TESTIMONY BEFORE THE COMMITTEE ON FINANCE
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Introduction

Chairman Baucus; Ranking Member Grassley; Members of the Senate Finance Committee. Thank you for giving me the opportunity to testify at today's hearing.

When ERISA (Employee Retirement Income Security Act) was passed in 1974, one of the law's major sponsors, Senator Jacob Javits, hailed it as "the greatest development in the life of the American worker since Social Security."[1] That optimism was secured by a promise contained in the preamble to the statute proclaiming ERISA's purpose: to provide "appropriate remedies, sanctions, and ready access to the federal courts."[2] Yet the story told over the past 35 years has been one revealing an utter betrayal of those lofty goals and an egregious absence of remedies, sanctions, and access to normal federal court procedures. Contrary to the clearly expressed legislative intent, the courts have transformed ERISA into a shield that protects insurance companies from having to face the consequences of unprincipled benefit denials and other breaches of fiduciary duty. Claimants are denied the right to trial by jury, a basic Constitutional right routinely available in every other type of insurance case and virtually all other civil litigation. In most cases, there is not even a trial. Instead, courts conduct reviews of claim records assembled and shaped by self-serving insurance companies without hearing any testimony whatsoever, under a procedure that gives more deference to the insurance company than a court would give a Social Security administrative law judge in its review of a Social Security disability benefit claim denial.[3] Thus, the worst that can happen to an insurance company that improperly withholds benefit payments, often for years after they are due, is that a court *may* require the benefits to be paid without additional cost or penalty, although the courts have created rules that further delay the payment of benefits. Instead of simply ordering the payment of benefits when the benefit denial has been overturned, the routine practice is for courts to send the case back to the insurance company, which allows the insurer another opportunity to come up with yet another reason to deny the benefits. No damages whatsoever are available for the harm caused

[1] 120 Cong. Rec. 29, 933 (1974) (statement of Senator Javits)
[2] 29 U.S.C. §1001(b)
[3] *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir. 1999)(Wood, J., dissenting)

when benefits are wrongfully denied such as bankruptcy, home foreclosure, or even death if necessary medical treatment has been denied.[4]

Commenting on this paradox, a federal judge in California several years ago issued a special opinion in a disability insurance case recognizing "there is no practical or legal deterrent to unscrupulous claims practices. Absent such deterrents, 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."[5] Another judge wrote,

> *Caveat Emptor!* This case attests to a promise bought and a promise broken. The vendor of disability insurance now tells us, with some legal support furnished by the United States Supreme Court, that a woman determined disabled by the Social Security Administration because of multiple disabilities which prevent any kind of work cannot be paid on the disability insurance she purchased through her employment. The plan and insurance language did not say, but the world should take notice, that when you buy insurance like this you are purchasing an invitation to a legal ritual in which you will be perfunctorily examined by expert physicians whose objective it is to find you not disabled, you will be determined not disabled by the insurance company principally because of the opinions of the unfriendly experts, and you will be denied benefits.[6]

Judicial voices such as these are few and far between. Instead insurers gloat over how ERISA has worked to their benefit, with one industry executive bragging in an internal memo:

> The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review.[7]

The current regime cries out for Congressional reform aimed at correcting the means by which most abuses arise:

- Abolish the right given insurers to grant themselves a deferential review and allow claimants the ability to present witnesses and evidence in open court;
- Provide for jury trials;

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[4] *Sarkisyan v. Cigna Healthcare of Cal., Inc.*, 613 F. Supp. 2d 1199 (C.D.Cal. 2009)
[5] *Dishman v. Unum Life Ins. Co. of Am.,* No. 96-0015 JSL, 1997 WL 906146 (C.D. Cal. May 9, 1997)
[6] *Loucks* v. *Liberty Life Assurance Co. of Boston*, 337 F. Supp. 2d 990, 991 (W.D. Mich. 2004) (vacated following post-judgment settlement)
[7] Provident Internal Memorandum October 2, 1995

- Preclude courts from "remanding" benefit claim disputes to the insurers;
- Permit awards of statutory or other damages in appropriate cases.

The Deferential Standard of Review

In a watershed 1989 Supreme Court ruling, *Firestone Tire & Rubber Co. v. Bruch,*[8] the Supreme Court dramatically altered the litigation of ERISA claims. Although the Court recognized the typical manner of adjudicating benefit claim disputes is through a plenary proceeding, it nonetheless sanctioned deferential review of benefit denials. As a consequence of *Firestone*, so long as certain language is written into the insurance policy, courts are compelled to defer to the insurance company's determination unless the claimant can prove the benefit denial was arbitrary and capricious[9] and not merely wrong, a concept that has been elevated above the goal of assuring an accurate claim decision. That point is illustrated by a comment made in a recent federal appellate ERISA ruling involving disability benefits which pronounced: "Under no formulation, however, may a court, faced with discretionary language like that in the plan instrument in this case, forget its duty of deference and its secondary rather than primary role in determining a claimant's right to benefits."[10]

The consequences of the application of an arbitrary and capricious standard of court review are profound given the recognition by the courts that "[t]he very existence of 'rights' under [employee benefit] plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has…"[11] Examples abound:

- An employee of a major accounting firm who first received disability benefits in 1994 when his HIV infection worsened and developed into full-blown AIDS lost his benefits in 2006 despite no improvement whatsoever in his health status. Even a physician hired by the insurance company found a lack of stamina to handle a 40-hour workweek. Nonetheless, because other doctors consulted by the insurance company who had never examined the claimant thought otherwise, the benefit termination was sustained based on the insurance company's discretionary authority.[12]

- A human resources specialist suffering from a spinal impairment had her benefits

[8] 489 U.S. 101 (1989)
[9] *Pokratz v. Jones Dairy Farm,* 771 F.2d 206, 209 (7th Cir. 1985)("The 'arbitrary or capricious' standard calls for less searching inquiry than the 'substantial evidence' standard that applies to Social Security disability cases. Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action. Any questions of judgment are left to the agency, or here to the administrator of the Plan.")
[10] *Evans v. Eaton Corp. Long Term Disability Plan,* 514 F.3d 315, 323 (4th Cir. 2008)
[11] *Herzberger v. Standard Ins.Co.,* 205 F.3d 327, 331 (7th Cir. 2000)
[12] *Jenkins v. Price Waterhouse Long Term Disability Plan,* 564 F.3d 856 (7th Cir. 2009)

terminated even though a consultant hired by the insurance company to review her claim initially found her disabled. The consultant changed his opinion, though, when shown snippets of surveillance video that a dissenting judge characterized as "a highlight reel of [the insured's]most active moments during several days of surveillance." Yet the decision was sustained as being within the insurer's discretion.[13]

- Despite the findings of an expert neurologist based on imaging studies that a data processing specialist was disabled on account of a seizure disorder, a court deferred to an insurance company's finding that the condition was psychiatric, which enabled the insurer to limit the duration of benefit payments to 24 months rather than to age 65. Although the court commented it may have reached an entirely different conclusion if the standard of review was not deferential[14] that finding was of little comfort to the employee who lost his benefits nonetheless.

- A court of appeals rejected a challenge that a disability insurer failed to perform an independent assessment of the claimant's disability. The court concluded it was permissible for the insurance company to rely solely on its employee physician-consultants even though those doctors never examined the insured; and the court accepted the insurance company doctors' opinions as *ipso facto* reliable without a trial where such opinions could be subject to cross-examination.[15]

- Despite reports from doctors at the Cleveland Clinic and other prestigious medical institutions certifying the disability of the executive director of a major summer festival, along with disability findings made by the Social Security Administration and a second independent disability insurance company, an insurance company's denial of benefits was upheld as not arbitrary and capricious based on contrary medical reports submitted by physicians frequently retained by the insurer who conducted pure paper reviews.[16]

And there are many more.

The arbitrary and capricious standard also permits insurance companies to interpret ambiguous policy terms in a self-serving manner, ignoring over 200 years of insurance law principles that require ambiguities in an insurance policy to be construed in favor of the insured. Even as to the basic definition of what constitutes a "disability," courts have permitted insurance companies to interpret a clause that defines disability as the insured's inability to perform all of his or her material job duties to mean that so long as the insured can perform a single job duty, they would not qualify.[17] That interpretation, if applied to someone like the late Christopher Reeve, a quadriplegic who

[13] *Mote v. Aetna Life Ins.Co.,* 502 F.3d 601 (7th Cir. 2007)
[14] *Fischer v. Liberty Life Assur.Co.,* 576 F.3d 369 (7th Cir. 2009)
[15] *Davis v. Unum Life Insur.Co. of America,* 444 F.3d 569 (7th Cir. 2006)
[16] *Black v. Long Term Disability Ins.,* 582 F.3d 738 (7th Cir. 2009)
[17] *Gallagher v. Reliance Standard Life Insur.Co.,* 305 F.3d 264 (4th Cir. 2002)

required a respirator in order to breathe but who was able to speak during limited times when the respirator was not needed, could not have qualified for benefits since speaking is a material job duty of an actor.

The acceptance of the arbitrary and capricious standard has also transformed judicial oversight of ERISA benefit claim disputes into quasi-administrative proceedings where the court conducts a review of a so-called "administrative record,"[18] which, despite its lofty appellation, is nothing more than a claim file created by an insurance company. Claimants are given no opportunity to cross-examine adverse medical or vocational experts, routine discovery procedures such as written interrogatories and depositions are denied, and no trial is held. No provision of ERISA sanctions such a practice; and Supreme Court precedent establishes the impropriety of courts holding review proceedings rather than trials in civil actions not governed by the Administrative Procedure Act.[19] This insidious practice has also led to courts' willingness to overlook wholesale flouting of ERISA claim standards developed by the Department of Labor. Under the guise of permitting "substantial compliance" with the ERISA rules, courts allow insurers to unduly delay claim decisions and deny benefit claimants any opportunity to rebut adverse evidence without any adverse consequences. Conversely, unsophisticated claimants who fail to meet complex and detailed rules governing the submission of claims and appeals are given no leeway whatsoever. An example is what occurs when an applicant for disability insurance receives a favorable Social Security disability determination, which, through no fault of the insured, is not obtained until after the claim appeals are exhausted. The general rule in such circumstances is that a court will refuse to give any consideration at all to such crucial evidence.[20] It is therefore no wonder that a leading ERISA scholar has observed: "[A] self-interested plan decisionmaker will take advantage of its license under Bruch to line its own pockets by denying meritorious claims."[21]

Jury Trials

Nowhere in ERISA is there a prohibition against jury trials, yet the federal courts have almost uniformly precluded jury trials of ERISA benefit disputes even though the identical claims were routinely tried to juries prior to ERISA.[22] Since disputes involving disability benefits are essentially claims for breach of contract, several commentators have challenged the rationale behind court rulings that have precluded jury trials of ERISA cases.[23] And no one has put it better than a federal judge who pointed to both the

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[18] *Perlman v. Swiss Bank Corp.*, 195 F.3d 975 (7th Cir. 1999)
[19] *Chandler v. Roudebush*, 425 U.S. 840 (1976)
[20] *Majeski v. Metropolitan Life Ins.Co.*, 590 F.3d 478 (7th Cir. 2009)
[21] Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA," 101 N.W. U. L. Rev. 1315, 1321 (2007)
[22] See, e.g., *Pearce v. General American Life Ins.Co.,* 637 F.2d 536 (8th Cir. 1980)
[23] Bogan, ERISA: Rethinking Firestone in Light of Great-West - Implications for Standard of Review and the Right to a Jury Trial in Welfare Benefit Claims, 37 J. Marshall L. Rev. 629 (2004)

history and value of juries in resolving disputes over entitlement to benefits, and remarked:

> Without juries, the pursuit of justice becomes increasingly archaic, with elite professionals talking to others, equally elite, in jargon the eloquence of which is in direct proportion to its unreality. Juries are the great leveling and democratizing element in the law. They give it its authority and generalized acceptance in ways that imposing buildings and sonorous openings cannot hope to match. Every step away from juries is a step which ultimately weakens the judiciary as the third branch of government.[24]

Remands

The ERISA law lacks any provision that justifies the practice of courts allowing insurance companies the opportunity to articulate new reasons for denying claims rather than simply ordering the payment of benefits when the claim determination is overturned. Yet courts routinely "remand" ERISA claims to insurers for reconsideration even though at least one court has recognized "[i]t would be a terribly unfair and inefficient use of judicial resources to continue remanding a case to the Committee to dig up new evidence until it found just the right support for its decision to deny an employee her benefits."[25] Not only are remands extra-statutory; they also fail to fully adjudicate the parties' rights and remedies, arguably in violation of Article III of the United States Constitution which mandates that federal courts issue final decrees of conclusive character.[26] Moreover, remands offer an excuse for insurers to sloppily or inadequately evaluate a claim in the first instance. Since insurance companies are aware they will be given further opportunities to develop new reasons for denying the claim, there is no incentive to make an accurate decision in the first instance. Consequently, the practice of remands clogs the federal court system with multiple rounds of litigation.

Damages/Penalties

The addition of damages or penalties to ERISA is a necessity due to the Supreme Court's interpretation of ERISA's limited remedies which has led to tragic results. An illustration of the existing vacuum in ERISA remedies is the case of *Amschwand v. Spherion,*[27] where a widow was denied life insurance indemnity on account of misrepresentations concerning coverage made by her late husband's employer. The court concluded that ERISA only permits equitable remedies; and that a claim for damages due to the misrepresentation was barred by ERISA. It is difficult to imagine that Congress intended to victimize an innocent widow by barring such a claim.

Conclusion

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[24] *Radford Trust v. First Unum Life Ins.Co. of Amer.,* 321 F.Supp.2d 226, 241 (D.Mass. 2004)
[25] *Dabertin v. HCR Manor Care, Inc.,* 373 F.3d 822, 832 (7th Cir. 2004)
[26] *Aetna Life Ins. Co. v. Haworth,* 300 U.S. 227, 241 (1937)
[27] 505 F.3d 342 (5th Cir. 2007); *cert. denied* 128 S.Ct. 2995 (2008)

The reason most frequently offered for preserving the existing ERISA regime is that the current state of the law holds down costs and thus encourages the formation of employee benefit plans. But that rationale is hardly a justification for a system in which courts give more deference to insurance companies than is given to federal administrative law judges. Moreover, since employee benefits are a valuable tool utilized by employers to recruit and retain prized employees, it is extremely unlikely that employers would cease sponsoring benefit plans. Nor is there a legitimate fear of markedly increased costs. The only available actuarial study on this issue reveals that potential cost increases resulting from the elimination of insurer discretion would lead to at most a modest 4% rise in premiums.[28] To analogize, both history and common sense suggests that most consumers would willingly pay a ticket charge of $104 to fly on an airline that has a near-perfect safety record rather than paying $100 to fly on an airline perceived as being less safe. That price is a small one to pay for the assurance of more solid rights to receive benefits when they are needed in times of sickness or injury and to have confidence that those who deserve benefits receive them expeditiously while those who are not deserving are denied for valid, defensible reasons.

The ways in which ERISA can be amended to bring about these changes are not unduly complex. One possibility would be to amend the definition of "welfare benefits" in ERISA[29] to clarify that the purchase of insurance as a means of funding employer-sponsored disability, health, or life insurance benefits excludes the resulting plan from ERISA altogether, leaving claimants with the existing protections of already well-established state laws, rights, and remedies. Another proposal would be to amend § 502 of ERISA[30] to provide that claims brought under insured plans will always be adjudicated in accordance with the same plenary standards and proceedings afforded any other civil action brought in federal court.[31] Finally, the language in § 502(a)(3)(B) which currently permits plan participants to seek *appropriate* equitable relief has led to a judicial interpretation that too often results in there being no relief whatsoever available to claimants such as those aggrieved by misrepresentations or omissions by employers.[32] Simplifying the statutory language to enable recovery of relief at large would remedy a great unfairness that currently exists. These proposed changes would restore the intent and purpose of the comprehensive benefits reform enacted by Congress more than thirty-five years ago. More importantly, such changes can help rebuild public confidence in insurance companies that have, for too long, been able to hide behind legislative shields and judicial protections that no other industry receives.

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[28] Milliman Inc. November 14, 2005

[29] 29 U.S.C. § 1002(1)

[30] 29 U.S.C. § 1132

[31] It is important to distinguish insured welfare benefit plans from Taft-Hartley plans or other self-funded plans which have governance, funding, and other procedural mechanisms in place offering greater protection to plan participants than insured plans.

[32] *Mertens v. Hewitt Associates*, 508 U.S. 248, 256, 124 L. Ed. 2d 161, 113 S. Ct. 2063 (1993)(interpreting "appropriate equitable relief" as limited to relief typically available in equity in the 18th century)