Taming the ERISA Beast:
Contesting the Denial of ERISA Insurance Claims

By Bob Rutter

ERISA is a crazy law.

The Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq., was supposed to be a great benefit to American workers, protecting them from unscrupulous employers who promised generous pensions that mysteriously vanished when retirement finally arrived.

ERISA was designed to fix this deplorable situation, and it largely has done so in the pension arena. But its tentacles have stretched far beyond pension reform. In trying to protect employees, the legislature—and the courts that have interpreted ERISA over the years—has given ERISA a breadth that would startle its original advocates.

Today, ERISA controls basically all employee benefits, not just pensions. This means that employer-sponsored life, disability, and health insurance all fall under the ERISA umbrella, and since most workers get these benefits from employers, the vast majority of such claims are now "ERISA claims" as opposed to traditional insurance claims.

And the rules governing ERISA claims are crazy. Far from protecting workers, these rules have become the scourge of workers, depriving them of benefits in a manner that would astonish anyone with even a cursory knowledge of how traditional insurance claims are handled.

Preemption of State Law Claims

An insurance policy is nothing more than a contract. We all learned in law school that the failure of one party to honor a contract gives rise to a claim for breach of contract. But not under ERISA.

ERISA preempts all state law claims, including claims for breach of contract, and substitutes the remedy allowed by the statute. That is, a claim "to recover benefits due to him under the terms of his plan." But isn't this just another way of wording a claim for breach of contract?

Perhaps, but what is more significant is that ERISA preemption also applies to state law claims for lack of good faith and the corresponding claim for punitive damages. Ohio law, for example, allows an insured to recover extra-contractual damages if an insurer's claim denial lacks reasonable justification. If the insurer acted maliciously, the insured may be entitled to punitive damages.

These are formidable arrows in the insured's quiver. But they do not exist under ERISA. If an insurer handling an ERISA claim denies coverage in bad faith or maliciously, the insured's remedy is limited to recovery of the amount due under the contract. That is, the insurer's punishment is limited to paying what it should have paid in the first place.

This is akin to punishing a bank robber by making him return the stolen funds. There is basically no downside to an insurer wrongfully denying a claim, because the worst thing that will ever happen is that it will have to pay the claim. And don't think insurance companies don't know this. They have grown emboldened to deny claims willy-nilly for any reason or no reason because they know that most insureds will not fight the denials and the ones that do—even if they succeed—will only get what they should have been paid in the first place.

Insurers Have Broad Discretion to Pay or Not to Pay

Under ERISA, the fox is guarding the hen house. The insurer is granted broad discretion to decide if it should pay the claim. Its decision is entitled to great deference by a reviewing

court. Under the usual standard of review, the insurer's decision to deny a claim will be affirmed unless it was arbitrary and capricious.

This is probably the single strongest defense to overcome in any ERISA case. It is also completely illogical. Since when does a party to a contract have unfettered discretion to decide whether or not it will honor the contract? I would have flunked Professor Austin's contracts class if I had ever made such a ridiculous argument.

How did we get to this point? Easy. All insurers had to do was include a clause in the contract saying that they had unfettered discretion to decide claims, and the courts—like good matadors—stepped aside and allowed the bull to pass.

Once insurers saw how easy it was to evade judicial review, they all reacted in the same predictable way. They included discretionary clauses in all of their policies. Why not? Again, there is no downside.

The effect of discretionary clauses is to turn upside down the best-known maxim of insurance law—insurance policies must be construed broadly in favor of the insured and a court must adopt any reasonable construction of a policy that favors coverage. Armed with broad discretion to "interpret" their own policies, insurers not surprisingly look for interpretations that avoid coverage. Courts defer to insurers as long as the insurer's position is at least arguably reasonable. Instead of being broadly construed to *favor* coverage, ERISA policies are broadly construed to *avoid* coverage.

Michigan and a few other states have enacted statutes or regulations banning discretionary clauses. In *American Council of Life Insurers v. Ross*, 558 F.3d 600 (2009), the Sixth Circuit upheld the Michigan rules, meaning that all ERISA claims in the state are subject to de novo review. The de novo standard is more favorable to ERISA claimants because it requires

that the court independently review the insurer's decision. Ohio has not enacted any similar rule, and is unlikely to do so given the pro-insurance mentality prevailing at the statehouse.

No Discovery in ERISA Cases

The normal reaction of a lawyer to a client who has a breach of contract claim is to file a lawsuit for breach of contract. After all, that is what lawyers do, right? Wrong. This is a big mistake in ERISA cases for a couple of reasons.

First, ERISA claimants are not entitled to discovery. The Federal Rules of Civil Procedure do not apply to ERISA cases. Instead, the courts have developed a unique procedure for ERISA cases. The cases are decided based on the administrative record that existed when the claim was denied. The justification for this rule traces back to the rule granting broad discretion to insurers. If an insurer did not have certain information when it made a claim decision, then how could it abuse its discretion by ignoring such information?

Based on this analysis, courts hold that there is no need to search for the truth. Rather, what is important is whether the insurer made the correct decision (remember unbridled discretion) based on the evidence that the insurer had before it—regardless of whether additional evidence would show that the decision was wrong. No discovery is necessary because discovery cannot change the evidence that was before the insurer back when the claim was decided.

This brings us to our second important point. A successful ERISA claim depends on the administrative record as developed during the administrative appeal. Most policies contain a provision allowing the insured to appeal a denial of benefits within 180 days of the denial. The appeal is to the same insurer that denied the claim, but it is supposed to be decided by a person or body not involved in the original claim denial. However, since discovery is not allowed it is often hard to tell how different these two decision-makers really are.

In any event, a successful appeal depends on a complete record. If the insured has any information that it wants the insurer to consider, then speak now or forever hold your peace. The insured must provide information so that it will become part of the administrative record. If the evidence does not convince the insurer, maybe it will be enough to convince the court at a later time. The situation is akin to that facing a lawyer at trial—make your record now or forget about arguing the issue on appeal. The appellate court—the district court in the ERISA context—can and will only consider the evidence in the administrative record at the time the insurer denied the claim, so put into the record everything you need to make your argument to the district court.

No Jury Trial—In Fact, No Trial at All

Assume that the insured's lawyer is on the ball and supplements the administrative record with a report from the treating doctor that says the insured is disabled. This report directly contradicts the insurer's report from the IME doctor saying the opposite. This is a factual dispute that must be resolved by a jury since we all know that juries resolve facts—not judges. Right?

Wrong again.

ERISA claimants are not entitled to a jury trial. In fact, there is no trial at all in most cases, not even a bench trial. Why? We once again get back to the issue of the insurer's discretionary authority. This discretion extends to fact-finding. The insurer has discretion to decide what facts to accept and what facts to reject. In essence, the courts have abdicated their responsibility to determine facts and transferred this duty to insurance companies.

Harkening back to a traditional breach of contract case, when is one party to a contract absolutely bound to accept the facts as determined by the adverse party. Bizarre? Illogical? Un-American? I submit that it is all of the above.

Some Courts Are Equally Dismayed

It is not just claimant's attorneys who find ERISA puzzling. Some judges have questioned the rules of the game that have developed piece-meal in the last 40 years. For example, *Andrews-Clarke v. Travelers Ins. Co.*, 984 F.Supp. 49 (D.Mass 1997) involved the death of an insured who had been refused mental health treatment that his doctors asserted was necessary to manage his psychiatric disorders. Judge William Young commented that:

> As a consequence of their failure to pre-approve—whether willful, or the result of negligent medical decisions made during the course of utilization review—Clarke never received the treatment he so desperately required, suffered horribly, and ultimately died needlessly at age forty-one.
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> Under traditional notions of justice, the harms alleged—if true—should entitle Diane Andrews-Clarke to some legal remedy on behalf of herself and her children against Travelers and Greenspring. Consider just one of her claims—breach of contract. This cause of action—that contractual promises can be enforced in the courts—pre-dates Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it.
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> Nevertheless, this Court has no choice but to pluck Diane Andrews-Clarke's case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of Travelers and Greenspring, to slam the courthouse doors in her face and leave her without any remedy.
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> This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system.

Federal District Judge Letts voiced his concerns about ERISA in *Dishman v. UNUM Life Ins. Co.*, 1997 WL 906146 (C.D.Cal.):

> [T]he facts of this case are so disturbing that they call into question the merit of the expansive scope of ERISA preemption. [The insurer's] unscrupulous conduct in this action may be closer to the norm of insurance company practice than the court has previously suspected. This case reveals that for benefit plans funded and administered by insurance companies, there is no practical or legal deterrent to unscrupulous claims practices.

> Absent such deterrence, the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.

These cases were decided 18 years ago, and Congress has not moved to alleviate the problem. In fact, the problem has worsened with the proliferation of discretionary clauses in virtually all employee benefit plans. Given what we know about the incoming Congress, it is safe to assume that legislative change is not on the horizon.

So What to Do?

The Supreme Court provided a ray of hope in *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011), a case that has been construed by some lower courts as slightly broadening the equitable remedies available under ERISA law, and perhaps allowing discovery in some limited situations.

Practitioners, however, should still be on alert. ERISA cases are difficult, complex, and full of potential pitfalls. Being a good trial lawyer is not enough to validate handling an ERISA case, especially since actual trials are virtually non-existent. ERISA cases are motion-driven, and claimant's counsel will likely be opposed by knowledgeable counsel who has handled—probably successfully—numerous prior ERISA cases.

Proceed at your own peril.