordant with my own, that to ignore the details of life, the sand upon a child's hand, the surprising paleness of a cottonwood's leaves, the new wrinkles near the eye, the client who sits silently, fearing everything and needing a clean, well-lighted shelter, to ignore these things in front of me that were without veneer, these things that were not being promoted by anyone and could not be sold, was a great sin, and a sin that was so easily committed.[72] I agreed that I did not deserve to live in a world that I ignored.[73]

But this selfish revelation, that a greater awareness might lead to a more fulfilling life, provided no help to Maria. On the contrary, it would no doubt depress her further, as her journey was so much different than mine and, because of her illness, so much more difficult. For her, awareness meant pain, and pain dominated all of her other perceptions. She was being paid Social Security Disability benefits and Henry had found a part-time job for ten bucks an hour with a furniture manufacturer, but they would never return to that place where they were before Maria's illness.

We talked about appealing her case, but I advised her that she would probably lose at the Fifth Circuit, that the opinions of that impenetrable ghost Dr. Diamond would again win the day. Her husband and I agreed that the rising hope that an appeal brings and then losing a second time might finally crush her. Out of guilt I called Maria a few times after our case was over, but I soon realized that there was no need to continue calling. She did not want to talk with me. I recently received a card from her in which she wrote as follows:

> "Jeff:
> This is probably the last time you will hear from me. I am not doing any better but at least I am getting Social Security and Henry is now working more hours with the kids in school. Without him I would be dead, not such a bad idea but they all tell me that they need me around. I don't know why, as I feel I am only a burden to everyone. Thanks again for trying to help me. I don't expect to be writing you again – you're just part of an experience which I need to somehow forget, but it's nothing personal and I wish you and your family the best.
>
> Best Regards, Maria
>
> P.S. I wish I had the strength to go and find Dr. Diamond and tell him about my life, but I don't. Why would he care, anyway?"

The last time she left my office, after we decided against an appeal, I promised her that one day I would try and tell her story as best I could. And that is what I did.

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1. Friedrich Nietzsche, The Genealogy of Morals 209-10 (Francis Goffing trans., Doubleday, Garden City N.Y. 1956).
2. In ERISA nomenclature, the document which affords benefits for the employee is called a benefit plan, even if the benefit plan is insured and the governing document is therefore an insurance policy.
3. The Fifth Circuit Court of Appeals is in New Orleans.
4. 29 U.S.C. § 1001 (1974).
5. Maria's employer was ultimately responsible for paying disability benefits under the plan, but contracted with a third-party claims administrator ("TPA") that specialized in reviewing and deciding (i.e. administering) disability claims. Some employers offer this type of ERISA plan, often called a self-insured plan (calling it a self-insured plan is a euphemism – it is an uninsured plan), and then others hire insurance carriers that are not only responsible for administering the claim, but are also responsible to pay the claim out of their own funds. These are insured plans. The same rules of claims administration apply to both kinds of plans, and therefore the discussions of the duties of claims administration in this story are applicable to both insurance carriers administering insured plans as well as TPA's that administer the claim but aren't responsible for paying the claim if it is approved.
6. Deluded that youth springs eternal, I still refer to myself as dude.
7. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
8. *Id.* at 50-51.
9. For example, in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002), Justice Scalia quotes *Mertens v. Hewitt Assocs.*, 508 U.S. 248(1993) in saying, "We have observed repeatedly that ERISA is a 'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private employee benefit system."
10. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985)
11. Soren Kierkegaard, The Diary of Soren Kierkegaard 19 (Peter P. Rohde, ed., Citadel Press 1993).
12. *Id*, at 15.
13. *Id.* at 78.
14. *Lee v. Benefit Plans Adm'r of Armco, Inc.*, 789 F. Supp. 856, 859 (S.D. Tex. 1992), vacated 992 F.2d 324 (5th Cir. 1993).
15. *Paris v. Profit Sharing Plan for Emps. of Howard B. Wolf, Inc.*, 637 F.2d 357, 362 (5th Cir. 1981).
16. *Pilot Life Ins. Co.*, 481 U.S. at 54.
17. The Secretary refers to the Secretary of Labor. See 29 U.S.C. § 1002(13).
18. *Mass. Mut. Life Ins. Co.*, 473 U.S. at 144.
19. There are six remedial provisions within § 1132(a), but two of the remaining three are reserved for the Secretary of Labor and the third remaining provision addresses disclosure violations concerning deferred benefits under pension plans.
20. Approximately a year after her termination, Maria and Henry could no longer pay the COBRA premiums so they became uninsured.
21. *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996).
22. *Id.* at 515.
23. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. at 204.
24. *Sereboff v. Mid Atl. Med. Servs., Inc.*, 126 U.S. 1869 (2006).
25. *Great-West Life and Annuity Ins. Co.*, 534 U.S. at 210-18. If one is interested in seeing the harsh results that occur as a result of this barrier to monetary damages, read the very recent decision

by the Fifth Circuit, *Amschwand v. Spherion Corp.*, 505 F.3d 342 (5th Cir. 2007). In *Amschwand*, even though it was clear that the plan fiduciary misrepresented the status of Mr. Amschwand's life insurance benefits, the court refused to allow Mr. Amschwand's widow the life insurance benefits as appropriate relief under § 1132(a)(3) of ERISA, noting that it was constrained by *Great-West* to deny relief. Defying common sense justice, the relief that was available to the widow for the plan fiduciary's misrepresentation that Amschwand was a covered participant under the group life insurance plan was return of the life insurance premiums that were paid, as that is deemed appropriate "equitable" relief under *Great-West* (This was not adjudicated, as Aetna, the group life insurer, happy to avoid coverage, voluntarily reimbursed their premiums).

26. *Rhorer v. Raytheon Eng'rs and Constructors, Inc.*, 181 F.3d 634 (5th Cir. 1999).

27. *Tolson v. Avondale Indus., Inc.*, 141 F.3d at 604 (5th Cir. 1998).

28. *Rhorer*, 181 F.3d at 639; Tolson, 141 F.3d at 610; their offspring includes *Constantine v. Am. Airlines Pension Benefit Plan*, 162 F. Supp. 2d 552 (N.D. Tex. 2001).

29. FYODOR DOSTOEVSKY, NOTES FROM THE UNDERGROUND 6 (Alfred Knopf 1993).

30. *Id.* at 13.

31. *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 394 (5th Cir. 2006).

32. *Vega v. Nat'l. Life Ins. Servs., Inc.*, 188 F.3d 287, 299 (5th Cir. 2006)

33. *Calamia v. Spivey*, 632 F.2d 1235, 1237 (5th Cir. 1980).

34. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

35. *Id.* at 115.

36. *Id.* at 112.

37. *Pierre v. C.T. Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir. 1991).

38. *Id.* at 1558.

39. *Rowan v. Unum Life Ins. Co. of Am.*, 119 F.3d 433, 435 (6th Cir. 1997); *Ramsey v. Hercules, Inc.* 77 F.3d 199 (7th Cir. 1996); *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991); *Reinking v. Philadelphia Am. Life Ins.* Co., 910 F.2d 1210 (4th Cir. 1990).

40. FRANZ KAFKA, THE TRIAL 3 (Alfred A. Knopf, Inc. 1937).

41. *Gothard v. Metro. Life Ins. Co.*, 491 F.3d 246, 249 (5th Cir. 2007)

42. ERNEST HEMINGWAY, *A Clean, Well-Lighted Place*, in THE SNOWS OF KILIMANJARO AND OTHER STORIES 32 (Charles Scribner's Sons 1927).

43. There is not a Fifth Circuit case which awards damages, i.e. benefits, to a claimant because a claims administrator fails or refuses to comply with 1133. In *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389 (5th Cir. 2006), Aetna was found to have failed to comply with review requirements but the award of benefits to Robinson in that case hinges upon the finding that there was no concrete evidence to support Aetna's denial. Also see the recent discussion of this issue in *Custer v. Murphy Oil USA, Inc.*, 503 F.3d 415 (5th Cir. 2007).

44. This "passing on of the expense" is an inapt description to plans in which the employer rather than an insurance carrier or TPA makes the ultimate decision. However, regardless of whether the final decision is outsourced or made in-house, the employer will probably bear most of the expense of a full and fair review of a denied claim.

45. Under the claims procedures promulgated by the Department of Labor which specifically describe the minimum requirements for a full and fair review of a denied claim, for health care and disability claims the review cannot afford deference to the first decision-maker and cannot be made by the same person who initially denied the claim. 29 C.F.R. § 2560.503-1(h)(3)(ii), made applicable to disability claims by 29 C.F.R. § 2560.503-1(h)(4).

46. It seems to logical to conclude that the quid pro quo for conducting a full and fair review (i.e. compliance with § 1133(2)) is that the administrator is then afforded deference in regards to its decision, and therefore the appropriate penalty for not complying with § 1133(2) is that the claimant should be afforded a *de novo* review. The Fifth Circuit has thus far not deviated from its general rule that substantive remedies, which might very well follow from a change in the standard of review, will not be awarded as a result of the administrator's failure to follow claims procedures. See the recent discussion of this issue in *Custer v. Murphy Oil USA, Inc.*, 503 F.3d 415 (5th Cir. 2007).

47. 29 C.F.R. § 2560.503-1(g).

48. 29 C.F.R. § 2560.503-1(h)(2)(iii).

49. As reiterated by the Fifth Circuit in *Robinson v. Aetna*, "mandating review of the specific ground for a termination (of benefits) is consistent with our policy of encouraging the parties to make a serious effort to resolve their disputes at the administrator's level before filing suit in district court." 443 F.3d 389, 393 (5th Cir. 2006).

50. *Booten v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997).

51. "Technical non-compliance with ERISA procedures will be excused so long as the purpose of § 1133 has been fulfilled." *Robinson*, 443 F.3d at 393 (5th Cir. 2006). ERISA procedures are reviewed for "substantial compliance".

52. Under the minimum claim regulations, for a disability or health care claim, the person who initially decided the claim cannot be the person who decides the appeal. 29 C.F.R. 2560.503-1(h)(3)(ii), made applicable to disability plans by 29 C.F.R. 2560.503-1(h)(4). The same corporation or carrier can decide the initial claim as well as the appeal, it just can't be the same person within that corporation or insurance company that decides both.

53. All of the names within this story are fictional, and this is not meant to refer to any living or dead consultant named Dr. Diamond or Dr. Steel. If there are consultants with those names, it is a coincidence.

54. In *Corry v. Liberty Life Assurance Co. of Boston*, 499 F.3d 389 (5th Cir. 2007). Liberty's records reviewers (expert witnesses) lost in the trial court because they did not consider Valerie Corry's subjective complaints of constant pain but won at the Fifth Court of Appeals, which overturned the decision, finding that the consulting experts sufficiently considered, albeit from a remote location, her complaints of severe pain. In this decision, the court accurately describes the case as a "battle of experts". The battlefield is eerily modern, as the treating physicians are the soldiers running through an open field as the consultants watch from a remote setting, waiting for the signal to obliterate them with the push of a button.

55. The Fifth Circuit subsequently discussed this rule in an unpublished opinion, *Keele v. JP Morgan Chase Long Term Disability Plan*, 221 F. App'x. 316 (5th Cir. 2007), and then, in its second reversal of a finding of abuse of discretion by a district court this forlorn summer (the summer of 2007 – the first being Gothard v. Metro. Life Ins. Co.), upheld this rule in *Corry v. Liberty Life Assurance Co. of Boston*. Valerie Corry is a fibromyalgia, chronic fatigue case not unlike Maria's, and she, like Maria, fell into that silent canyon where one falls when he or she is ill and cannot work but cannot qualify for benefits.

56. "Lying is inconsistent with the duty of loyalty owed by all

fiduciaries and codified in section 404(a)(1) of ERISA." *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996).

57. 493 F.3d 533 (5th Cir. 2007).

58. Not atypically at all, the so-called committee, according to the opinion the Compaq Welfare Benefits Administrative Committee, was a committee of one person. *Wade*, at page 536. No doubt the Summary Plan Description ("SPD") of the plan given to Wade described the final appeal as being before this committee and did not disclose that the committee would be one person. Poor Wade if he inferred from this that the final decision on his benefit claim, i.e. the fiduciary's decision, would be a decision refined through some sort of Socratic dialogue between committee members.

59. *Wade*, 493 F.3d at 536. ValueOptions was the administrator for the first two levels of appeal.

60. *Id.* at 539.

61. *Id.* at 536-537.

62. *Id.* at 540. The panel does not really explain how the fiduciary, the committee of one, corrected the procedural deficiencies of the first two decisions. It says that the final decision complied with § 1133 and that it was based upon a re-review of the evidence by a consultant previously used as well as another medical consultant, but this hardly informs the claimant and promotes future dialogue between the claimant and the administrator.

63. *Id.* at 540.

64. *Sweatman v. Commercial Union Ins. Co.*, 39 F.3d 594, 598 (5th Cir. 1994) (citing *Sage v. Automation, Inc. Pension Plan and Trust*, 845 F.2d 885, 893-94 (10th Cir. 1988) (quoting *Grossmuller v. Int'l Union Local 813*, 715 F.2d 853, 858 n. 5 (3d Cir. 1983)).

65. At the time that *Schadler* was decided, the manner and content of the initial denial was at 29 C.F.R. § 2560.503-1(f); although unchanged, it is now forth in 29 C.F.R. § 2560.503-1(g).

66. 29 U.S.C. § 1022, 1024(b).

67. 29 C.F.R. § 2560.503-1(g).

68. Immanuel Kant (1724-1804), a Prussian philosopher, believed that as rational beings we innately understand what is right and wrong, and that to be moral beings we must "act only on that maxim whereby thou canst at the same time will that it become a universal law." Taken from W.T. JONES, A HISTORY OF WESTERN PHILOSOPHY: KANT AND THE NINETEENTH CENTURY 77 (Harcourt Brace Jovanovich 1975).

69. As I believe that these disclosures describe "circumstances which may result in disqualification,, ineligibility, or denial or loss of benefits", I think most of them, perhaps phrased differently, are required by ERISA under 29 U.S.C. § 1022(b). These disclosures are typically not made, however.

70. A phrase stolen from my good friend, Bjorn Bergman.

71. ALBERT CAMUS, THE MYTH OF SISYPHUS AND OTHER ESSAYS 119-23 (Justin O'Brien, trans., Alfred A. Knopf, Inc., 1955).

72. In his book, *True at First Light*, set in Africa, while he is sitting in camp, Hemingway (the book is written in the first person) realizes that he has paid attention only to the birds that were good to eat or were scavengers or predators, those birds that were significant to hunters. He describes his failure to see the other birds all around him and says "This looking and not seeing things was a great sin, I thought, and one that was easy to fall into." ERNEST HEMINGWAY, TRUE AT FIRST LIGHT 176 (Scribner 1999).

73. *Id.*