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THE PERILOUS AND EVER-CHANGING
PROCEDURAL RULES OF PURSUING AN ERISA
CLAIMS CASE
Kathryn J. Kennedy*

I. INTRODUCTION TO ERISA'S UNIQUE CIVIL PROCEDURE
RULES

Because millions of employees and self-employed individuals are covered
under private and voluntary employee benefit plans today, filing to receive
benefits covered under such plans has become commonplace. However, the
acceptance of benefit requests, especially for health benefits, is anything but
commonplace. Due to the high cost of maintenance of health benefits, it has
actually become commonplace to see certain health benefits denied to claimants
on various theories, e.g., medical necessity, investigatory/experimental
exclusions, and other analogous cost-containment provisions. Once a claimant is
faced with a benefits denial under a plan, the exercise of the claimant’s
substantive rights is contingent upon numerous civil procedure rules under the
Employee Retirement Income Security Act (“ERISA”). These rules are in a
constant state of flux and development at both the judicial and regulatory levels.

Congress has attempted unsuccessfully over recent years to strengthen
claimants’ substantive and procedural rights to health benefits, including those
under ERISA plans. Such legislative efforts have been coined the “patients’ bill

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their excellent assistance.

(codified and amended in various sections of title 26 and 29 of the U.S.C.). ERISA is the federal
labor law which, together with section 401 of the Internal Revenue Code, I.R.C. § 401 (2001),
regulates the adoption and maintenance of voluntary employer-sponsored retirement and welfare
plans. ERISA’s provisions were codified in title 29 of the United States Code, whereas the related
tax provisions of the Internal Revenue Code were codified in title 26 of the United States Code.
The Department of Labor (hereinafter referred to as the “DOL”) has authority under part 5 of title I
of ERISA to administer and regulate its civil enforcement provisions and claims procedure

2 See Bipartisan Patient Protection Act of 2001, H.R. 2563, 107th Cong. (2001); Bipartisan Patient
106th Cong. (1999); Patients’ Bill of Rights Plus Act of 1999, S. 300 IS, 106th Cong. (1999);
Quality Care for the Uninsured Act of 1999, H.R. 2990 IH, 106th Cong. (1999) (amended and
renamed as Patients’ Bill of Rights Plus Act, H.R. 2990 EAS, 106th Cong. (1999)); Bipartisan
Consensus Managed Care Improvement Act of 1999, H.R. 2723 IH, 106th Cong. (1999); Patients’
(1999); Patients’ Bill of Rights Act of 1998, S. 2529 PCS, 105th Cong. (1998); Patients’ Bill of
of rights.” A presidential advisory commission under President Clinton made
specific recommendations concerning the expansion of consumer protections in
the health care industry, including substantive and procedural rights under
ERISA.3 In late 1997, President Clinton urged Congress to implement the
Commission’s recommendations, and, in reaction to weakened legislative efforts,
directed federal regulatory agencies to initiate administrative actions consistent
with the Commission’s recommendations.4 As a result, the DOL made sweeping
proposed changes in 1998 to ERISA’s claims procedure regulations, implementing
a number of the Commission’s recommendations.5 These DOL proposals put aside
the initial claim procedure regulations that were promulgated in 19776 and made
substantial regulatory changes, including attempts to repeal a number of judicially
formulated doctrines used for years in the litigation of ERISA claims.7 Despite
the unsuccessful attempts of the Clinton administration to legislate changes under
ERISA, the DOL proposed regulations became final in the latter days of the Clinton
administration, with some modification and a delayed effective date until 2002.8

In August 2001, there appeared to be sufficient bipartisan support and
presidential approval for the passage of a patients’ bill of rights by the 107th
Congress.9 The compromise piece of legislation did not expand consumer
protections as far as the Commission’s recommendations, and thus would not
have been as broad as the requirements under the impending DOL regulations.
The extended date of the proposed legislation until October 2002,10 and the
further extension of the effective date of the impending DOL regulations until
2003,11 would have provided the courts with additional time to address how the

3 President Clinton’s Advisory Commission on Consumer Protection and Quality in the Health
Care Industry issued recommendations in its November 20, 1997 report (referred to as the
“Consumer Bill of Rights and Responsibilities”).
(referred to in the text as the initial DOL claim procedure regulations).
in the text as the proposed DOL claims procedure regulations).
6 Id.
7 Id.
(referred to in the text as the impending DOL claims procedure regulations). These regulations
were initially effective for claims filed under a plan on or after January 1, 2002. 65 Fed. Reg.
70,271 (Nov. 21, 2000). The Bush administration placed a 60-day freeze on the effective date of
regulations issued during the latter months of the Clinton administration. See Memorandum For
the Heads and Acting Heads of Executive Departments and Agencies, Subject: Regulatory Review,
January 20, 2001, issued by Andrew H. Card, Jr. Assistant to the President and Chief of Staff at
numbered 2 and 3 in House Report 107-184); Bipartisan Patient Protection Act of 2001, S. 1052,
10 Both Bipartisan Patient Protection Act bills have delayed the effective date of their proposed
legislation until October 1, 2002. H.R. 2563; S. 1052.
11 The DOL delayed the impending claims procedure regulations between six months and one year
from the initial date of January 1, 2002, in order to afford group health plans additional time to
legislative changes mesh with the present rules, as well as the validity of the DOL’s exercise of regulatory power to implement sweeping changes. Unfortunately, due to the terrorists’ attacks of September 11, 2001, the focus of the 107th Congress has been shifted to anti-terrorist legislation, and away from other issues, including the patients’ bill of rights. Thus, any legislative changes in the area of expanded employee benefits rights will be deferred to subsequent years, leaving the courts with the continued challenge of formulating ERISA participants’ rights and enforcement procedures, especially in light of the DOL regulations which promulgate rules that have not yet reached legislative approval. Of course, given the change to a Republican administration in 2001, the DOL may be directed to rescind their regulations and adopt alternative regulations prior to the 2003 effective date.

This article will examine the profound changes over the past twenty-six years in the development of ERISA’s civil procedure requirements; because the language of ERISA is silent as to many of these requirements, many rules have been developed through judicial doctrine. Such judicially-crafted civil procedure requirements have proven to be outcome determinative in certain benefit claim suits, affording a mighty shield for plan sponsors and insurers in the denial of benefit claims. As each of the eleven civil procedure rules is discussed (Sections III. A through III. K, below), the author will note how each such rule would be altered under the proposed legislation and under the impending DOL final regulations. While ERISA offers a variety of causes of action, this article is limited to the civil procedure rules applicable to the adjudication of benefit claims under ERISA plans, and to the resulting major public-policy implications for benefit structure and scope.

II. BACKGROUND INFORMATION

ERISA is an acronym for the Employee Retirement Income Security Act of 1974, originally designed to protect participants’ rights under employee benefit plans and to provide plan sponsors and other plan fiduciaries with uniform sets of rules regarding the standards of conduct, responsibility and obligations under such plans. As these employee benefit plans are voluntary in nature, the courts...
have been cognizant of the plan sponsor's settlor rights in the drafting, amending, and termination of such plans.\textsuperscript{13} However, once employees are provided benefits through these plans, ERISA sets forth appropriate causes of actions, remedies, sanctions and access to the federal courts to enforce such rights,\textsuperscript{14} preempting state legislation and regulations to the contrary.\textsuperscript{15} Under ERISA's broad preemption clause, Congress recognized the states' police powers over the insurance, banking, and securities businesses and granted continued state regulation of such laws on employee benefit plans through its "savings clause."\textsuperscript{16} However, to prevent a state law from recognizing self-insured employee benefit plans as an "insurance company" for purposes of its regulation, ERISA's "deemer clause" necessarily limits the states' regulatory power.\textsuperscript{17}

Despite its explicit causes of actions, remedies and sanctions, ERISA itself was silent on a number of important procedural aspects necessary to enforce a claimant's substantive rights.\textsuperscript{18} As noted by the Ninth Circuit in \textit{Scott v. Gulf Oil Corp.}, "Congress intended for the courts, borrowing from state law where appropriate, and guided by the policies expressed in ERISA and other federal labor laws, to fashion a body of federal common law to govern ERISA suits."\textsuperscript{19} Thus, for the past twenty-six years since ERISA's enactment, the federal courts have been busy fashioning and developing a federal common law in those contexts where ERISA is silent.\textsuperscript{20} The evolution of ERISA's civil procedure rules by the federal courts has resulted in a unique set of rules that can easily trap

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\textsuperscript{13} See \textit{Lockheed Corp. v. Spink}, 517 U.S. 882, 890 (1996) (affirming the employer's settlor powers to establish, amend and modify the terms of the plans and refusing to extend ERISA's fiduciary duties with respect to such actions); \textit{Anderson v. Resolution Trust Corp.}, 66 F.3d 956, 960 (8th Cir. 1995) (affirming the plan sponsor's powers to amend or terminate the plan as business decisions, not fiduciary acts); \textit{Haberern v. Kaupp Vascular Surgeons Ltd. Defined Benefit Pension Plan}, 24 F.3d 1491, 1497-99 (3d Cir. 1994) (stating that the determination of compensation for purposes of benefit purposes was not a fiduciary act), \textit{cert. denied}, 513 U.S. 1149 (1995); \textit{Belade v. ITT Corp.}, 909 F.2d 736, 737-38 (2d Cir. 1990) (stating that the exclusion of a specific group of employees was not a fiduciary act).


(\textit{Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefits plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulations.})

\textsuperscript{16} 29 U.S.C. § 1144(b) (2001) (referring to what is known as ERISA's "savings clause").

\textsuperscript{17} 29 U.S.C. § 1144(b)(2)(B) (referring to what is known as ERISA's "deemer clause").


\textsuperscript{19} 754 F.2d 1499, 1502 (9th Cir. 1985).

\textsuperscript{20} \textit{See Helms v. Monsanto Co.}, 728 F.2d 1416, 1420 (11th Cir. 1984).
an unsuspecting claimant and his/her representative. Additionally, a party’s use of these rules can “heavily influence” the outcome of the suit, not only at the administrative level, but also at the judicial level. While such result is obviously in direct conflict with ERISA’s legislative intent to promote the right to benefits for participants and beneficiaries, the result is consistent with the general federal civil procedures rules, which have been described as pro-defendant.

In order to strengthen participants’ rights, employees and self-employed workers have become increasingly vocal in requesting legislative changes, especially in the context of health care benefits, including employee health plans covered by ERISA. In late 1996, President Clinton appointed a presidential advisory commission, known as the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the “Commission”), to make specific recommendations regarding consumer rights in the health care system. By November, the Commission issued its recommendations (referred to as the “Consumer Bill of Rights and Responsibilities”) promoting the following health consumer protections: better access to information; choice of health care providers; faster access to emergency services; consumer participation in treatment choices; assurances of nondiscrimination and confidentiality in the delivery of medical services; and grievance and appeals procedures. President Clinton urged Congress to make the legislative changes necessary to implement the Commission’s recommendations applicable to private health plans, providers, and health care facilities. At the same time, the President also issued a memorandum to the Secretaries of Defense, Labor, Health and Human Services, and Veterans Affairs,

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21 See 29 U.S.C. § 1001(b) (1994) (declaring that the policy of ERISA is
to protect . . . 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).

F.3d 305 (7th Cir. 1995) (describing Rules 68 and 35 of the Federal Rules of Civil Procedure as
pro-defendant, but acknowledging that in many other respects, the rules may be described as pro-
plaintiff); Irving Joyner, Litigating Police Misconduct Claims in North Carolina, 19 N.C. CENT.
L.J. 113, 143-44 (1991) (discussing means of reducing the cost of discovery for the plaintiff);


24 See Medical Savings Account: Economist, Aide Call MSAS Key to Efforts to Reform Health
System, 24 BNA PENSIONS & BENEFITS 46 (November 25, 1997); States Said Already Enforcing
Rights for Managed Care Consumers, BNA PENSIONS & BENEFITS DAILY (BNA) (Dec. 8, 1997). A
copy of the bill of rights document issued by the Commission and reported to the President of the
United States is available on its Internet home page at http://www.hcqualitycommission.gov (last
revised Nov. 14, 2001).

25 See U.S. CONGRESS, CONGRESSIONAL RESEARCH SERVICES, CRS ISSUE BRIEF: MANAGED HEALTH
directing them to use their regulatory powers through regulations, advisories, and other guidance to implement the Commission’s recommendations.\textsuperscript{26}

Pursuant to these directives, in September 1998, the DOL made sweeping proposed changes to ERISA’s claims procedure regulations, implementing a number of the Commission’s recommendations, as well as repealing a number of judicial doctrines used in litigating ERISA claims.\textsuperscript{27} The DOL received heavy criticism and an unprecedented number of comments from employers, plans, and health care providers on their proposals.\textsuperscript{28} Because Congress failed to pass legislative changes during 1999 and 2000, the DOL issued, in the final days of the Clinton Administration, final patients’ rights claims procedural regulations that included many of these failed legislative initiatives.\textsuperscript{29} The effective date of these final rules was initially delayed until 2002;\textsuperscript{30} however, in the wake of mid-2001 legislative efforts that appeared to have greater chance of passage, the DOL delayed the rules’ effective date an additional six months to one year.\textsuperscript{31} Legislative efforts that had a real chance for passage in mid-2001 were proposed to be effective in October 2002.\textsuperscript{32} The 2001 legislative compromises did not broaden patients’ rights to the full extent of the Commission’s recommendations.

\textsuperscript{26} See Memorandum on Federal Agency Compliance with the Patient Bill of Rights, 34 WEEKLY COMP. PRES. DOC. 298 (Feb. 20, 1998).

\textsuperscript{27} See 29 C.F.R § 2560.503-1 (2001). In a press release issued prior to the proposed regulations, Secretary of Labor Alexis Herman acknowledged that the “DOL has been limited by the statute in its ability to ensure that ERISA-covered health plans have sufficient consumer protections.” See Press Release, Pension and Welfare Benefits Administration, Labor Department Announces Initiatives to Implement President Clinton’s Consumer Bill of Rights Directive (Feb. 20, 1998), available at http://www.dol.gov/opa/media/press/pwba/pwb98069.htm. In her testimony before the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, DOL Assistant Secretary Berg noted the advantages of various House and Senate bills, such as S. 1890/H.R.3605, the Patients’ Bill of Rights Act of 1998 sponsored by Sen. Daschle (D-S.D.) and Rep. Dingell (D-Mich.); and the Patient Access to Responsible Care Act (S. 644/H.R. 1415), introduced by Sen. D’Amato (R-N.Y.) and Rep. Norwood (R-Ga.), which addressed the strengthening of health plans’ internal claims procedures, the right to appeal to outside parties, and the improper denial and delay in the processing of health benefit claims. See Elizabeth A. White, Berg Calls For Further Protections Under ERISA For Health Plan Participants, BNA PENSION & BENEFITS DAILY (BNA) (May 15, 1998).

\textsuperscript{28} See Preamble, 65 Fed. Reg. 70,246 (Nov. 21, 2000), where the DOL reported that over 700 written comments were received and over 60 speakers appeared at the public hearing.

\textsuperscript{29} See 29 C.F.R § 2560.503-1 (2001). As noted on the DOL’s fact sheet, these patients’ rights claims procedure changes were designed to “ensure that group health plan participants in today’s managed care environment have access to a faster, fairer, fuller process for benefit determinations.” www.DOLclaimsFactSheet.html (January 25, 2001). As such, the regulations provide faster response time for health benefit claim decisions; faster appeal time of denial claims; review of an adverse benefit determination made de novo by a named fiduciary that was not the initial claim reviewer; faster access to courts even prior to exhaustion of administrative remedies if the plan fails to comply with the regulations in all respects. Id.

\textsuperscript{30} See 29 C.F.R. § 2560.503-1(o) (applying the regulations to claims filed under a plan on or after January 1, 2002).


or DOL finalized regulations. Thus, future questions for the courts to address will include the adoption of any new legislative changes to ERISA’s civil procedure rules, as well as the regulatory powers of the DOL to implement changes not contained in the final patients’ bill of rights, and to repeal judicially formulated doctrines under ERISA which have not been altered by legislation.

III. EVOLUTION OF ERISA’S CIVIL PROCEDURE RULES

If a participant or beneficiary believes he or she is entitled to a benefit under an ERISA plan, the first step in pursuit of the benefit is to file a claim for benefit under the plan. If the claim is denied, the plan must provide an internal review procedure in order for the claimant to appeal the initial benefits’ denial. If benefits are denied at this second level, ERISA affords a cause of action for such benefit denial. While such a claim for benefits is a substantive issue, there are a number of significant and perilous procedural rules confronting a claimant before he or she can pursue a benefits denial cause of action: whether the law of ERISA is even applicable; whether an ERISA cause of action may be alleged; whether the plaintiff has standing to bring the ERISA cause of action; what courts have subject matter jurisdiction over the ERISA cause of action; whether the defendant can remove the case from state court to federal court; which courts have venue; whether ERISA’s statute of limitations has expired; whether the plaintiff must exhaust the plan’s administrative remedies prior to initiating a cause of action; what is the judicial standard of review applicable to the fiduciary’s decision to deny the claim; whether the courts are limited by the administrative record of the plan’s fiduciary or whether new evidence may be submitted by the plaintiff; and, finally, whether the plaintiff is entitled to a jury trial. The answer to each question is a stepping stone to the next question and will ultimately determine whether the plaintiff is successful in his or her appeal. Since the regulatory and judicial rules are not always consistent in the application of each question, the outcome of the plaintiff’s appeal is anything but clear. The lack of uniformity also frustrates plan administrators who attempt to apply the plan’s claim procedure rules on a consistent fashion, regardless of the various jurisdictions of possible claimants.

A. Whether ERISA is Applicable

ERISA applies only to covered employee benefit plans; those plans which are established and maintained by an employer or an employee organization. Thus the first step is to ascertain whether the plan in question is a covered ERISA plan or whether it is subject to one of the numerous exceptions under ERISA’s rules. The second step is then to ascertain whether such plan is one that is established

37 See 29 U.S.C. §§ 1002(1), (2).
or maintained by an employer or employee organization. The final issue in order to allege an ERISA cause of action is whether the claim for relief "relates to" the ERISA covered plan. Unless all three elements are present, the claimant will be unsuccessful in his/her initial pursuit of an ERISA cause of action for benefits.

An ERISA covered plan is essential in order to assert an ERISA cause of action, otherwise federal courts will lack jurisdiction over the matter.\(^3\) As to whether the plan in question is covered, ERISA is generally applicable to a wide variety of employee welfare benefit plans\(^3\) and employee pension benefit plans.\(^4\) Exclusion from ERISA's overall mandates exist only for a select group of employee benefit plans, such as governmental plans; church plans; plans designed to comply with state workmen compensation laws, unemployment compensation, or disability insurance laws; plans maintained for nonresident aliens; and unfunded excess benefit plans (which provide pension-type benefits in excess of the maximum contribution/benefit limitations imposed by the Internal Revenue Code's qualification rules for highly paid individuals).\(^4\) Unless the plan falls within one of these named exceptions, it will be governed by the federal rules of ERISA and state laws attempting to regulate such plans will be deemed preempted.

The second question focuses on whether the covered employee benefit plan is "established or maintained" by an employer and/or an employee organization. Generally this is not an issue; employers desire to establish and maintain employee benefit plans in order to deliver tax-exempt welfare or pension/profit

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\(^4\) See 29 U.S.C. §§ 1002(1), (2) (2000) (defining an employee pension benefit plan as

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sharing benefits to their employees. However, the issue does surface in group insurance programs offered to the employees by the employer/employee organization, where the latter is simply acting as a conduit for the payment of group insurance benefits (i.e., the employer simply remits the insurance premiums to the insurer). In its regulations, the DOL has a safe harbor provision that insulates the employer/employee organization from ERISA coverage provided four conditions are satisfied: (1) the employer/employee organization does not make any contributions of its own to the insurer; (2) employee participation in the program is voluntary; (3) the sole function of the employer/employee organization is to collect and remit the premiums to the insurer (without endorsement of the program); and (4) no consideration is received other than reasonable compensation for these administrative services. Most often, litigation is directed at the third factor—whether the employer’s level of involvement is more than minimal. Some circuits find that minimal employer involvement is sufficient for employer involvement with the plan. Other circuits require substantially more to hold the employer responsible for the plan. Two circuits have gone beyond the use of the DOL’s safe harbors to pose the question of whether an ERISA plan exists.

The final question in determining ERISA’s applicability turns to ERISA’s preemption clause; a clause which preempted state laws that “relate to” a covered ERISA plan, unless permitted by the savings clause. Such an issue becomes extremely important if the claimant is asserting a state cause of action for relief, either solely or in connection with the ERISA denial for benefits claim. If the claim for relief does not relate to a covered ERISA plan, it is not covered under ERISA and therefore not preemptive of state law, paving the way for state adjudication of the plaintiff’s rights. For plaintiffs, state causes of action may

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44 See Crull v. GEM Ins. Co. 58 F.3d 1386, 1390 (9th Cir. 1995) (acting as administrator and performing administrative tasks beyond the payment of premiums amounted to employer involvement); Peterson v. Am. Life & Health Ins. Co., 48 F.3d 404, 408 (9th Cir. 1995) (choosing and contacting the insurance carrier and distributing information regarding the plan constituted involvement by the employer), cert. denied, 516 U.S. 942 (1995).
45 See Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118, 1121-22 (9th Cir. 1998). See also Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (requiring more than the mere purchase of insurance to conclusively prove the existence of a plan).
provide for more relief than provided under ERISA, as the latter presently denies extracontractual and putative damages.  

B. ERISA Causes of Action

Once ERISA has been determined to be applicable, there are a variety of different causes of action that may be considered under ERISA, each with different classes of plaintiffs and defendants and each with a different set of remedies. In the context of a benefit denial claim, ERISA section 502(a)(1) explicitly provides relief to a plan participant or beneficiary to recover benefits due under the plan. The intent of the cause of action is to permit a participant or beneficiary to enforce personal monetary rights under the terms of the plan, not to assert statutory violations under ERISA.


48 Following the Supreme Court’s direction in Russell, 473 U.S. 134, the federal courts look narrowly to the particular ERISA section 502 claim being alleged and the claim for relief. See Jordan v. Fed. Express Corp., 116 F.3d 1005, 1011-14 (3d Cir. 1997). Thus, litigators are advised to allege the specific claim for relief under the specific cause of action listed within ERISA section 502.

49 The DOL may intervene and act as a receiver in civil actions brought by a plan participant or beneficiary if a novel ERISA issue is at stake or the rights/responsibilities of a large number of ERISA claimants may be affected by the outcome of such case. See Marshall v. Snyder, 430 F. Supp. 1224, 1226-28 (E.D.N.Y. 1977), aff’d in part, remanded in part, 572 F.2d 894 (2d Cir. 1978).

also provides equitable relief to enforce the payment of benefits due under the plan or to provide declaratory relief as to the claimant’s right to benefits under the plan. The defendant may either be the plan, as it is liable to pay benefits, or the plan administrator, if it has discretionary powers under the plan to interpret plan provisions and determine eligibility for benefits. A plan administrator with only ministerial functions regarding the payment of benefits is not a suitable defendant in a benefit denial claims action.

An alternate cause of action for a benefit denial claim that may be alleged is suit for breach of fiduciary duty under ERISA section 502(a)(2), on the theory that either (1) the plan administrator as fiduciary is required under the plan to pay benefits in accordance with the plan terms, and failure to do so constitutes a breach of that fiduciary duty, or (2) that systematic failure to pay benefit claims may rise to the level of a fiduciary breach. Unfortunately the Supreme Court has limited relief under this specific cause of action to the plan as a whole, and not individual relief, making it unattractive for an individual plaintiff lawsuit. Hence a claimant alleging such a cause of action does so as representative of the plan participants/beneficiaries.

Another possible cause of action a participant/beneficiary may pursue in a benefits denial claim is suit under ERISA section 502(a)(3) to enjoin activities that violate ERISA or the terms of the plan so as to obtain other equitable relief to redress such violations. However, the courts will not entertain claims that

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51 See Crocco v. Xerox Corp., 137 F.3d 105, 107-08 (2d Cir. 1998) (noting that the plan, not the employer, is the proper defendant in a benefit denials claim as the plan); Giardono v. Jones, 867 F.2d 409, 411-12 (7th Cir. 1989); Sahlie v. Nolen, 984 F. Supp. 1389, 1394 (M.D. Ala. 1997). But see Fenton Indus., Inc., v. Nat’l Shopmen’s Pension Fund, 674 F.2d 1300, 1304-05 (9th Cir. 1982) (permitting the employer as defendant provided the plaintiff’s injury was within the zone of ERISA protected interests); Beegan v. Associated Press, 43 F. Supp. 2d 70 (D. Me. 1999) (permitting employer as defendant due to its control over the administrative aspects of the plan); Best v. Nissan Motor Corp., 973 F. Supp. 770 (M.D. Tenn. 1997).


54 See Mass. Mut. Life Ins. Co. v. Russel, 473 U.S. 134, 142 (1985) (holding that an individual delay in the processing of benefit claims did not warrant a claim for breach of fiduciary duties under ERISA). But cf. Caterino v. Barry, 8 F.3d 878 (1st Cir. 1993) (finding that failure to transfer fund assets to a separate pension fund was not arbitrary); Phillips v. Alaska Hotel and Rest. Emp. Pension Fund, 944 F.2d 509, 519 (9th Cir. 1991) (finding that restrictive vesting standards were neither arbitrary nor capricious), as amended, 1991 U.S. App. LEXIS 28491 (9th Cir. Dec. 6, 1991), cert. denied, 504 U.S. 911 (1992); Ganton Tech. v. Nat’l Indus. Group Pension Plan, 865 F. Supp. 201, 209 (S.D.N.Y. 1994) (considering the resolution of claims in contexts of whether the benefit programs were designed by the plan fiduciaries, and not the plan administrator).

55 See Russell, 473 U.S. at 142 n.9.

56 See Varity Corp. v. Howe, 516 U.S. 489, 512 (1996) (referring to the ERISA section 502(a)(3) causes of action as the “catch all” provisions which act as a “safety net”).
include breaches of fiduciary duties under this subsection, as an adequate remedy is available under ERISA section 502(a)(2).\textsuperscript{57} Hence, claims not covered specifically under the other subsections of ERISA section 502 may fall under this “catch all” provision, which serves a “safety net” function by affording equitable relief for such violations.\textsuperscript{58} The defendant under such cause of action is the plan fiduciary or non-fiduciary who allegedly violated ERISA or the terms of the plan. Remedies under such cause of action include “appropriate equitable relief,” thus affording an additional remedy not provided for under section 502(a)(2) (limited to section 409 relief) or section 502(a)(1)(B) (recovery of benefits, enforcement or clarification of rights).\textsuperscript{59} The courts are in agreement that relief under this cause of action is generally denied if the individual participant/beneficiary is seeking relief under both sections 502(a)(1)(B) and 502(a)(3) in the same suit.\textsuperscript{60}

The applicable availability of relief under the various ERISA causes of action make a simple cause of action for a participant extremely outcome determinative, as the type of relief sought will drive the cause of action pleaded by the plaintiff. Other applicable ERISA civil procedure aspects will also prove to be outcome determinative – e.g., judicial standard of review, administrative record considered by the courts.

The end result of a considerable amount of ERISA litigation has been to protect the defendant from liability. The recent patients’ bills of rights passed by the House and Senate in mid-2001 would add to the list of ERISA causes of action, providing a cause of action for failure to exercise ordinary care in the delivery of health benefits.\textsuperscript{61} Damages under this cause of action could extend to punitive and pain and suffering forms of relief.\textsuperscript{62} The recently finalized DOL regulations attempt not only to rebut, but to usurp such preferences. The author speculates that the volume of ERISA claims litigation will increase exponentially if the now-finalized DOL regulations are upheld by the courts; the courts’ response to the DOL regulations will either accept or limit the volume of such litigation.

\textsuperscript{57} Id.
\textsuperscript{58} Id.
\textsuperscript{59} See id.
\textsuperscript{60} See Forsyth v. Humana, Inc., 114 F.3d 1467, 1475 (9th Cir. 1997).
\textsuperscript{62} H.R. 2563, passed by the House on August 2, 2001, provides a cause of action relating to the provision of health care benefits where there was failure to exercise ordinary care, but excludes treating physicians as possible defendants. Under this House version, noneconomic damages would be capped at $1.5 million and states would have the power to limit the extent of total damages. Id. The Senate’s bill, S. 1052, passed on June 14, 2001, would provide a similar cause of action under ERISA, but excludes treating physicians and hospitals as possible defendants. Additionally, this version limits punitive damages to $5 million and would not allow states to limit the extent of damages. Id.
C. Standing to Sue Under ERISA

Each ERISA cause of action is afforded to a unique class of potential plaintiffs. Thus, the fact that someone or some entity has a complaint involving an employee benefit plan is only the beginning of the inquiry. Under ERISA section 502's civil enforcement provisions for a claims denial or plan/ERISA violation claim, there are four specific classes of potential plaintiffs allowed to bring suit: plan participants, plan beneficiaries, plan fiduciaries, and the Secretary of the Labor. Other parties are left without any remedy under ERISA's causes of action. Such result (i.e., being without an ERISA cause of action) may be either a sword or a shield for the claimant involved due to the courts' implementation of ERISA's preemption clause.

ERISA defines “plan participant” as “any employee or former employee of an employer . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan . . . or whose beneficiaries may be eligible to receive any such benefit.” Thus, the definition sets up four categories of participants: employees who are eligible or may be eligible for a benefit, and former employees who are eligible or may be eligible for a benefit. As to the category of “employee,” the Supreme Court in *Nationwide Mutual Ins. Co. v. Darden* adopted the common law definition of employee for this purpose.

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63 See Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 27 (1983) (stating that “ERISA carefully enumerates the parties entitled to seek relief under § 502; it does not provide anyone other than participants, beneficiaries, or fiduciaries with an express cause of action”); McBride v. PLM Int'l, Inc., 179 F.3d 737, 742 (9th Cir. 1999) (stating the list of potential claimants given in ERISA section 502 is exclusive); Coyne & Delaney Co. v. Blue Cross & Blue Shield, 102 F.3d 712, 715 (4th Cir. 1996) (holding that fiduciaries are not authorized to sue for benefits); Self-Ins. Inst. of Am. v. Korioth, 993 F.2d 479, 484-85 (5th Cir. 1993) (holding that a trade association has standing as fiduciary); Coleman v. Champion Int'l Corp., 992 F.2d 530, 536 (5th Cir. 1993) (holding that the participant’s son was not a beneficiary and had no standing); Jamail, Inc. v. Carpenters Dist. Council Pension & Welfare Trusts, 954 F.2d 299, 303 (5th Cir. 1992) (excluding employers from the list of those entitled to a private cause of action); Cripps v. Life Ins. Co. of N. Am., 980 F.2d 1261, 1265 (9th Cir. 1992) (rejecting an insurance company’s standing as it did not fall within ERISA’s list of enumerated parties); Teagardner v. Republic-Franklin, Inc. Pension Plan, 909 F.2d 947, 954 (6th Cir. 1990) (rejecting plaintiff’s standing as they were no longer participants or beneficiaries); New Jersey State AFL-CIO v. New Jersey, 747 F.2d 891, 893 (3d Cir. 1984) (holding that labor unions are not participants or beneficiaries under ERISA).

64 Plaintiffs sufficiently removed from the plan so as to lack standing may then be able to benefit from state causes of actions or defenses that may be “too tenuous, remote or peripheral a manner” to “relate to” a plan covered under ERISA, which are not subject to ERISA’s preemption clause. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983).


67 Id. See also the thirteen-factor definition enunciated by the Supreme Court in Community for Creative Non-Violence v. Reid, 490 U.S. 730, 751-52 (1989) (including such factors as: the hiring party’s right to control the manner and means by which the product is accomplished . . . ; the skill required; the source of the instrumentalities and tools; the location of the work; the duration of the relationship between the parties; whether the hiring party has the right to assign additional projects to the hired party; the extent of the hired party’s discretion over when and how long to work; the method of payment; the hired party’s role in hiring and paying...
The Supreme Court found ERISA’s definition of an “employee” as “any individual employed by an employer” to be “completely circular and explain[ing] nothing.” Thus it resorted to the common law test and agency principles for guidance. The traditional common law test used to distinguish employees from independent contractors has thirteen factors to consider, none of which are the sole determinative of the result.

The DOL has noted in its regulations that plans covering only sole proprietors, owners or partners (all of which are not common-law employees) are not employee benefits plans for purposes of ERISA. Since a sole proprietor, owner, or partner of a business is not an “employee” for purposes of ERISA, the consequence for such individuals is that they lack standing as “employees” to bring a suit for relief under an ERISA plan. Most courts rely on the DOL regulations and hold that sole proprietors, owners, partners, and even outside directors are not “employees” for purposes of ERISA.

However, a common question that may arise for sole proprietors, owners and partners who participate in plans with other common law employees is whether such individuals have dual status as employee and owner/partner in order to have standing to pursue a benefit claims case. In such a context, there is a split among the circuit courts as to the owner/partner’s standing to sue in the context

 assistants; whether the work is part of the regular business of the hiring party; whether the hiring party is in business; the provision of employee benefits; and the tax treatment of the hired party).

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68 Darden, 503 U.S. at 323.
69 Id. at 323-24.
71 See 29 C.F.R. § 2510.3(a)(1)-(2) (2001) (stating that [a]n individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and [a] partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership).
72 See Kennedy v. Allied Mut. Ins. Co., 952 F.2d 262, 264 (9th Cir. 1991) (negating the use of ERISA for plans whose only beneficiaries are company owners).
73 See Robertson v. Alexander Grant Co., 798 F.2d 868, 871 (5th Cir. 1986) (relying upon DOL regulations to hold that partners are not employees); Grantham v. Beatrice Co., 776 F. Supp. 391, 400-03 (N.D. Ill. 1991) (holding that outside directors are not employees). These cases arise in the context of a plaintiff asserting state law claims and the defendant challenging that such claims are preempted by ERISA. See Spurlock v. Employers Health Ins. Co., 13 F. Supp. 2d 884 (E.D. Wis. 1998); Apffel v. Blue Cross Blue Shield, 972 F. Supp. 396 (S.D. Tex. 1997).
of a plan that also covers common-law employees. Some courts reason that although the owner/partner is not an employee under the plan, he or she is a beneficiary under the ERISA plan and thus has standing as “beneficiary” to sue for ERISA benefits. Others circuits continue to rely on the explicit words of ERISA or the DOL regulations noted earlier which exclude owners/partners from the class of “employee” or “participant.”

In *Firestone Tire & Rubber Co. v. Bruch*, the Supreme Court expanded the category of former employees with standing to sue to include employees who “have . . . a reasonable expectation of returning to covered employment” or who have “a colorable claim” to vested benefits. In *Firestone*, an employer maintained a termination pay plan and two other unfunded employee benefit plans covered under ERISA. When the employer sold one of its plastics divisions to Occidental Petroleum Co., the employees of which were promptly rehired by Occidental Petroleum, six affected employees sought severance benefits under the employer’s termination pay plan and sought information about their benefits under all three plans. In denying the request for information, the employer argued that the affected employees were no longer plan “participants” and thus had no standing. In rejecting the Third Circuit’s interpretation that a participant is anyone who claims to be one, the Supreme Court stated a more natural interpretation of the term “participant” includes employees or those reasonably expected to be employees. Such interpretation also applies to the term “former participant,” such that former employees with a “reasonable expectation of returning to covered employment” or those with “a colorable claim to vested benefits” have standing to sue.

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76 See Wolk v. UNUM Life Ins. of Am., 186 F.3d 352, 356 (3d Cir. 1999) (holding that a partner is a beneficiary); Vega, 188 F.3d at 294 (holding that sole owner is a beneficiary); Robinson, 58 F.3d at 369-70 (holding that a sole shareholder is a beneficiary); Peterson, 48 F.3d at 409 (holding that any person designated to receive benefits is a beneficiary); Bellisario v. Lone Star Life Ins., 871 F. Supp. 374, 379 (C.D. Cal. 1994) (holding that any person designated to receive benefits is a beneficiary).

77 See Fugarino, 969 F.2d at 185-86 (relying on DOL regulations to conclude that a sole proprietor is not a participant or beneficiary and his spouse and son are dependents, not beneficiaries, under the plan); Kwatchet, 879 F.2d at 961-62 (affirming the DOL’s decision to ban owner-employees from plan participation); Giardono, 867 F.2d at 411-12 (rejecting the argument that a sole proprietor qualifies as a plan participant); Peckham, 653 F.2d at 426-27 (relying on ERISA’s anti-assignment clause to prohibit employers from benefitting under the plan).


79 Id. at 105.

80 Id. at 105-06.

81 Id. at 106.

82 Id. at 117.

83 *Firestone*, 489 U.S. at 117.
Courts have not given specific factors to utilize in ascertaining Firestone's first prong—"reasonable expectation of returning to covered employment." In conclusory statements, the courts have affirmed that once an employee terminates employment, it is not reasonable to presume that the terminated employee will automatically be reemployed. In collective bargaining contexts, the courts have been willing to examine evidence relating to the claimant's statutory or contractual rights to reemployment or the claimant's recall rights under a collective bargaining agreement in ascertaining the reasonableness of reemployment.

However, regarding Firestone's second prong—"colorable claim" to benefits—the courts are split in their interpretation as to how broad the net extends to potential claimants. The issue that has caused this division among courts involves situations where a former employee has already received all vested benefits in a lump sum payment at the time of distribution under a plan that was later amended to change the method used in determining lump sum payments. In such situations, the Tenth Circuit has held that the claimant had no "colorable claim" because he received all that he was entitled to when he accepted the distribution, citing two earlier cases from the Fifth Circuit. Although the claimant was seeking additional benefits under the plan due to the plan amendment, the court noted that he did not have a colorable claim to those benefits, as those benefits had not vested at the time. The court also remarked that the claimant had not sought reinstatement, and therefore had no reasonable

85 See Panaras v. Liquid Carbonic Indus., 74 F.3d 786, 790 (7th Cir. 1996) (concluding that since the claimant had terminated employment, there was no reasonable expectation of becoming reemployed); Curtis v. Nev. Bonding Corp., 53 F.3d 1023, 1027 (9th Cir. 1995) (concluding that termination of employment does not give rise to a reasonable expectation of reemployment); Alexander v. Anheuser-Busch Cos., 990 F.2d 536, 539 (10th Cir. 1993) (noting that the claimant had not requested reinstatement of employment in the complaint which was indicative of his intent not to seek reemployment).
86 See Shawley, 989 F.2d at 658 (noting that there were neither statutory nor contractual rights for former employees guaranteeing rehire); Zydal v. Dresser Indus., Inc., 764 F. Supp. 277 (W.D.N.Y. 1991), modified, 798 F. Supp. 975, 981 (W.D.N.Y. 1991) (affirming the use of the collective bargaining agreement, prior practices, express promises and the pension plan provisions in determining the claimant's expectation of returning to their former union positions).
87 See Christopher v. Mobil Oil Corp., 950 F.2d 1209, 1221 (5th Cir. 1992) (permitting terminated participants who had received distributions to have standing if the employer's conduct was in violation of ERISA), cert. denied, 506 U.S. 820 (1992); Mitchell v. Mobil Oil Corp., 896 F.2d 463, 474 (10th Cir. 1990) (holding that a terminated participant who had received vested benefits had no "colorable claim" because he received a total distribution of his benefits from the plan), cert. denied, 498 U.S. 898 (1990).
88 See Christopher, 950 F.2d at 1212-13; Mitchell, 896 F.2d at 466.
89 See Mitchell, 896 F.2d at 474 (citing Yancy v. American Petrofina, Inc., 768 F.2d 707, 708-09 (5th Cir. 1985) (per curiam) and Joseph v. New Orleans Electric Pension & Retirement Plan, 754 F.2d 628, 630 (5th Cir. 1985), cert. denied, 474 U.S. 1006 (1985), both holding that once a participant receives all his vested benefits, he no longer is considered a plan participant).
90 Id.
expectation of returning to reemployment. Therefore, the claim for benefits was a claim for compensatory damages, not for enforcement of ERISA benefits.

Two years later, the Fifth Circuit in *Christopher v. Mobil Oil Corp.* had the occasion to apply the *Mitchell* holding and affirm its earlier decisions regarding standing to sue. The *Christopher* case involved similar facts to the *Mitchell* case – claimant seeking additional ERISA benefits due to plan amendments enacted by the employer subsequent to their retirement. The lower court had dismissed the ERISA complaint on the grounds that the claimants were not "participants" seeking recovery of ERISA benefits. The Fifth Circuit looked to the interpretation of "colorable claim" noted in the *Firestone* decision (decided in 1989) and rejected a "straightforward formula" applicable to all standing questions. Thus, the Fifth Circuit adopted a more liberal "but for" standard: "it would seem more logical to say that but for the employer's conduct alleged to be in violation of ERISA, the employee would be a current employee with a reasonable expectation of receiving benefits, and the employer should not be able through its own malfeasance to defeat the employee's standing." The Fifth Circuit's "but for" test has become the majority rule. However, the Tenth Circuit retains its contrary view even in light of the *Firestone* decision.

A secondary standing issue arises as to the validity of an ERISA action where a plaintiff's claim is derivative through an individual who would have had

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91 *Id.*
92 *Id.*
93 950 F.2d 1209, 1220-21 (5th Cir. 1992).
94 *Id.* at 1212-13.
95 *Id.* at 1213.
96 *Id.* at 1221.
97 *Id.*
98 *See* McBride v. PLM Int'l, Inc., 179 F.3d 737, 743 (9th Cir. 1999) (affirming the use of the "but for" test); Panaras v. Liquid Carbonic Indus., 74 F.3d 786, 791 (7th Cir. 1996) (holding that "standing is available to any former employee who has a colorable claim to benefits which the employer promised to provide pursuant to the employment relationship and which a nonfrivolous argument suggests have accrued to the employee's benefit," citing *Vartanian* v. Monsanto Co., 14 F.3d 697, 703 (1st Cir. 1994), and *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1221 (5th Cir. 1992)); Swinney v. Gen. Motors Corp., 46 F.3d 512, 518 (6th Cir. 1995) (affirming the "but for" test used by the majority of circuits); Adamson v. Armco, Inc., 44 F.3d 650, 655 (8th Cir. 1995) (limiting use of the "but for" standard to situations where the fiduciary's action deprived the plaintiff of standing, not when the claimants' loss of participant status resulted from their own actions, e.g., employees who voluntarily quit and sue for severance benefits), *cert. denied*, 516 U.S. 823 (1995); *Vartanian*, 14 F.3d at 702 (noting that the sole question was whether the plaintiff was within "the zone of interest ERISA was intended to protect" and, if so, allowing standing); Mullins v. Pfizer, Inc., 23 F.3d 663, 668 (2d Cir. 1994) (affirming the "but for" test); Shawley v. Bethlehem Steel Corp., 989 F.2d 652, 659 (3d Cir. 1993) (using the "but for" standard but deciding that the plaintiffs had not shown that the defendant's actions divested them of employment status).
99 *See* Raymond v. Mobil Oil Corp., 983 F.2d 1528, 1536 (10th Cir. 1993) (rejecting the *Christopher* "but for" test), *cert. denied*, 510 U.S. 822 (1993). *See also* Stanton v. Gulf Oil Corp., 792 F.2d 432, 435 (4th Cir. 1986) (stating that "[t]he effect of reading a 'but for' test is to impose participant status on every single employee who but for some future contingency may become eligible"); Jackson v. Sears, Roebuck & Co., 648 F.2d 225, 228-29 (5th Cir. 1981) (rejecting a "but for" analysis in determining standing).
standing to sue (e.g., estate of the participant/beneficiary or an insurer with assignment rights). The federal courts permit, without much discussion, a personal representative of a deceased or disabled participant or beneficiary to assert a claim for benefits, apparently presuming jurisdiction under ERISA.\(^{100}\)

However, the standing of health care providers and insurance companies as assignees has not been presumed, but has been litigated instead. The majority of the circuits have upheld the standing of assignees of participants’ and beneficiaries’ welfare benefit claims, noting that ERISA’s anti-assignment clause is applicable only for pension benefits.\(^{101}\)

In *Hermann Hospital v. MEBA Medical & Benefits Plan*,\(^{102}\) the Fifth Circuit formulated two models for standing under ERISA claim cases – independent standing (where the plaintiff is a participant or beneficiary) and derivative standing (where health care benefits have been assigned by the participant or beneficiary, conferring derivative status to the assignee). The court recognized that the health care provider was not a beneficiary; however, acknowledging that ERISA permits the assignment of health care benefits, a valid assignment permits a participant or beneficiary to confer standing to a health care provider if the assignment was valid.\(^{103}\) In forming its decision, the Fifth Circuit relied on the holding in *Misic v. The Building Service Employees Health and Welfare Trust*

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\(^{101}\) See HealthSouth Rehab. Hosp. v. Am. Nat’l Red Cross, 101 F.3d 1005, 1008 (4th Cir. 1996) (rejecting the Christopher “but for” test), *cert. denied*, 520 U.S. 1264 (1997); St. Francis Reg’l Med. Ctr. v. Blue Cross & Blue Shield, Inc., 49 F.3d 1460, 1464 (10th Cir. 1995) (interpreting ERISA to permit the assignability of benefits to free negotiations and subject to contract); Cromwell v. Equicor-EQUITABLE HCA Corp., 944 F.2d 1272, 1278 (6th Cir. 1991) (rejecting the assignment of a health care provider as it was neither a participant nor beneficiary); Kennedy v. Conn. Gen. Life Ins. Co., 924 F.2d 698, 700 (7th Cir. 1991) (finding that the health care provider was a beneficiary with standing to sue); Ark. Blue Cross & Blue Shield v. St. Mary’s Hosp., 947 F.2d 1341, 1349-50 (8th Cir. 1991) (upholding a state assignment statute applicable to ERISA welfare benefit plans), *cert. denied*, 504 U.S. 957 (1992); Davidowitz v. Delta Dental Plan, Inc., 946 F.2d 1476, 1480-81 (9th Cir. 1991) (upholding a welfare plan’s anti-assignment clause to bar assignment of benefits); Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d 1286, 1289 (5th Cir. 1988) (noting the absence of any statutory language which would prohibit such assignments); Misic v. Bldg. Serv. Employees Health & Welfare Trust, 789 F.2d 1374, 1378 (9th Cir. 1986) (permitting the assignee to stand in the shoes of the assignor); Wash. Hosp. Ctr. Corp. v. Group Hospitalization and Med. Servs., Inc., 758 F. Supp. 750, 755 (D.D.C. 1991) (holding that assignment of welfare benefits are valid and not contrary to public policy).

\(^{102}\) 845 F.2d 1286, 1289 (5th Cir. 1988).

\(^{103}\) *Hermann*, 845 F.2d at 1289 (noting that the assignment of health care benefits to providers “facilitates rather than hampers the employee’s receipt of health benefits”).
which stated that the assignee “stands in the shoes” of the assignor, such that, if the assignment is valid, the assignee may assert whatever rights the assignor possessed.\textsuperscript{104} The courts affirming standing of health care assignees require that the assignment be valid and that the plan does not have an express provision prohibiting such assignments.\textsuperscript{105}

The Seventh Circuit has also upheld the standing of a health care provider as assignee of benefits, but it has done so on the theory that the provider could show a “colorable claim” as a beneficiary as defined by ERISA.\textsuperscript{106} As ERISA defines a “beneficiary” as “a person designated by a participant . . . who is or may become entitled to a benefit” under the plan, the court noted that the health care provider became a beneficiary when designated by the participant in the assignment agreement.\textsuperscript{107}

The Third Circuit has eluded the issue of whether a health care provider has standing to sue, but has noted in dicta that ERISA’s standing provision should be strictly construed.\textsuperscript{108} The lower district courts within the Third Circuit have split on whether assignees have standing to enforce their substantive rights under ERISA.\textsuperscript{109}

\textsuperscript{104} 789 F.2d 1374, 1378 (9th Cir. 1986).
\textsuperscript{105} See Kennedy v. Conn. Gen. Life Ins. Co., 924 F.2d 698, 700 (7th Cir. 1991) (permitting claims only where the assignments are in accordance with the terms of the plans); Ark. Blue Cross & Blue Shield v. St. Mary’s Hosp., 947 F.2d 1341, 1345 (8th Cir. 1991) (examining whether a state statute invalidating a plan provision regarding assignment of benefits was preempted by ERISA); Davidowitz v. Delta Dental Plan, Inc., 946 F.2d 1476, 1481 (9th Cir. 1991) (upholding the plan’s express non-assignment clause); Hermann Hosp. v. MEBA Medical and Benefits Plan, 845 F.2d 1286, 1289 (5th Cir. 1988) (remanding to the district court the issue as to the validity of the assignment); Home Nutritional Servs., Inc. v. Blue Cross & Blue Shield, Inc., 1993 U.S. Dist. LEXIS 12240, at *4 (D. Mass. Aug. 24, 1993) (discussing concession by plaintiff that non-assignment language in ERISA plans may be enforced against health care providers); Parkside Lutheran Hosp. v. R.J. Zeltner & Assoc., 788 F. Supp. 1002, 1005 (N.D. Ill 1992) (enforcing the validity of the plan’s anti-assignment clause); Wash. Hosp. Ctr. Corp. v. Group Hospitalization & Med. Servs., Inc., 758 F. Supp. 750, 755 (D.D.C. 1991) (affirming the validity of an anti-assignment clause). \textit{But see} Lutheran Med. Ctr. v. Contractors, Laborers, Teamsters & Eng’rs. Health & Welfare Plan, 25 F.3d 616, 619 (8th Cir. 1994) (upholding the plan’s anti-assignment provision but only as to assignment of rights, not to assignment of causes of actions).

\textsuperscript{106} See Decatur Mem’l Hosp. v. Conn. Gen. Life Ins. Co., 990 F.2d 925, 927 (7th Cir. 1993) (holding that an assignee of benefits under an ERISA plan becomes a “statutory” beneficiary with standing to enforce benefits); Kennedy v. Conn. Gen. Life Ins. Co., 924 F.2d 698 (7th Cir. 1991) (finding that the health care assignee was a beneficiary due to the participant’s assignment).

\textsuperscript{107} Kennedy, 924 F.2d at 700 (applying \textit{Firestone’s “colorable claim” approach for participant standing to beneficiary standing}).

\textsuperscript{108} See Allstate Ins. Co. v. 65 Sec. Plan, 879 F.2d 90, 94 (3d Cir. 1989) (noting that subrogee lacks standing to sue under ERISA section 502 and limiting standing to participants and beneficiaries); N.E. Dept.’s Ladies’ Garment Workers Health & Welfare Fund v. Teamsters Local 229 Welfare Fund, 764 F.2d 147, 153-54 (3d Cir. 1985) (noting that ERISA permits only participants and beneficiaries to sue, not persons suing on their behalf).

Health care plans and insurers on the other side of the fence wishing to prohibit the assignment of welfare benefits rely on ERISA's preemption clause. ERISA contains a specific anti-assignment/alienation provision for pension benefits but is silent regarding the anti-assignment/alienation of welfare benefits;\(^{10}\) thus, the issue arises as to whether Congress' silence permits contractual or state-created causes of action or whether such causes of actions are preempted by ERISA. The Eighth, Ninth, Tenth and District of Columbia Circuits have enforced the plan's contractual right of anti-assignment of welfare benefits, but prohibit state's anti-assignment statutes of welfare benefits because the state statute is preempted under ERISA.\(^{11}\) What makes these cases so unusual from a civil procedure aspect is that standing may be created through contractual terms (a state common law right), especially under welfare plans that are often unilaterally drafted by the employer, not by both parties; however, similar state-created standing rights are deemed preempted under ERISA's broad preemption clause. By allowing ERISA's procedural rules to be dictated by the explicit plan terms, courts favor the drafter's expertise in lieu of the substantive rights of the plan participants and beneficiaries.

The proposed patients' bills of rights considered by Congress have not altered the theory of standing under the ERISA causes of actions noted above;


\(^{11}\) See St. Francis Reg. Med. Ctr. v. Blue Cross & Blue Shield, 49 F.3d 1460, 1464-65 (10th Cir. 1995) (holding that the Kansas statute regarding assignability of insurance benefits for ERISA benefits was preempted); Ark. Blue Cross & Blue Shield v. St. Mary's Hosp., 947 F.2d 1341, 1351 (8th Cir. 1991) (concluding that the Arkansas assignment statute related to the ERISA plan and therefore was preempted); Davidowitz v. Delta Dental Plan of Cal., Inc., 946 F.2d 1476, 1480-81 (9th Cir. 1991) (affirming the express plan provision that prohibited assignments due to Congress' intent to allow plans such freedom so that "competitive, cost effective, medical expenses reducing structures as might evolve"); Wash. Hosp. Ctr. Corp. v. Group Hospitalization and Med. Servs., Inc., 758 F. Supp. 750, 755 n.5 (D.D.C. 1991) (affirming the insurer's explicit reservation in the policy to prohibit assignment as consistent with ERISA's public policy).
however, the bill of rights do vary as to who is an enumerated party under the newly created ERISA cause of action for failure to exercise ordinary care in the delivery of health benefits. The impending DOL regulations likewise do not attempt to alter standing of any of the enumerated parties under the present ERISA causes of actions.

D. Subject Matter and Personal Jurisdiction

1. Exclusive vs. Concurrent Jurisdiction

Under the explicit rules of ERISA section 502(e)(1), federal courts are generally granted exclusive jurisdiction over most ERISA causes of actions, regardless of the amount in controversy or the citizenship of the parties. This creates the presumption of federal court jurisdiction unless the defendant can prove concurrent jurisdiction in state court. An exception to exclusive federal jurisdiction exists for benefit denial claims under ERISA section 502(a)(1)(B), conferring concurrent jurisdiction to federal and state courts, even though federal law will govern in either locale.

112 See Bipartisan Patient Protection Act of 2001, H.R. 2563, 107th Cong. (2001) (as amended by numbered 2 and 3 in House Report 107-184); Bipartisan Patient Protection Act of 2001, S. 1052, 107th Cong. (2001). House bill 2563 would exclude treating physicians and hospitals as potential defendants under the newly created ERISA cause of action; Senate bill 1052 would extend a similar exclusion to physicians and hospitals, but also excludes employers and plan sponsors provided they had not engaged in "direct participation."

113 29 U.S.C. § 1132(f) (1994) (providing the federal courts with jurisdiction for benefit denial claims without regard to the amount in controversy).

114 See Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 64 (1987) (quoting H. R. Conf. Rep. No. 93-1280, at 327 (1974) (providing that the "Conference Report on ERISA describing the civil enforcement provisions of § 502(a) says ... [w]ith respect to suits to enforce benefit rights under the plan ... they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction"); Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 25 (1983) (quoting 29 U.S.C. § 1132(e)(1) when stating that the "statute further states that the district courts of the United States shall have exclusive jurisdiction of civil actions brought by the Secretary or by a participant, beneficiary, or fiduciary, except for actions by a participant or beneficiary to recover benefits due"); Nowak v. Ironworkers Local 6 Pension Fund, 81 F.3d 1182, 1189 (2d Cir. 1996) (concluding that ERISA section 502(a)(1)(B) gives a plan participant or beneficiary a cause of action "to recover benefits due to him under the terms of his plan," and ERISA section 502(e)(1) gives state courts and federal district courts concurrent jurisdiction of actions under section 502(a)(1)(B)); Fuller v. Ulland, 76 F.3d 957, 960 (8th Cir. 1996) (citing International Ass'n of Entrepreneurs of America v. Angoff, 58 F.3d 1266, 1271 (8th Cir. 1995) (finding no need to determine whether federal jurisdiction over the preemption issues exists because is well established that the state court has concurrent jurisdiction to determine ERISA status)); Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264, 267 (1st Cir. 1994) (holding that federal and state courts have concurrent jurisdiction over ERISA section 502(a)(1)(B) claims); Barrowclough v. Kidder Peabody & Co., 752 F.2d 923, 936 (3d Cir. 1985) (citing ERISA section 502(a)(1)(B) which provides that "state courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction" over ERISA section 502(a)(1)(B) claims); Menhorn v. Firestone Tire & Rubber Co., 738 F.2d 1496, 1500 (9th Cir. 1984) (articulating that "Congress granted the federal courts jurisdiction, in part exclusive, in part concurrent with state courts, over matters falling within ERISA's explicit provisions"); Livolsi v. Ram Constr. Co., 728 F.2d 600, 601 (9th Cir. 1984) (concluding that federal and state courts have concurrent jurisdiction...
Presumably, the theory is that with regards to something so basic as employee benefit claims, the employee/beneficiary should be granted the convenience of state or federal court jurisdiction. Claimants obviously may prefer state courts due to familiarity, length of court calendar, a more sympathetic forum and procedures, possibility of a jury trial, and general lack of familiarity with ERISA's technical issues.

As noted earlier, courts generally require that the plaintiff's cause of action involve a plan subject to ERISA in order to have subject matter jurisdiction. The Third Circuit considers the question of whether or not an ERISA plan exists to be "integral to the merits of a claim" for purposes of ERISA section 502, integral not only to the court's jurisdiction, but also validity of the claim.\footnote{Over actions brought under ERISA section 502(a)(1)(B)); White v. Enron Corp. Merger Severance Plan, 686 F. Supp. 582, 583 (N.D. Tex. 1988) (stating that an action brought under section 512 of ERISA is one in which state courts and federal courts have concurrent jurisdiction). The use of concurrent state jurisdiction presumes that the case involves the interpretation or application of the terms of the plan, not an interpretation of the terms of ERISA. See Healey v. Healey, 910 F. Supp. 249, 251 (E.D.N.C. 1996) (stating that an ERISA section 502(a)(1)(B) "may be brought by a participant or beneficiary . . . to recover benefits due 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"); Mackey v. Lanier Collections Agency & Serv., Inc., 486 U.S. 825, 832-33 (1988) (stating "we consider the several types of civil suits under ERISA . . . one such suit is for benefits due under the terms of the plan which may be brought in either federal or state court"); 1975 Salaried Ret. Plan for Eligible Employees of Crucible, Inc. v. Nobers, 968 F.2d 401, 406-07 (3d Cir. 1992) (providing that when a claim "relates to, or implicates construction" of terms under ERISA, federal jurisdiction over the claim is exclusive), cert. denied, 506 U.S. 1086 (1993); Shoefor v. Stuart Hack Co., 970 F.2d 1316, 1319 (4th Cir. 1992) (determining whether ERISA fiduciary duties existed was within the exclusive jurisdiction of the federal courts); Farrell v. Auto. Club of Mich., 870 F.2d 1129, 1133 (6th Cir. 1989) (concluding that "serious breaches of Defendant's fiduciary duty" as prescribed under ERISA could be construed as an exclusively federal claim); Chilton v. Savannah Foods & Indus., 814 F.2d 620, 622-23 (11th Cir. 1987) (finding that a claim for eligibility in an ESOP cannot be remanded to state court); Levy v. Lewis, 635 F.2d 960, 966 (2d Cir. 1980) (holding that ERISA provided for concurrent federal and state jurisdiction over suits to enforce the terms of welfare benefit and pension plans, while imposing exclusive federal jurisdiction over other ERISA claims including those for breach of fiduciary duties).}

\footnote{See Metro. Life Ins. Co., 481 U.S. at 65 (finding that ERISA's legislative history consistently sets out a clear intention that section 502(a)(1)(B) suits brought by participants and beneficiaries are federal questions for the purpose of federal court jurisdiction).}

\footnote{See Fuller v. Ulland, 76 F.3d 957, 960 (8th Cir. 1996) (articulating that in order to benefit from ERISA preemption it must first establish that the plan is an ERISA-covered plan, fund or program); United Elec. Radio & Machine Workers v. 163 Pleasant Street Corp., 987 F.2d 39, 48 (1st Cir. 1993) (finding that the district court has personal jurisdiction over claims arising under ERISA); Bongiorno v. Assoc. in Adolescent Psychiatry, S.C., 17 EBC 1847 (N.D. Ill. 1993) (holding that since no employee benefit plan was in effect prior to the plaintiff's claim, there is no basis for invoking federal jurisdiction based on an ERISA plan, and therefore, the ERISA claims will be dismissed for lack of subject matter jurisdiction), summary judgment denied in part, and granted in part, appeal dismissed, 1994 U.S. Dist. LEXIS 18446, at *12 (N.D. Ill. Dec. 23, 1994).}

\footnote{See Henglein v. Informal Plan for Plant Shutdown Benefits for Salaried Employees, 974 F.2d 391, 397-98 (3d Cir. 1992) (concluding that the existence of an employee benefit plan is integral to the merits of a claim because not only will a claim be dismissed for lack of jurisdiction, but the claim may also be disposed of based on the merits of the case: judgment for defendant because no benefits were due to the plaintiff because no plan existed), cert. denied, 514 U.S. 1036 (1995).}
2. Supplemental Jurisdiction

If the claimant anticipates limited remedies under ERISA's causes of action, he or she may wish to assert supplemental state causes of action, with more liberal remedies, preferably adjudicated within the state arena. If the state court adjudicates both the ERISA benefit denial claim and other state claims, it certainly has concurrent jurisdiction over the ERISA claim. However, if the ERISA benefit denial claim and the other state claims are before a federal court, the issue of supplemental jurisdiction (pendent jurisdiction) arises. Because ERISA is silent on supplemental jurisdiction, the federal courts have evolved a general civil procedural rule of supplemental jurisdiction in such contexts.\(^\text{118}\) The federal courts are permitted to exercise supplemental jurisdiction over the related state law claims, even if the federal claims are later dismissed.\(^\text{119}\)

Under the proposed patients' bills of rights, ERISA's preemption clause would be altered only with respect to claims brought under the newly created ERISA cause of action.\(^\text{120}\) The impending DOL regulations, however, do address the preemptive effect of the claim procedure regulations on state law. The DOL

\(^\text{118}\) See, e.g., Finz v. Schlesinger, 957 F.2d 78, 83-84 (2d Cir. 1992) (concluding that a district court's decision to retain jurisdiction over a pendent state claim, once it had determined the underlying federal claim was not an abuse of discretion because it would have been inefficient for the district court not to have addressed the merits of the state law issues), cert. denied, 506 U.S. 822 (1992); S. Council of Indus. Workers v. Ford, 83 F.3d 966, 969 (8th Cir. 1996) (providing that in any breach of fiduciary duty action where the district courts have original jurisdiction, the district courts shall have supplemental jurisdiction over all other claims that are related to the ERISA claims that they form part of the same case or controversy); Nishimoto v. Federman-Bachrach & Assoc., 903 F.2d 709, 714 (9th Cir. 1990) (holding that because the state law claims derived from the same nucleus of operative facts as the ERISA claim, they were pendent to the ERISA claim, and the district court had jurisdiction over them irrespective of whether the claims should have been filed originally in the district court); Sorosky v. Burroughs Corp., 826 F.2d 794, 800 (9th Cir. 1987) (holding that the district court may exercise pendent jurisdiction over state law claims arising from a nucleus of operative fact common to both the state law claims and the ERISA claim).

\(^\text{119}\) See Nowak v. Ironworkers Local 6 Pension Fund, 81 F.3d 1182, 1191-92 (2d Cir. 1996) (holding that because the ERISA claim provided a basis for original jurisdiction, the district court had the discretion to retain jurisdiction over the plaintiff's supplemental state law claims once it dismissed the underlying federal claim); S. Council of Indus. Workers, 83 F.3d at 969 (providing that since it is well established that an ERISA claim is a federal claim, supplemental jurisdiction exists over state-law claims where, as here, “the federal-law claims and state-law claims in the case derive from a common nucleus of operative fact and are such that [the plaintiff] would ordinarily be expected to try them all in one judicial proceeding”) (internal quotations omitted); Finz, 957 F.2d at 83 (finding that a district court's decision to retain jurisdiction over a pendent state claim, once it has determined that the underlying federal claim should be dismissed, is not an abuse of discretion); Peckham v. Bd. Of Trustees of Int'l Bhd. of Painters and Allied Trades Union, 653 F.2d 424, 428 (10th Cir. 1981) (finding that the plaintiff class had no claim under ERISA because they were not participants of the ERISA plan, but reversed and remanded the case instructing the district court to consider related state law claims). See also Carnegie-Mellon Univ. v. Cohill, 484 U.S. 343, 353 (1988) (setting forth the following four factors in determining in general whether federal courts should remand supplemental claims: economy, fairness, convenience and comity).

states that its regulations do not preempt state insurance laws that impose review procedures for disputes between patients and health care providers or insurers, unless the state law prevents their application.\footnote{See 29 C.F.R. § 2560.503-1(k)(1) (2001); Preamble, 65 Fed. Reg. 70,254 (Nov. 21, 2000).} Such state insurance laws are viewed as providing external requirements for dispute resolution, which are not required by the DOL regulations. However, such state insurance laws may not require the patient to submit to such outside review procedures in order to be entitled to file suit for an ERISA cause of action.\footnote{See 29 C.F.R. § 2560.503-1(k)(2) (2001); Preamble, 65 Fed. Reg. at 70,254 (Nov. 21, 2000).}

### E. Removal to Federal District Court

If a plaintiff wishes to assert both an ERISA cause of action and a state case of action regarding the benefit denial, ERISA’s concurrent jurisdiction doctrine will permit the claimant to pursue the claims in state court, applying federal law with respect to the ERISA claim and state law with respect to the state claim. Under the normal rules of federal jurisdiction, a defendant may remove an ERISA claim and/or state claim properly filed under the state court’s concurrent jurisdiction to federal district court, provided the technical requirements for removal are met.\footnote{See 28 U.S.C. § 1441 (2001) (stating general principles of removal).} Such a strategy may be desirable from the defendant’s standpoint due to the court’s proximity, longer length of calendar, greater sophistication with ERISA rules, application of ERISA’s deferential judicial standard of review, and denial of jury trials.

While ERISA’s terms are silent on the issue of removal, federal courts have utilized the general jurisdictional principles to formulate a common law removal doctrine under ERISA and have adopted the jurisdictional “well-pleaded” complaint rule.\footnote{See Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 10 (1983); Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 65-66 (1987); Brown v. Conn. Gen. Life Ins. Co., 934 F.2d 1193, 1196 (11th Cir. 1991); Allstate Ins. Co. v. 65 Security Plan, 879 F.2d 90, 93 (3d Cir. 1989). For a general discussion of the “well-pleaded” complaint rule, see 14 B. CHARLES ALAN WRIGHT, ARTHUR R. MILLER & EDWARD H. COOPER, FEDERAL PRACTICE AND PROCEDURE § 3721 (2d ed. 1997).} Thus, removal to federal court may be justified only if the plaintiff’s complaint “arises under” federal law and such determination must be based on “what necessarily appears in the plaintiff’s statement of his own claim . . . , unaided by anything alleged in anticipation of defenses which it is thought the defendant may interpose.”\footnote{Taylor v. Anderson, 234 U.S. 74, 75-76 (1914) (appearing with favor in \textit{Franchise Tax Board of Cal.}, 463 U.S. at 10). See also Phillips Petroleum Co. v. Texaco, Inc., 415 U.S. 125, 127-28 (1974); Danca v. Private Health Care Sys., Inc., 185 F.3d 1, 4 (1st Cir. 1999); \textit{In re U.S. Healthcare, Inc.}, 193 F.3d 151, 160 (3d Cir. 1999); Copling v. Container Store, 174 F.3d 590, 594 (5th Cir. 1999); Giles v. NYLCare Health Plans, Inc., 172 F.3d 332, 336 (5th Cir. 1999); Heimmann v. Nat’l Elevator Indus. Pension Fund, 187 F.3d 493, 499 (5th Cir. 1999); Hull v. Fallon, 188 F.3d 939 (8th Cir. 1999); Lyons v. Alaska Teamsters Employer Serv. Corp., 188 F.3d 1170, 1171 (9th Cir. 1999).} Normally, the defendant’s reliance on an ERISA preemption defense to a state complaint will not be automatic grounds for removal, as such defense is part of the defendant’s suit and does not appear on
the face of the plaintiff’s complaint. However, the federal courts have recognized an exception to the “well-pleaded” complaint rule in the ERISA context if ERISA has so completely preempted state law as to displace state law jurisdiction. Once completely preempted by federal law, the state claim may be “recharacterized” as one arising under federal law and thus subject to removal to federal court. Thus, the issue hinges upon whether the state cause of action has been completely preempted by federal law (thereby recharacterizing the action as an ERISA section 502 cause of action with exclusive remedies under ERISA and permitting removal to federal court), or preempted due to conflict preemption (which merely displaces the state law and does not afford the basis for removal to federal court).

In the context of a claimant filing in state court solely on a state cause of action (e.g., a plan participant suing an HMO for negligent medical services in the delivery of plan benefits), the Supreme Court has extended the “well pleaded” complaint exception to certain state causes of action because of ERISA’s expansive preemption clause. According to the Court, removal of a state cause of action to federal court is justified so “that Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims necessarily is federal in character.” While ERISA preemption does not in and of itself convert a state claim into an action arising under federal law, removal of a state cause of action to federal court may be permitted because


128 See Danca v. Private Health Care Sys., Inc., 185 F.3d 1, 4-5 (1st Cir. 1999); In re U.S. Healthcare, Inc., 193 F.3d 151, 160 (3d Cir. 1999); McClelland v. Gronwaldt, 155 F.3d 507, 517 (5th Cir. 1998).

129 See Copling, 174 F.3d at 595; Giles, 172 F.3d at 337; Heimann, 187 F.3d at 499-500; Butero, 174 F.3d at 1212.


131 Id. The Supreme Court in this decision adopted a complete preemption interpretation of ERISA’s preemption clause which has been extended to permit removal of a wide variety of state causes of actions. Id. For a general discussion of the “well-pleaded” complaint rule, see 14 B. CHARLES ALAN WRIGHT, ARTHUR R. MILLER & EDWARD H. COOPER, FEDERAL PRACTICE AND PROCEDURE § 3721 (3d ed. 1997).
“Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of §502(a) [of ERISA] removable to federal court.” 132 In deciding ERISA preemption issues, the federal courts have struggled over the issue of whether the state cause of action in question has been completely preempted or only preempted under a conflict preemption theory by ERISA. 133 This is due in part to the Supreme Court’s shift away from a “completion preemption” interpretation of ERISA to a “conflict preemption” interpretation, 134 as well as the lower courts’ struggle to reconcile the recent Supreme Court preemption cases with the Court’s earlier cases, as well as with their own circuit precedents.

In the context of a suit for benefit claims, the Supreme Court has held that ERISA preempts any state law breach of contract and tort claims involving the negligent processing of benefit claims. 135 In addition, courts have affirmed ERISA’s preemption of any state wrongful denial, improper processing, or misrepresentation or fraud allegation regarding the payment of plan benefits. 136

133 See Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1212 (11th Cir. 1999) (discussing the elements of removal under the preemption analysis).
134 See Egelhoff v. Egelhoff, 121 S. Ct. 1322, 1327 (2001) (upholding the preemption of state regulation of community property law and divorce law; in favor of ERISA’s policy of promoting a uniform administrative scheme); Boggs v. Boggs, 520 U.S. 833, 844 (1997); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 138 (1990) (affirming the deliberately expansive language of ERISA’s preemption clause to establish pension plan regulation as exclusively a federal concern); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (interpreting ERISA’s preemption clause broadly by focusing on the phrase relate to and giving it a broad common-sense meaning); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96 (1983) (interpreting ERISA’s preemption clause and noting the “breadth of [514(a)’s] preemptive reach is apparent from that section’s language”). But cf. De Buono v. NYSA-ILA Med. and Clinical Servs. Fund, 520 U.S. 806, 813 (1997) (ignoring the “relate to” language and instead exploring Congress’ intent to determine if a state law fell within ERISAs preemptive scope); Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc., 519 U.S. 316, 335-36 (1997) (rejecting the use of the “relate to” language as a test for preemption, but instead using it to identify fields of law preempted by ERISA); N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (upholding a state health care initiative that assessed surcharges on medical bills of patients on the assumption that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress); John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 99 (1993) (retreating from a broad interpretation of the phrase “relate to” and instead focusing on a more traditional preemption analysis, noting that “we discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis”).
135 See Pilot Life Ins. Co., 481 U.S. at 47-48 (preempting state claims that “relate to” the ERISA plan and affirming ERISA’s exclusive remedy for allegations of improper claims processing). See also Beegan v. Assoc. Press, 43 F. Supp. 2d 70, 76 (D. Me. 1999) (holding the plaintiff’s breach of contract claims were preempted by ERISA); Case v. Hosp. of St. Raphael, 38 F. Supp. 2d 207 (D. Conn. 1999) (affirming that state contractual benefit claims and related tort claims are preempted by ERISA in light of the Supreme Court’s holding in Pilot Life Ins. Co., despite the court’s retreat from the premise).
136 See Hull v. Fallon, 188 F.3d 939, 943 (8th Cir. 1999) (preempting state medical malpractice claims), cert. denied, 528 U.S. 1189 (2000); Turner v. Fallon Cmty. Health Plan Inc., 127 F.3d 196, 198 (1st Cir. 1997) (preempting a state wrongful death claim, even if the claimant would be without a remedy), cert. denied, 118 S. Ct. 1512 (1998); Christopher v. Mobil Oil Corp., 950 F.2d 1209,
The key remaining preemption issue in benefit claim cases is whether state medical malpractice claims will be deemed preempted under ERISA. The highest courts of New York and Pennsylvania have preserved state claims against an HMO or its physicians in medical malpractice suits.

A defendant in any ERISA benefit denial claim case will certainly request removal to federal court on the theory that any related state cause of action has been completely preempted by ERISA. Such result may indeed become outcome determinative in favor of the defendant due to the federal courts' limited judicial review and limitations on remedies for ERISA claims benefit payments. In effect, remedies under state causes of action are bypassed as a result of the defendant's reliance upon ERISA's preemption clause.

The recent proposed patients' bill of rights attempts to alter the courts' removal doctrine. The House version permits removal to federal court for suits against the employer, but provides state court access for suits against health insurers. The bill would also affect removal since it would alter ERISA's preemption clause to permit certain state laws affording protections to patients in the health care system. The impending DOL regulations are silent on the courts' removal doctrine; however, the regulations specify that if a claimant initiates a cause of action in state court, in lieu of federal court, state law procedures need not be exhausted.

F. Venue

Regarding the choice of federal district court in which an ERISA section 502(a) cause of action may be brought, ERISA's legislative language adopts a pro-participant/beneficiary policy and provides a liberal choice of venue so as to provide ready access to federal courts. Venue lies in any federal district court

1218 (5th Cir. 1992) (preempting wrongful discharge by fraud and negligent misrepresentation claims).

137 The Supreme Court has granted certiorari in Rush Prudential HMO, Inc., v. Moran, 230 F.3d 959 (7th Cir. 2000), cert. granted, 121 S. Ct. 2589 (2001), to consider whether state laws that subject the decisions for health treatment under managed-care arrangements to independent review are preempted under ERISA. While the case involves Illinois law, thirty-seven states and the District of Columbia have similar independent review requirements. Id.


140 See H.R. 2563 (as amended by numbered 2 and 3 in House Report 107-184); S. 1052.

141 See 29 C.F.R. § 2560.503-1(k)(2)(ii) (2001). Given that ERISA section 514 does not specifically authorize the DOL to initiate regulations under that section, it is questionable that the DOL's regulatory power can extend this far. Id.

in which the plan is administered, where the fiduciary breach took place, or where at least one defendant resides or may be found. Such provisions provide the plaintiff with several forums and an opportunity to "forum shop," but only within the federal district courts and not any state courts. A defendant wishing to request a transfer of venue must abide with the general jurisdiction rules of 28 U.S.C. § 1404. The existing patients' bill of rights and impending DOL regulations are silent on the issue of venue.

G. Statute of Limitations

While ERISA contains explicit statutes of limitations for various types of violations (e.g., violations of plan claims, fiduciary violations, prohibited transaction restrictions, etc.), there is no explicit statute of limitations for benefit claim cases. Most courts have incorporated the forum state's most analogous statute of limitation, generally using the state's statute of limitations for written contract actions. Others have used the state's statute of limitations.


for actions involving recovery of wages or breach of employment contract.\textsuperscript{148} In cases where the plan specifies its choice of applicable state law, courts still favor the forum state's statute of limitation over the plan's "governing law" provision.\textsuperscript{149}

While some courts have recognized that the plan may impose a shorter statute of limitations,\textsuperscript{150} they distinguish between the length of the statute of limitations and the determination of when a claim for relief accrues. The latter issue is regarded as a question of federal law.\textsuperscript{151} Thus, courts will not routinely enforce a plan limitation which attempts to specify when the claim accrues.\textsuperscript{152}

As to the issue of when a claim for relief under ERISA section 502(a)(1)(B) accrues, the majority of circuit courts generally agree that accrual begins when a formal and final denial of benefits under the plan's claims procedure has occurred.\textsuperscript{153} Such consensus of opinion made sense under the initial DOL claim


\textsuperscript{149} See Gluck, 960 F.2d at 1179-80; Champion Int'l. Corp. v. United Paperworkers Int'l Union, 779 F.2d 328, 332-34 (6th Cir. 1985).


\textsuperscript{152} See Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program, 222 F.3d 643 (9th Cir. 2000).

\textsuperscript{153} See Hogan, 969 F.2d at 145; Stevens v. Employer-Teamsters Joint Council No. 84 Pension Fund, 979 F.2d 444, 451 (6th Cir. 1992); Tolle, 977 F.2d at 1139; Larsen v. NMU Pension Trust,
procedure regulations which required a claimant’s compliance only if the plan’s review procedures were *reasonable*. Whether or not a claim had been properly filed was relevant as a failure to comply with certain aspects (e.g., notification of denial to the claimant) and rendered the claim *denied*, thereby permitting the claimant to proceed to the next stage of the review process. Thus, a variety of court cases exist focusing on the reasonableness of a given plan’s procedures. The impending DOL regulations eliminate the express requirement of filing a benefit request and permit the claimant to proceed directly to litigation, bypassing the internal claims procedures, if the plan fails to comply with any and all aspects of the regulations. Such result is in direct conflict with the judicial doctrine of exhaustion that will be discussed next in the article.

The proposed patients’ bill of rights make no amendments to alter ERISA section 413.

**H. Exhaustion of the Plan’s Internal Claims Procedures**

1. The Courts’ Doctrine of Exhaustion and its Exceptions

Due to the silence of ERISA *and* the DOL regulations (at least for the first twenty-six years after ERISA’s passage) on the issue of exhaustion of internal claims procedures prior to litigation, the federal courts developed an exhaustion of administrative remedies doctrine in the ERISA benefit denial contexts.


See Jurash v. Hartford Life Ins. Co., 2000 U.S. Dist. LEXIS 4479 (S.D.N.Y. Apr. 7, 2000); Hutzenlaub v. Local 240 Pension Fund, 2000 U.S. Dist. LEXIS 21245 (E.D.N.Y. Mar. 21, 2000); Birdsell v. U.P.S., 94 F.3d 1130, 1133 (8th Cir. 1996); Bali v. Blue Cross & Blue Shield Ass’n, 873 F.2d 1043, 1048 (7th Cir. 1989). See also Schadler v. Anthem Life Ins. Co., 147 F.3d 388, 395 (5th Cir. 1998) (requiring as a basis for the reasonableness requirements, the end product of a claims review process wherein § 1133 and its regulations have been followed faithfully is a benefits decision that is thoroughly informed by the relevant facts and the terms of the plan and, if benefits are denied, includes an explanation of the denial that is adequate to insure meaningful review of that denial).


While ERISA has no express provision requiring exhaustion of administrative remedies prior to suit, the courts have imposed a judicially required mandate in order to bring a civil action for benefits. See Ravencraft v. UNUM Life Ins. Co., 212 F.3d 341, 343 (6th Cir. 2000); Perrino v. S. Bell Tel. & Tel. Co., 209 F.3d 1309, 1315 (11th Cir. 2000); Schlepper v. Purina Benefits Ass’n, 170 F.3d 1157, 1158 (8th Cir. 1999); Layes v. Mead Corp., 132 F.3d 1246, 1252 (8th Cir. 1998); McGraw v. Prudential Ins. Co. of Am., 137 F.3d 1253, 1263-64 (10th Cir. 1998); Hall v. Nat’l

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Focusing on language from ERISA’s congressional conference committee that the enforcement provision should be fashioned in a manner similar to those under section 301 of the Labor-Management Relations Act 1947 (LMRA) which requires claimants to exhaust grievance procedures prior to litigation, courts have used labor principles in fashioning such an exhaustion doctrine.\(^{159}\)

The public policy behind the use of such an exhaustion doctrine has been best enunciated by the Ninth Circuit in *Amato v. Bernard*.\(^{160}\) In *Amato*, the court praised the doctrine’s ability to prevent “premature judicial intervention;” to permit the plan administrator to assemble evidence and factual record explaining their reasoning process and to apply their expertise and discretion in managing the plan’s funds, correcting errors and interpreting ambiguous plan provisions; and to avoid litigating disputes that may be resolved at the administrative level.\(^{161}\)

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159 See *Makar v. Health Care Corp. of the Mid-Atlantic*, 872 F.2d 80, 82 (4th Cir. 1989) (noting that though ERISA does not contain an explicit exhaustion provision[,] . . . an ERISA claimant generally is required to exhaust the remedies provided by the employee benefit plan in which he participates as a prerequisite to an ERISA action for denial of benefits under [ERISA section 510]. This exhaustion requirement rests upon the Act’s text and structure as well as the strong federal interest encouraging private resolution of ERISA disputes.).

160 See also, *Wolf v. Nat’l Shopmen Pension Fund*, 728 F.2d 182, 186 (3d Cir. 1984); *Denton v. First Nat’l Bank*, 765 F.2d 1295, 1300-01 (5th Cir. 1985); *Amato v. Bernard*, 618 F.2d 559, 566 (9th Cir. 1980); *Communications Workers of Am. v. AT&T*, 40 F.3d 426, 431-33 (D.C. Cir. 1994).

161 Id. For case law supporting the *Amato* reasoning, see *Communications Workers of Am. v. AT&T*, 40 F.3d 426, 431-33 (D.C. Cir. 1994); *Kennedy v. Empire Blue Cross and Blue Shield*, 989
Later, the Fifth Circuit elaborated upon these primary concerns and included other goals: the fulfillment of Congress’ desire to have the plan’s designated fiduciary, not the courts, administer the plans for which they are liable; the fashioning of an administrative record for the courts’ review if necessary; and the use of a deferential, not de novo, judicial standard of review of the fiduciary’s decision. Other courts have noted that the use of the exhaustion doctrine fostered additional public interests including encouragement of private resolution of ERISA claims, reduction of plan costs, better use of plan funds by using the internal plan procedures before premature judicial interference, opportunity afforded to plan administrators to correct errors and to promote the consistent treatment of the denial of claims, and the opportunity to assemble a factual record for the court’s review if later necessary.

F.2d 588, 592-93 (2d Cir. 1993); Powell v. AT&T Communications, Inc., 938 F.2d 823, 826 (7th Cir. 1991). See also Diaz v. United Agric. Employee Welfare Benefit Plan & Trust, 50 F.3d 1478, 1483 (9th Cir. 1995) (noting the following policy reasons for support of the exhaustion doctrine: “the reduction of frivolous litigation, the promotion of consistent treatment of claims, the provision of a nonadversarial method of claims settlement, the minimization of costs of claim settlement and a proper reliance on administrative expertise”).

See Denton v. First Nat’l Bank, 765 F.2d 1295, 1300-01 (5th Cir. 1985) (affirming the Amato court’s requirement of exhaustion by stating

[the Amato court required benefit claimants to exhaust their administrative remedies prior to seeking federal court review of a benefit denial. The court based its decision on an examination of the legislative history of ERISA which clearly suggested that Congress intended to grant authority to the courts to apply the exhaustion doctrine in suits arising under the Act. The Amato court stressed that the literal language and policies of ERISA require benefit Plans to provide administrative remedies to persons whose benefits had been denied. Also important to the court was Congress’ intention to grant trustees the broad managerial discretion necessary to establish and operate ERISA qualified pension Plans . . . [t]hus, Congress’ ERISA fiduciary framework mandates the exhaustion requirement.

(internal quotations omitted)).

See Costantino v. TRW, Inc., 13 F.3d 969, 975 (6th Cir. 1994) (noting that exhaustion promotes the public policy of encouraging private resolution of disputes under ERISA); Wilczynski v. Lumbermen’s Mut. Cas. Co., 93 F.3d 397, 402 (7th Cir. 1996) (citing Powell, 983 F.2d at 825, for the proposition that exhaustion promotes the policy reason of allowing the plan fiduciary to exercise its expertise and to efficiently manage the administration of the plan, as well as the promotion of consistent treatment of claims; use of a nonadversarial dispute resolution process; and reduction in both plan costs and time allotment for claim settlement); Taylor v. Bakery & Confectionary Union & Indus. Int’l Welfare Fund, 455 F. Supp. 816, 820 (E.D.N.C. 1978) (focusing on the cost savings rationale for having an exhaustion policy, noting that

[i]f claimants were allowed to litigate the validity of their claims before a final trustee decision was rendered, the costs of dispute settlement would increase markedly for employers. Employees would also suffer financially because, rather than utilize a simple procedure which allows them to deal directly with their employer, they would have to employ an attorney and bear the costs of adversary litigation in the courts.);

Brown v. Babcock & Wilcox Co., 589 F. Supp. 64, 68 (S.D. Ga. 1984) (holding that exhaustion of administrative remedies promotes the development of a factual record for judicial review and
Due to the pervasive policy reasons supporting the exhaustion of administrative remedies, all the circuits require the claimant to exhaust administrative procedures prior to litigating an ERISA benefits claim. Aside from ERISA’s compelling legislative history on this issue, the courts’ use of the exhaustion doctrine in benefit denial cases is also consistent with the general principles of judicial rule-making which require a case or controversy to be “ripe” for adjudication, favoring the use of administrative remedies prior to the intervention by the courts. If the claimant has failed to exhaust the internal plan administrative remedies, the federal courts will not consider the merits of the claim. Some courts render a summary judgment, whereas other courts remand the claim for reconsideration by the plan administrator, suspending the court action until the internal claims procedures had been completed. Less frequently, the courts have dismissed a claim with prejudice because the claimant missed the plan’s sixty day or more frame for requesting review. In certain instances, the court has barred the claimant who ignored the benefit denial

upholds Congress’ intent that the management and administration of ERISA plans remains with the trustees). For a full description of the federal courts’ ERISA exhaustion theory, see Thomas J. Griffith and J.G. Payton, Exhaustion of Internal Remedies, BUSINESS LAWS, INC., 115 Supp. 6 (August 1999).


165 See Abbott Labs. v. Gardner, 387 U.S. 136, 141 (1967) (limiting judicial review to that of the administrator’s action, absent “clear and convincing evidence of a contrary legislative intent”). See also 13A CHARLES ALAN WRIGHT, ARTHUR R. MILLER & EDWARD H. COOPER, FEDERAL PRACTICE AND PROCEDURE § 3532 (1984) (explaining that the judicial doctrine of “ripeness” favors judicial economy by postponing judicial review until administrative avenues have been utilized).

166 See Berger, 911 F.2d at 916 (stating that the exhaustion requirement will be “strictly enforced”); Weldon v. Kraft, Inc., 896 F.2d 793, 800 (3d Cir. 1990) (“Except in limited circumstances . . . , a federal court will not entertain an ERISA claim unless the plaintiff has exhausted the remedies available under the plan.”).

167 See Schadler v. Anthem Life Ins. Co., 147 F.3d 388, 395 (5th Cir. 1998) (remanding the matter to the plan administrator for development of a full factual record); Smith v. Blue Cross & Blue Shield United, 959 F.2d 655, 658-59 (7th Cir. 1992) (affirming the district court’s use of summary judgment); Makar v. Health Care Corp. (Carefirst), 872 F.2d 80, 82-83 (4th Cir. 1989) (remanding the case due to “strong federal interest” in exhaustion); Amato v. Bernard, 618 F.2d 559, 566 (9th Cir. 1980) (affirming the district court’s use of summary judgment).

process any judicial review. Due to a plan's time frame (e.g., sixty days) for filing for review of a benefits claim and the importance of exhaustion of such administrative remedies, failure to heed the plan's time-table may delay or bar judicial review of a claim. The scope of the exhaustion doctrine, however, does not extend to additional issues or theories, thereby permitting the claimant to raise such issues or theories later at trial.

The courts have developed several logical exceptions to the exhaustion doctrine: (1) where meaningful access to the review procedures is unavailable; (2) where meaningful access to the review procedures would prove futile; or (3) where there is danger of irreparable harm. The first exception was

169 See Wolf v. Nat'l Shopmen Pension Fund, 728 F.2d 182, 186 (3d Cir. 1984) (limiting ERISA section 502(a) to require only claim exhaustion, not issue or theory exhaustion); Tiger v. AT&T Tech. Plan for Employees' Pension, Disability Benefits, 633 F. Supp. 532, 534 (E.D.N.Y. 1986) (precluding judicial review for failure to pursue administrative remedies within the plan's time frame); Taylor v. S. Cent. Bell, 422 So. 2d 528, 529 (La. App. 1982) (barring judicial relief for failure to pursue and exhaust administrative remedies).

170 See Wolf, 728 F.2d at 186 (holding that ERISA's exhaustion doctrine extends to only claims exhaustion, not issue or theory exhaustion); Jenkins v. Local 705 Int'l Bhd. of Teamster Pension Plan, 713 F.2d 247, 254 (7th Cir. 1983) (permitting consideration of both the claimant's old and new claim for early retirement benefits).

171 See Lee v. Cal. Butchers' Pension Trust Fund, 154 F.3d 1075, 1080 (9th Cir. 1998) (stating that "when a plan's review apparatus has been abolished there is no need for a claimant to go through the formalities"); Hall v. Nat'l Gypsum Co., 105 F.3d 225, 232 (5th Cir. 1997) (denying meaningful access to appeal procedures does not require exhaustion); Wilczynski v. Lumbermens Mut. Cas. Co., 93 F.3d 397, 402-04 (7th Cir. 1996) (permitting an exception to the exhaustion requirement where the plaintiff was denied meaningful access); Conley v. Pitney Bowes, 34 F.3d 714, 718-19 (8th Cir. 1994) (waiving exhaustion requirement due to employer's failure to notify the employee of the appeal procedures); Curry v. Contract Fabricators Inc. Profit Sharing Plan, 891 F.2d 842, 846-47 (11th Cir. 1990) (permitting an exception to the exhaustion doctrine where the plaintiff was denied meaningful access to the appeals procedure). But cf. McKenzie v. Gen. Tel. Co., 41 F.3d 1310, 1316 (9th Cir. 1994) (holding that failure to provide the summary plan description to the claimant who was familiar with the standards does not waive the exhaustion requirement), cert. denied, 514 U.S. 1066 (1995); Heller v. Fortis Benefits Ins. Co., 142 F.3d 487, 493 (D.C. Cir. 1998) (denying summary judgment due to substantial compliance with the claims procedure requirements), cert. denied, 525 U.S. 930 (1998); Wilczynski v. Kemper Nat'l Ins. Co., 998 F. Supp. 931, 944 (N.D. Ill. 1998) (requiring claimant to exhaust administrative remedies even though the company's review procedure exhibited some procedural defects, they were as a whole in compliance with the statutory requirements).

172 See McGraw v. Prudential Ins. Co. of Am., 137 F.3d 1253, 1264 (10th Cir. 1998) (recognizing the futility exception); Costantino v. TRW, Inc., 13 F.3d 969, 974 (6th Cir. 1994) (noting the exception to traditional exhaustion principles "when resort to the administrative route is futile"); Smith v. Blue Cross & Blue Shield United, 959 F.2d 655, 658-59 (7th Cir. 1992) (recognizing the futility exception to the exhaustion doctrine, though holding that the futility exception did not apply to the plaintiffs in the case); Riggs v. A.J. Ballard Tire & Oil Co., 1992 U.S. App. LEXIS 31134, at *5 (9th Cir. Nov. 19, 1992) (failing to exhaust is excused if it would be futile); Horan v. Kaiser Steel Ret. Plan, 947 F.2d 1412, 1416 (9th Cir. 1991) (affirming the district court's discretion to waive exhaustion when to do so would be futile); Berger v. Edgewater Steel Co., 911 F.2d 911, 916 (3d Cir. 1990) (recognizing futility as an exception to the use of the exhaustion doctrine), cert. denied, 499 U.S. 920 (1991); O'Bryhim v. Reliance Standard Life Ins. Co., 997 F. Supp. 728, 731 (E.D. Va. 1998) (permitting judicial review upon a "clear and positive" showing of futility).

173 See generally Turner v. Fallon Cnty. Unity Health Plan, Inc., 127 F.3d 196, 200 (1st Cir. 1997) (stating "a failure to exhaust is easily forgiven for good reason, and no reason is better than an
fashioned by the Eleventh Circuit in *Curry v. Contract Fabricators Inc. Profit Sharing Plan*,\(^\text{174}\) in which case the plan or plan fiduciary withheld necessary documents and its reasons for denying the claim. Because the plan fiduciary controlled the administrative review process and denied the claimant access to such process, the court deemed it pointless to require the claimant to exhaust the very procedures that were denied to him.\(^\text{175}\) Courts have extended this exception to other similar situations (*e.g.*, where the claimant was not notified of the appeals procedures or was refused the opportunity to participate in the review;\(^\text{176}\) where the plan fiduciary misled the claimant about benefit payments from medical providers and failed to share information with the claimant;\(^\text{177}\) and where the plaintiff had completed the traditional two-step review process but wish to bypass the third level of review because she had no additional information to supply).\(^\text{178}\)

Courts have developed another exception to the exhaustion requirement when proceeding with the review process would be “clearly useless”\(^\text{179}\) or “futile”\(^\text{180}\) (e.g., claimant told prior to review process that the decision would not be changed). In the case landmark case *Fallick v. Nationwide Mutual Insurance Co.*, rendered by the Sixth Circuit, the plaintiff had established futility by \(^{174}\) 891 F.2d 842 (11th Cir. 1990).  
\(^{175}\) Id. at 846-47 (“When a plan administrator in control of the available review procedures denies a claimant meaningful access to those procedures, the district court has discretion not to require exhaustion.”).  
\(^{176}\) See Conley v. Pitney Bowes, 34 F.3d 714, 718 (8th Cir. 1994); Novak v. TRW, Inc. 822 F. Supp. 963, 969 (E.D.N.Y. 1993) (waiving exhaustion requirement where the claimant was not informed of his administrative remedies); Clay v. ILC Data Device Corp., 771 F. Supp. 40, 45 (E.D.N.Y. 1991) (dismissing exhaustion as defense the plan never informed the claimant of his administrative remedies).  
\(^{177}\) See Bowerman v. Wal-Mart Stores, Inc., 226 F.3d 574, 586-87 (7th Cir. 2000) (using equitable estoppel principles to preclude the assertion of exhaustion due to the plan administrator’s misrepresentation to the claimant); Burris v. IASD Health Servs. Corp., 19 EBC 2680 (S.D. Iowa 1995).  
\(^{178}\) Hager v. NationsBank, N.A. 167 F.3d 245 (5th Cir. 1999).  
\(^{179}\) McGraw v. Prudential Ins. Co., 137 F.3d 1253, 1264 (10th Cir. 1998) (recognizing that “a claimant must make a clear and positive showing of futility” as an excuse for not exhausting administrative remedies (internal quotations omitted)).  
\(^{180}\) See Corsini v. United Healthcare Corp. 965 F. Supp. 265, 269 (D.R.I. 1997); Harrow v. Prudential Ins. Co. of Am., 76 F. Supp. 2d 558, 562 (D.N.J. 1999). Similar to the use of the estoppel theory for the first exception to the meaningful access requirements, two circuits have used an alternative rationale to the futility exception by allowing the claimant to advance the argument that the administrative appeals process provides an “inadequate remedy.” Cf. Perrino v. S. Bell Tel. & Tel. Co., 209 F.3d 1309, 1315-16 (11th Cir. 2000) (adding that the exhaustion requirement should be excused where the administrative remedies are inadequate); McGraw, 137 F.3d at 1263 (stating that the district courts have excused exhaustion when the remedy provided is inadequate).
showing that the defendant insurance company had engaged in a two-year discussion with the plaintiff regarding the methodology of calculating reasonable and customary charges and made no attempt to “seriously reconsider” such methodology.\footnote{161}{162 F.3d 410, 421 (6th Cir. 1998).} In finding the \textit{futility} of pursuing such internal procedures, the court mentioned the following factors: (1) exhaustion would be costly to the plaintiff class and defendant due to litigation fees, (2) the defendant made no attempt to reconsider the methodology used for processing claims, and (3) the factual record had already been well established.\footnote{182}{Id. at 420-21.}

Most courts require that the claimant actually present clear and accurate proof of the futility of the appeal, and not merely rely upon the claimant’s allegation.\footnote{183}{See McGraw, 137 F.3d at 1263 (affirming district court’s refusal to rely upon the plaintiff’s “bare allegation” of futility); Robyns v. Reliance Standard Life Ins. Co., 130 F.3d 1231, 1238 (7th Cir. 1997) (requiring the claimant to show that denial was a “certainty”); Diaz v. United Agric. Employee Welfare Benefit Plan & Trust, 50 F.3d 1478, 1485-86 (9th Cir. 1995) (holding that speculation regarding the futility of the administrative process was not sufficient); Kennedy v. Empire Blue Cross & Blue Shield, 989 F.2d 588, 592 (2d Cir. 1993) (requiring a “clear and positive showing”); Coleman v. Pension Benefit Guar. Corp., 94 F. Supp. 2d 18, 23 (D.D.C. 2000) (conditioning the use of the futility exception upon the requirement that there be a “certainty of an adverse decision”); Stewart v. NYNEX Corp., 78 F. Supp. 2d 172, 183 (S.D.N.Y. 1999) (requiring a “clear and positive showing”); Harrow v. Prudential Ins. Co. of Am., 76 F. Supp. 2d 558, 562 (requiring a “clear and positive showing”).} The fact that the internal appellate reviewer is the same entity or person as the initial internal decider is normally not sufficient evidence to prove applicability of the futility exception.\footnote{184}{See Springer v. Wal-Mart Assocs. Group Health Plan, 908 F.2d 897, 901 (11th Cir. 1990); Ames v. Am. Nat'l Can Co., 170 F.3d 751, 756 (7th Cir. 1999). 29 C.F.R. § 2560.503-1(h)(3)(ii) (2001) requires an independent appellate reviewer to be utilized, thus assuring the independence of the review process. If such requirement was upheld as valid, it would decrease the use of the futility exception. § 2560.503(h)(3)(ii).} Also, the use of such an exception may be required to be asserted at the district court level; one circuit has held that failure to assert such exception at the district level waives the issue upon appeal.\footnote{185}{Schmookler v. Empire Blue Cross & Blue Shield, 1997 U.S. App. LEXIS 2279, at *6 (2d Cir. Feb. 14, 1997).}

More recently, the courts have identified a third exception to exhaustion in contexts where the claimant would be irreparably harmed by delaying the review.\footnote{186}{See generally Turner v. Fallon Cnty. Unity Health Plan, Inc., 127 F.3d 196, 200 (1st Cir. 1997) (stating that “[a] failure to exhaust is easily forgiven for good reason, and no reason is better than an imminent threat to life or health”), \textit{cert. denied}, 523 U.S. 1072 (1998); Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 961 (8th Cir. 1995) (concluding that exhaustion of administrative remedies was not required since missing treatment coupled with the plaintiff’s grave illness constituted irreparable harm); Wilson v. Globe Specialty Prods., Inc., 117 F. Supp. 2d 92, 99 (D. Mass. 2000) (excusing the requirement of exhaustion in the context of irreparable harm); Watts v. Organogenesis, Inc. 30 F. Supp. 2d 101, 104 (D. Mass. 1998) (noting that ERISA’s requirements need not be exhausted when a plaintiff faces an imminent threat to life or health).} This exception to the exhaustion doctrine, typically involving medical claims where the life of the participant/beneficiary is in jeopardy, is one that has...
repeatedly appeared in legislative attempts to permit immediate review by the courts.\footnote{See Bipartisan Patient Protection Act of 2001, H.R. 2563, 107th Cong. (2001); Bipartisan Patient Protection Act of 2001, S. 1052, 107th Cong. (2001); Patients' Bill of Rights Act of 1999, S. 326, 106th Cong. (1999); Patients' Bill of Rights Plus Act of 1999, S. 300 IS, 106th Cong. (1999); Quality Care for the Uninsured Act of 1999, H.R. 2990 IH, 106th Cong. (1999) (amended and renamed as Patients' Bill of Rights Plus Act, H.R. 2990 EAS, 106th Cong. (1999)); Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2723 IH, 106th Cong. (1999); Patients' Bill of Rights Plus Act of 1999, S. 1344, 106th Cong. (1999) (incorporated into Patients' Bill of Rights Plus Act of 1999, H.R. 2990 EAS, 106th Cong. (1999)); Patients' Bill of Rights Act of 1999, S. 240, 106th Cong. (1999); Patients' Bill of Rights Act of 1999, H.R. 358, 106th Cong. (1999); Patients' Bill of Rights Act of 1998, S. 2529 PCS, 105th Cong. (1998); Patients' Bill of Rights Act of 1998, H.R. 3605 IH, 105th Cong. (1998); Patients' Bill of Rights Act of 1998, S. 1890 (1998); Patient Access to Responsible Care Act of 1997, H.R. 1415, 105th Cong. (1997).} In lieu of relying upon one of these three exceptions, two courts have relied upon the doctrine of estoppel to prevent the defense from claiming that the plaintiff failed to exhaust administrative remedies. In the case of Bourgeois v. Pension Plan for Employees of Santa Fe International Corps.,\footnote{215 F.3d 475 (5th Cir. 2000).} the claimant had negotiated with the employer's most senior officers regarding his claim payment instead of the plan administrator, and when he later initiated a lawsuit for benefit denial, the defendant asserted that the claim was time-barred.\footnote{Id. at 478.} While no evidence was provided that it would have been futile to proceed with the administrative remedies, the Fifth Circuit held that the defendants were estopped from asserting the time-bar defense since the high-ranking officers negotiated the benefits issue without proper authority.\footnote{Id. at 481–82.} The court limited its holding when it concluded that “[i]n sum, while not ruling out the possibility that estoppel might allow a claimant to overcome a defense based on failure to exhaust, we instead merely estop the defendants from arguing that Bourgeois’s claim is time-barred before the Committee.”\footnote{Id. at 482.}

In the second decision, Gallegos v. Mt. Sinai Medical Center,\footnote{210 F.3d 803 (7th Cir. 2000) (finding that defendant was not “estopped from asserting failure to exhaust administrative remedies as a defense” because the plaintiff did not rely on misrepresentations to her detriment), cert. denied, 531 U.S. 827 (2000).} the Seventh Circuit discussed the estoppel theory when it noted that although the claimant had been properly informed of the claims procedure, the plaintiff relied upon the written misrepresentations by the insurer or plan administrator.\footnote{Id. at 810.} These two decisions may be used by other courts to expand the number of excuses permitted to the exhaustion of administrative remedies theory.

2. Reasonableness of the Internal Claims Procedures

In fashioning the judicial requirement of exhaustion of administrative remedies, the courts have been very cognizant of ERISA’s two-fold requirement...
necessitating an internal claims procedure for every employee benefit plan. Under ERISA section 503, the statute requires the following:

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. 194

Thus, if part or all of a claimant’s benefit claim is denied, 195 ERISA directs the plan administrator first, to provide to the claimant adequate and understandable written reasons for the denial and, second, to afford a “full and fair review” of such denial by an appropriate named fiduciary. 196 Thus, ERISA provides two levels to the benefit determination: (1) the initial determination as to whether or not the claim will be paid or denied (with resulting notification rules attached), and (2) the second level where the denial may be appealed internally, affording the claimant to a “full and fair” review of the initial determination. Under the courts’ exhaustion doctrine, both levels of review must be satisfied before adjudicating the matter in court.

The initial 1977 DOL claim procedure regulations stated that a plan’s internal claims procedure would be reasonable only if the procedure was explained in the summary plan description, was not unduly complicated, provided written notice of the plan’s time limits, and otherwise complied with the DOL regulations’ notice requirements and review procedures rules. 197 The initial regulations also required that the review procedures were not written or administered in a way that “inhibits or hampers the process.” 198 Given the use of such terms as “adequate,” 199 “reasonableness,” 200 and “full and fair,” 201 neither

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195 Under the impending DOL claims regulations, the DOL adopts the phrase “adverse benefit determination” in lieu of the term “benefit denial” as it is intended to include not only denials in the payment of benefits, but also terminations or reductions in providing benefits, refusals due to cost containment measures, and failures of coverage on the basis that the item is “experimental, investigational, or not medically necessary or appropriate.” 29 C.F.R. § 2560.503-1(j)(2) (2001). Settlor decisions such as plan amendment or termination are not intended to be covered under the phrase “adverse benefit determination.” See Preamble, 63 Fed. Reg. 48,391 (Sept. 9, 1998).
196 See 29 U.S.C. § 1133(2) (requiring the plan to “afford a reasonable opportunity to any participant whose claims for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim”).
197 29 C.F.R. § 2560.503-1(b).
198 29 C.F.R. § 2560.503-1(b)(1)(3).
200 See 29 C.F.R. § 2560.503-1(b) (requiring “[e]very employee benefit plan [to] establish and maintain reasonable claims procedures”); 29 C.F.R. § 2560.503-1(h) (requiring that every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a “reasonable opportunity to appeal” a denied claim).
the statute nor the initial regulations imposed a rigid and exacting claims procedure process, nor did either require the use of a second and different fiduciary for purposes of conducting the full and fair review appeals process.

3. Adequacy of the Full and Fair Review at the Internal Appeals Level

Much of the claims procedure litigation has focused on the second level of the claims process – the internal appeal of the initial benefits denial that affords the claimant with a “full and fair” review of the initial determination. In regards to this review process, the initial 1977 regulations mandated that a plan’s review procedures provide the right of the claimant to initiate an appeal, to review pertinent documents, and to submit issues and comments.202 Time frames had to be specified by the plan, and could not exceed certain maximums in the regulations (e.g., appeal of denial to be made no later than sixty days after receipt of the request).203

The courts have interpreted the full and fair review requirement to serve two purposes: “to permit a plan’s administrators to resolve disputes in an efficient, streamlined, non-adversarial manner” and to “ensure that a plan participant is protected from arbitrary or unprincipled decision-making.”204 While noting that ERISA’s “procedural guidelines are at the foundation of ERISA”205 and are intended to protect participants and beneficiaries “from arbitrary or unprincipled decision-making,”206 the courts affirm the right of the designated plan fiduciary rather than the courts, to administer the plan and process claims.207 The intent of ERISA’s claims procedure is to afford the plan administrator sufficient time and evidence to make an informed decision.208

Litigation surrounding the full and fair review requirement has focused on the documents necessarily considered in the review process,209 the quality and

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201 See 29 U.S.C. § 1133(2) (requiring “a full and fair review”); 29 C.F.R. § 2560.503-1(g) (stating that “a full and fair review of the claim and its denial may be obtained”).
202 29 C.F.R. § 2560.503-1(g)(1).
203 29 C.F.R. § 2560.503-1(h)(1).
204 Ellis v. Metro. Life Ins. Co., 126 F.3d 228, 236-37 (4th Cir. 1997). See also Collins v. Cent. States, S.E. & S.W. Areas Health & Welfare Fund, 18 F.3d 556, 561 (8th Cir. 1994) (mandating that a full and fair review process requires fiduciaries “to set forth the rationale underlying their decision so that the claimant may adequately prepare an appeal to the federal courts, and so that a federal court may properly review the [t]rustees’ decision” (internal quotations omitted)).
207 See Quesinberry v. Life Ins. Co., 987 F.2d 1017, 1025 (4th Cir. 1993) (citing Perry v. Simplicity Engineering, 900 F.2d 963, 966 (6th Cir. 1990), and Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1007 (4th Cir. 1985), for the proposition that the district court should not be made a substitute plan administrator); Nagele v. Elec. Data Sys. Corp., 193 F.R.D. 94, 101 (W.D.N.Y. 2000) (requiring that the decision-maker consider all the evidence as part of a full and fair review).
208 Grossmuller, 715 F.2d at 858 n.5 (requiring the decision-maker to consider both sides and “develop a complete and impartial record”).
209 See 29 C.F.R. § 2560.503-1(g)(ii) (2001) (requiring that “pertinent documents” be discussed). See also Ellis v. Metro. Life Ins. Co., 126 F.3d 228 (4th Cir. 1997) (holding that a failure to provide...
extent of the evidence considered by the fiduciary, use of witness testimony and appearance of counsel, and lack of information given to the claimant. The majority of circuits have required only substantial compliance to the statutory and regulatory claim procedure rules, in lieu of a rigid, complete standard of compliance. Only where the courts have discovered serious violations of the DOL regulations have they held a lack of adequate due process. However, given the lack of an explicit substantive remedy for pertinent documents constitutes a denial of full and fair review; Dade v. Sherwin-Williams Co., 128 F.3d 1135, 1142-43 (7th Cir. 1997) (upholding the plan’s obligation to provide pertinent documents but acknowledging the lack of remedy for such failure); Wilczynski v. Lumbermens Mut. Cas. Co, 93 F.3d 397, 405-07 (7th Cir. 1996) (rejecting the claimant’s request for the entire file as too broad, but affirming the right of the claimant to receive pertinent documents); Curry v. Contract Fabricators Inc. Profit Sharing Plan, 891 F.2d 842, 846-47 (11th Cir. 1990) (noting that failure to turnover plan documents elaborating remedies and plan administrator’s reasons for denial of claim amounts to a denial of meaningful access); Russo v. Abington Mem’l Hosp. Healthcare Plan, 907 F. Supp. 857, 862 (E.D. Pa. 1995) (noting that failure to furnish pertinent documents constitutes a denial of meaningful access to the appeals process).

See Halpin v. W.W. Grainger Inc., 962 F.2d 685, 689 (7th Cir. 1992). See also Bernstein v. Capitalcare, Inc., 70 F.3d 783, 790 (4th Cir. 1995) (remanding case to afford claimant with a full and fair review due to the lack of evidence in the administrative record); Cox v. Mid-Am. Dairymen, Inc., 965 F.2d 569, 573-74 (8th Cir. 1992) (holding that the review process lacked sufficient evidence to substantiate denial), rev’d on other grounds, 13 F.3d 272 (8th Cir. 1993); Lidoshore v. Health Fund 917, 994 F. Supp. 229, 236-37 (S.D.N.Y. 1998) (stating that “at the very least, a full and fair review requires that the fiduciary inform the participant or beneficiary of the evidence that the fiduciary relied upon and provide an opportunity to examine that evidence and to submit written comments or rebuttal documents” (internal quotations omitted)). But cf. Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 382 (10th Cir. 1992) (upholding full and fair review as claimant was invited to submit additional evidence but failed to do so).

See Grossmuller, 715 F.2d at 857-58 (ignoring the plan’s own practice of permitting testimony of witnesses but denying it to the claimant constituted a denial of a full and fair review). But see Hlinka v. Bethlehem Steel Corp., 863 F.2d 279, 282-87 (3d Cir. 1988) (finding a full and fair review present even though counsel and claimant were not present at the review session); Brown v. Ret. Comm. of the Briggs & Stratton Ret. Plan, 797 F.2d 521, 534 (7th Cir. 1986) (stating that a full and fair review does not require the presence of counsel), cert. denied, 479 U.S. 1094 (1987).

See Weaver v. Phoenix Home Life Mut. Ins. Co., 990 F.2d 154, 157-59 (4th Cir. 1993) (failing to disclose basis for denial was insufficient); Vanderklok v. Provident Life & Accident Ins. Co., 956 F.2d 610, 615-17 (6th Cir. 1992) (holding a conclusory denial letter to be inadequate); Halpin, 962 F.2d at 688-94 (finding that the plan acted arbitrarily in not advising claimant as to what information to be submitted upon appeal); S. Fla. Blood Bank, Inc. v. Futch, 764 So.2d 715, 726 (Fla. Dist. Ct. App. 2000) (not requiring claimant to resort to administrative remedies as they would be “clearly useless”).

procedural violations under ERISA section 503, courts have been unable to reach a consensus regarding the appropriate penalty for such violations. Most courts simply remand the case to the plan fiduciary for reconsideration of the benefit denial;\textsuperscript{215} others will grant the benefit being requested.\textsuperscript{216} Repeated and flagrant disregard for the plan's claim procedures may amount to a breach of fiduciary duty, resulting in remedies as provided by ERISA section 502(a)(2).\textsuperscript{217}

4. Legislative Attempts to Provide Patients with the Right to Independent Medical Review

Recent legislative efforts have attempted to provide greater consumer protections in the health care industry, specifically focused on providing patients with the right to independent medical review for denial of medical care under health plans and expansive federal remedies in the event the patient has been injured by the wrongful denial or delay of medical care.\textsuperscript{218} In the context of group health plans covered by ERISA, legislative efforts would appear to be necessary to amend ERISA section 503 claims procedures (as the use of independent medical review is not presently required for denials of medical care)

\textsuperscript{214} Schleibaum v. Kmart Corp., 153 F.3d 496, 499-500 (7th Cir. 1998) (affirming district courts' finding that substantial noncompliance denied the claimant full and fair review), cert. denied, 525 U.S. 1105 (1999); Weaver v. Phoenix Home Life Mut. Life Co., 990 F.2d 154, 158 (4th Cir. 1993) (holding that a total lack of explanation resulted in a denial of full and fair review); Vanderklok, 956 F.2d at 616 (holding that a lack of explanation denied a full and fair review); Halpin, 962 F.2d at 693-94 (finding a lack of explanation and evidence on behalf of the administration denied a full and fair review).

\textsuperscript{215} See Bernstein v. Capitalcare, Inc., 70 F.3d 783, 790 (4th Cir. 1995); Jett v. Blue Cross & Blue Shield, 890 F.2d 1137, 1139-40 (11th Cir. 1989); Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1007 (4th Cir. 1985); Denton v. First Nat'l Bank, 765 F.2d 1295, 1304 (5th Cir. 1985); Wardle v. Cent. States Pension Fund, 627 F.2d 820, 824 (7th Cir. 1980).

\textsuperscript{216} See Parker v. BankAmerica Corp., 50 F.3d 757, 769 (9th Cir. 1995) (affirming recovery of benefits when the claimant can show that procedural violations caused substantive harm); Weaver, 990 F.2d at 159 (noting that remand is the proper course for procedural violations, but deciding the case as the evidence clearly indicated that the plan administrator abused its discretion); Vanderklok v. Provident Life and Accident Ins. Co., Inc., 956 F.2d 610, 616 (6th Cir. 1992) (holding that procedural errors by the plan administrator amounted to "a significant error on a question of law, which requires that the decision to deny benefits be overturned"). But see Lake v. Metro. Life Ins. Co., 73 F.3d 1372, 1378 (6th Cir. 1996) (stating that "plaintiffs would not be entitled to recover substantive damages even if we found ... violations of the procedural sections of ERISA").

\textsuperscript{217} See, e.g., Blau v. Del Monte Corp., 748 F.2d 1348, 1353-54 (9th Cir. 1988).

and ERISA section 514 preemption clause (to permit state claims for wrongful
denial or delay in benefit claims against ERISA plans).

Both the recently passed House and Senate patients’ rights legislation
proposed changes to ERISA’s section 503 claim procedure requirements
requiring faster response times to benefit requests and requests for information;
more stringent requirements as to information that must appear in the denial
notice; expedited reviews of benefit denial, conducted by a individual with
appropriate expertise who was not involved in the initial determination; review
by health care professional for denials based on lack of medical necessity or
experimental/investigational treatment or requiring an evaluation of medical
facts; and use of an independent external appeals procedure. Both bills
provide for an additional ERISA section 502 cause of action for failure to comply
with the requirements of the bill of rights, supplying remedies for the wrongful
denial or delay of medical care for claimants under employee benefit plans. Both
bills would require patients to exhaust the plan’s initial claims procedures
and internal appeals process prior to bringing a suit under the newly created
cause of action.

5. Overhaul of the Exhaustion Doctrine Under the Impending DOL
Regulations

Responding to the directive of the Clinton administration to implement the
Commissions’ recommendations, the DOL proposed regulations in 1998, later
finalized in 2000, that made drastic changes to the claims procedure rules. At the
first stage of the benefit review, the DOL intensified the requirements necessary
to adequately notify claimants of a denial (e.g., drastically accelerated the time
limits for review of health claims based on the type of claim, replacing the
former window period with significantly shorter time periods). The intent of
such accelerated time commitment was to increase response time to claimants,
especially in life-threatening situations, which has been the motivation behind
various patients’ bills of rights. The regulations also required, for health and
disability plans, disclosure of the internal rules, protocol or criterion used in
benefit determinations, as well as an explanation of scientific or clinical
judgment used if the denial was based on medical necessity or experimental in
nature.

219 See Bipartisan Patient Protection Act of 2001, H.R. 2563, 107th Cong. (2001); Bipartisan
Patient Protection Act of 2001, S. 1052, 107th Cong. (2001); see also supra text accompanying
note 62.
220 See H.R. 2563 (as amended by numbered 2 and 3 in House Report 107-184); S. 1052.
221 See H.R. 2563 (as amended by numbered 2 and 3 in House Report 107-184); S. 1052.
223 29 C.F.R. § 2560.503-1(g). The DOL regulations alter the time periods based on whether the
claim is for urgent care, pre-service or post-service claims, mandating a much shorter period of
time for urgent care claims. Id.
224 Id. According to the Preamble in the DOL proposed regulations, this fifth requirement was
necessary to “satisfy the claimant’s need to understand the evidentiary basis for the decision and
therefore to determine whether an appeal is justified and how such an appeal might best be
Regarding ERISA’s second stage of claims procedure – the full and fair review stage – the DOL finalized 2000 regulations made sweeping changes, requiring the de novo review of every benefit denial at this second stage of review by a fiduciary who was not the same fiduciary (nor subordinate) used in the initial review, and, if such review of benefits was based on medical judgment, requiring consultation with a health care professional independent of the professional involved in the initial review and who has competent experience within the medical field. Disclosure of pertinent files at this stage would be affected as the description of “relevant documents” would now be increased to include any document relied upon in making the decision; any document generated in the course of making the decision whether or not relied upon; documents that demonstrate the employer’s compliance with the administrative processes and safeguards now required under the regulations; and for health/disability claims, a statement of the plan’s policy concerning the denied treatment option or benefit for the claimant’s diagnosis. Since Congress has been introducing legislation to provide many of these same protections, Congress must believe that the DOL does not have the regulatory power to accomplish these goals. Thus, it is likely that the DOL 2000 regulations will be withdrawn or substantially altered if and when a patients’ bill of rights is passed in Congress.

The most far-reaching stretch of the DOL’s regulatory power occurs in its newest regulations where it attempts to dismiss the judicial requirement of exhaustion of administrative remedies, something that even the bold legislative efforts do not attempt. The DOL regulations prescribe that the sanction for failure to comply with any aspects of the reformulated claims procedure regulations is immediate access to courts, despite the determination of any benefit denial, or availability of any administrative record. In the Preamble to its impending regulations, the DOL noted that commentators had suggested adopting a standard of good faith compliance as a measure for requiring administrative exhaustion, or adopting the judicial exhaustion doctrine unless the administrative processes pose an actual harm to the claimant. However, the DOL rejected those measures, insisting that claimants should not be required to comply with a plan’s claims procedures if these procedures do not rigidly comply pursued.”

226 29 C.F.R. § 2560.503-1(m)(8).
227 See 29 C.F.R. § 2560.503-1(l). See also Davenport v. Harry N. Abrams, Inc., 249 F.3d 130, 133 (2d Cir. 2001) (acknowledging the three-fold purposes of the exhaustion requirement: to uphold Congress’ desire that ERISA trustees, not the federal courts, be responsible for their actions; to provide a sufficiently clear record of administrative action if litigation later ensues; and to assure that any judicial review of the fiduciary’s action or inaction is made under the arbitrary and capricious standard).
228 29 C.F.R. § 2650.503-1(l).
with the regulations. Based on the reasons reiterated by the courts in their formulation of the judicial doctrine of exhaustion, it is highly doubtful that the courts would eliminate this requirement absent legislative authority.

I. Judicial Standard of Review

The statutory language of ERISA is silent regarding the applicable judicial standard of review of any ERISA causes of actions, including the denial of benefit claims. Pre-ERISA, a number of courts in the employee benefits context began using the “arbitrary and capricious” judicial standard applicable under labor law. This standard, articulated in a line of cases deriving from Danti v. Lewis, applied the arbitrary and capricious standard to non-union benefit denial claims. The result was to afford deferential review of the fiduciary’s decision to deny benefits. When ERISA was passed in 1974 without an applicable standard of review, the courts continued their use of the arbitrary and capricious standard. Thus, courts would not overturn the fiduciary’s decision so long as it was rationally justifiable and made in good faith, regardless of whether it was the

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230 Id. at 70,256.
232 Rehmar v. Smith, 555 F.2d 1362, 1371 (9th Cir. 1976) (referring to cases that have followed the decision in Danti, 312 F.2d 345, as the Danti cases).
233 See, e.g., Bachelder v. Communications Satellite Corp., 837 F.2d 519, 521-23 (1st Cir. 1988) (applying the arbitrary and capricious standard to the termination of cash distributions from a stock ownership plan); Accardi v. Control Data Corp., 836 F.2d 126, 128 (2d Cir. 1987) (using the arbitrary and capricious standard in the contexts of denials under the severance pay plan), aff'd, 869 F.2d 25 (2d Cir. 1989); Whipp v. Seafarers Vacation Plan, 832 F.2d 853, 855 (4th Cir. 1987) (holding that the arbitrary and capricious standard was the applicable standard for review of the acts of trustees regarding plan administration); Nevill v. Shell Oil Co., 835 F.2d 209, 212 (9th Cir. 1987) (upholding the denial of the Special Separation Allowance to the employees as it was not arbitrary nor capricious); Naugle v. O'Connell, 833 F.2d 1391, 1393 (10th Cir. 1987) (recognizing that the eligibility requirements were not subject to collective bargaining, and requiring the use of the arbitrary and capricious standard to overturn the denial of benefits); Deak v. Masters, Mates and Pilots Pension Plan, 821 F.2d 572, 577-79 (11th Cir. 1987) (discussing the use of the arbitrary and capricious standard), cert. denied, 484 U.S. 1005 (1988); Berry v. Ciba-Geigy Corp. 761 F.2d 1003, 1006 (4th Cir. 1985) (noting the use of the arbitrary and capricious standard regarding the actions of the private plan trustee); Denton v. First Nat'l Bank, 765 F.2d 1295, 1300 (5th Cir. 1985), reh'g denied, 772 F.2d 904 (5th Cir. 1985) (requiring the use of the arbitrary and capricious standard for actions and inactions of fiduciaries); Pokratz v. Jones Dairy Farm, 771 F.2d 206, 208 (7th Cir. 1985) (requiring the arbitrary and capricious standard to overturn the plan's denial of disability benefits); Bayles v. Cent. States., S.E. & S.W. Areas Pension Fund, 602 F.2d 97, 99 (8th Cir. 1979) (affirming the trustee's actions unless found to be arbitrary and capricious). See also Bradley R. Duncan, Note, Legislation Under ERISA: Judicial Review of Fiduciary Claim Denials Under ERISA: An Alternative to the Arbitrary & Capricious Test, 71 CORNELL L. REV. 986, 987 n.8 (1986).
best decision under the circumstances.\textsuperscript{234} By 1989, there was dissention among the circuits, as some felt the use of such a deferential standard was not justified in contexts where the plan administrator was not necessarily impartial in the determination of benefits.\textsuperscript{235} The Supreme Court utilized \textit{certiorari} in the case of \textit{Firestone Tire and Rubber Co. v. Bruch}\textsuperscript{236} to resolve the split among the circuits. In rejecting the use of labor law, the Court turned to trust law, thereby focusing on the explicit terms of the plan in determining whether the plan administrator had the discretionary powers to make benefits determinations.\textsuperscript{237} Absent such explicit discretionary powers, the judicial standard would be \textit{de novo}, which results in a plenary review of the decision of the plan administrator.\textsuperscript{238} In the event the appropriate powers had been conferred, the Court mentioned the other trust law standard – "abuse of discretion" – and specifically referred to the

\textsuperscript{234} See Whipp v. Seafarers Vacation Plan, 832 F.2d 853, 855-56 (4th Cir. 1987); Atkinson v. Sheet Metal Workers' Trust Funds, 833 F.2d 864, 865 (9th Cir. 1987); Hancock v. Montgomery Ward Long Term Disability Trust, 787 F.2d 1302, 1307 (9th Cir. 1986); Blakeman v. Mead Containers, 779 F.2d 1146, 1150 (6th Cir. 1985); Lawrence v. Westerhaus, 780 F.2d 1321, 1322 (8th Cir. 1985); Morse v. Stanley, 732 F.2d 1139, 1145-46 (2d Cir. 1984); Wolf v. Nat'l Shopmen Pension Fund, 728 F.2d 182, 189 (3d Cir. 1984); Johnson v. Franco, 727 F.2d 442, 447 (5th Cir. 1984); Allen v. UMW 1979 Benefit Plan & Trust, 726 F.2d 352, 354 (7th Cir. 1984); LeFebre v. Westinghouse Elec. Corp., 747 F.2d 197, 199 (9th Cir. 1984); Miles v. New York Teamsters Conference Pension and Ret. Fund, 698 F.2d 593, 601 (2d Cir. 1983), \textit{cert. denied}, 464 U.S. 829 (1983); Dennard v. Richards Group, Inc., 681 F.2d 306, 313 (5th Cir. 1982).

\textsuperscript{235} See Brown v. Blue Cross & Blue Shield, Inc., 698 F.2d 1556, 1560 (11th Cir. 1990) (referring to cases pre-\textit{Firestone}, the court noted that the circuits varied regarding the deference affording the trustee/fiduciary's decisions based on the presence of a conflict of interest), \textit{cert. denied}, 498 U.S. 1040 (1991); Sage v. Automation, Inc. Pension Plan & Trust, 845 F.2d 885, 895 (10th Cir. 1988) (stating that the arbitrary and capricious standard was sufficiently flexible to examine trustee bias); Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1052-53 (7th Cir. 1987) (affirming the flexibility of the arbitrary and capricious standard in taking bias into account); Gilbert v. Burlington Indus., Inc., 765 F.2d 320, 328-29 (2d Cir. 1985) (reviewing the denial of benefits under the arbitrary and capricious standard); Holland v. Burlington Indus., Inc., 772 F.2d 1140, 1149 (4th Cir. 1985) (noting that there was only a single standard to apply, denied use of a "less deferential" standard); Jung v. FMC Corp., 755 F.2d 708, 711-12 (9th Cir. 1985) (using the arbitrary and capricious standard despite the granting of less deference to the trustee's decision); Maggard v. O'Connell, 671 F.2d 568, 571 (D.C. Cir. 1982) (requiring "review with greater care" when applying the arbitrary and capricious standard in the conflict of interest contexts); Dennard v. Richards Group, Inc., 681 F.2d 306, 314 (5th Cir. 1982) (outlining the factors to use in the application of the arbitrary and capricious standard, including conflict of interest).

\textsuperscript{236} 489 U.S. 101 (1989).

\textsuperscript{237} Id. at 110-11 (stating that the lower court's use of the labor law standard improperly relied upon a jurisdictional analogy between LMRA and ERISA).

\textsuperscript{238} Id. at 112-13

(The trust law \textit{de novo} standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA. Actions challenging an employer's denial of benefits before enactment of ERISA were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee's claim as it would have any other contract claim by looking to the terms of the plan and other manifestations of the parties' intent.)
Second Restatement of Trusts. As the case in question did not specifically reserve appropriate powers to the plan administrator, the case was remanded for de novo review. As a result, the Firestone holding was viewed as narrow and restrictive, since the plan sponsor certainly could draft the proper discretionary powers in the plan to ensure deferential review and to avoid de novo review.

In litigating an ERISA benefit denial case, it is critical whether the court applies a de novo standard or an arbitrary and capricious standard in reviewing the plan administrator’s decision. The claimant obviously prefers the de novo standard as it affords an independent review of the decision by the courts; whereas the defendant prefers the highly deferential arbitrary and capricious standard, affirming the plan administrator’s decision unless it was “arbitrary, capricious, or made in bad faith... not supported by substantial evidence.”

Which standard is applied sharply determines the outcome of the case.

A number of issues have faced the courts after Firestone as they continue to fashion a judicial standard of review in ERISA benefit denial cases. The first focuses on the plan language necessary to shift from the de novo standard. The

239 Id. at 115. See also Restatement (Second) of Trusts, which refers to a number of factors in the application of the abuse of discretion standard:

[In determining the question whether the trustee is guilty of an abuse of discretion in exercising or failing to exercise a power, the following circumstances may be relevant: (1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee’s conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.]


240 Firestone, 489 U.S. at 118.


majority view is that the necessary discretionary powers be explicit (not inferred from other powers) in the plan document. While the courts do not require the use of specific words such as "discretion" or "deference," obviously the clearer and more explicit the grant of discretionary authority, the greater is the likelihood of avoiding the de novo standard of review. Much litigation in this area is directed at the terms "proof of loss" or "satisfactory proof of loss" found in typical insurance contracts. Such language is argued by the insurers to grant sufficient discretionary powers for determining benefits because the discretion as to whether the proof for loss has been met rests with the insurer. The courts have not supported such an argument. Just recently, the Seventh Circuit proposed safe harbor plan language, to guarantee that the necessary discretionary powers


244 See McDaniel v. Chevron Corp., 203 F.3d 1099, 1107 (9th Cir. 2000) (indicating that an administrator with the sole discretion to interpret plan terms is permissible); Bendixen v. Standard Ins. Co., 185 F.3d 939, 943 n.1 (9th Cir. 1999) (permitting plan language where plan administrator's decisions were conclusive and binding); Friedrich v. Intel Corp., 181 F.3d 1105, 1110 n.5 (9th Cir. 1999) (affirming the language "sole discretion to interpret the terms of the Plan and to determine eligibility for benefits" as a discretionary power); Donaho v. FMC Corp., 74 F.3d 894, 898 (8th Cir. 1996) (holding that "discretionary authority to construe and interpret the terms of the Plan, including, but not limited to, deciding all questions of eligibility" is acceptable); Kotrotsis v. Gtx Corp. Non-Contributory Pension Plan for Salaried Employees, 970 F.2d 1165, 1168 (3d Cir. 1992) (approving plan language rendering the plan administrator's decisions final and binding).

245 See Kearney v. Standard Ins. Co., 175 F.3d 1084, 1089 (9th Cir. 1999).

246 See Herzburger v. Standard Ins. Co., 205 F.3d 327, 332 (7th Cir. 2000) (holding that the "satisfactory proof" language is not sufficient to grant discretionary authority); Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 251-52 (2d Cir. 1999) (concluding that language in a plan that required a claimant to "submit satisfactory proof of Total Disability to us" demands an objective standard, not a subjective one, in determining loss); Kearney v. Standard Ins. Co., 175 F.3d 1084, 1089-90 (9th Cir. 1999) (holding that the typical insurance language "satisfactory written proof" of loss does not confer discretionary authority to the insurer); Brown v. Seitz Foods, Inc., Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998) (affirming that provisions such as "[t]o be considered disabled," "as long as the definition of total disability is satisfied," and "due . . . proof of loss" do not confer discretionary power to decide claims). But see Patterson v. Caterpillar, Inc. 70 F.3d 503, 505 (7th Cir. 1995) (approving language "upon receipt by . . . due proof . . . of such disability" as sufficient to grant discretion); Donato v. Metro. Life Ins. Co., 19 F.3d 375, 379-80 (7th Cir. 1994) (waiving the requirement that plan language contain an explicit grant of discretionary authority); Bali v. Blue Cross & Blue Shield Ass'n, 873 F.2d 1043, 1047 (7th Cir. 1989) (approving language "evidence satisfactory to the Committee" as a discretionary grant of authority).
have been conferred upon the plan administrator, in an effort to resolve the issue.\textsuperscript{247}

Once the necessary discretionary powers had been reserved to the plan administrator in the document, the next issue facing the courts was what appropriate judicial standard of review to use. All the circuits agreed that the two applicable judicial standards of review in ERISA benefit denial cases are the \textit{de novo} standard and the more deferential abuse of discretion standard.\textsuperscript{248} However, most courts continue to use the labor law arbitrary and capricious standard rather than the abuse of discretion standard as the deferential standard of review, noting in passing that the two standards are equivalent in the ERISA context.\textsuperscript{249} Only the Fourth Circuit views the applicable abuse of discretion differently, seeing it as a less deferential standard than the arbitrary and capricious standard.\textsuperscript{250}

Under the highly deferential arbitrary and capricious standard, the majority of circuits will uphold the plan administrator’s denial of benefits unless such determination was “arbitrary, capricious, or made in bad faith, . . . not supported

\textsuperscript{247} Herzberger, 205 F.3d at 331 (recommending such safe harbor language for inclusion under ERISA plans: “[h] benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them”).

\textsuperscript{248} See Pinto v. Reliance Standard Life Ins. Co., 214 F.2d 377, 379 (3d Cir. 2000); Barnhart v. Unum Life Ins. Co. of Am., 179 F.3d 583, 588-90 (8th Cir. 1999); Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 183-84 (1st Cir. 1998); Sullivan v. LTV Aerospace & Def. Co., 82 F.3d 1251, 1255 (2d Cir. 1996); Snow v. Standard Ins. Co., 87 F.3d 327, 330-31 (9th Cir. 1996); Chambers v. Family Health Plan Corp., 100 F.3d 818, 825-26 (10th Cir. 1996); Doe v. Group Hospitalization & Med. Servs., 3 F.3d 80, 85 (4th Cir. 1993); Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556, 1560-63 (11th Cir. 1990), cert. denied, 498 U.S. 1040 (1991); Van Boxel v. Journal Co. Employee’s Pension Trust, 836 F.2d 1048, 1052-53 (7th Cir. 1987). The Fourth, Fifth, Eighth, Ninth and Tenth Circuits prefer the use of the terms “abuse of discretion” over “arbitrary and capricious.” See Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 341-42 (4th Cir. 2000); Meditrust Fin. Servs. Corp. v. Sterling Chem., Inc., 168 F.3d 211, 214 (5th Cir. 1999); Barnhart v. Unum Life Ins. Co. of Am., 179 F.3d 583, 588 (8th Cir. 1999); McGraw v. Prudential Ins. Co. of Am., 137 F.3d 1253, 1258-59 (10th Cir. 1998). Compare the above cases with the Eleventh Circuit holding in Marecek v. BellSouth Services, Inc., 49 F.3d 702, 704 (11th Cir. 1995), which states that there are three standards of review: “(1) \textit{de novo}, applicable where the plan administrator is not afforded discretion; (2) arbitrary and capricious where the plan administrator possesses discretion; and (3) heightened arbitrary and capricious where there is a conflict of interest.”

\textsuperscript{249} See Meditrust Fin. Servs. Corp. v. Sterling Chem., Inc., 168 F.3d 211, 214 (5th Cir. 1999); Ross v. Ind. Teacher’s Ass’n Ins. Trust, 159 F.3d 1001, 1009 (7th Cir. 1998); DeWitt v. Penn-Del Directory Corp., 106 F.3d 514, 520 (3d Cir. 1997); Morton v. Smith, 91 F.3d 867, 870 (7th Cir. 1996); Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir. 1996); Chambers v. Family Health Plan Corp., 100 F.3d 818, 825 n.1 (10th Cir. 1996); Atwood v. Newmont Gold Co., 45 F.3d 1317, 1321 n.1 (9th Cir. 1995); Wildbur v. ARCO Chem. Co., 974 F.2d 631, 635 (5th Cir. 1992); Cox v. Mid-Am. Dairymen, Inc., 965 F.2d 569, 571-72 (8th Cir. 1992) (Cox I), \textit{aff’d after remand}, 13 F.3d 272 (8th Cir. 1993) (Cox II); Miller v. Metro. Life Ins. Co., 925 F.2d 979, 984 (6th Cir. 1991); Jett v. Blue Cross & Blue Shield, 890 F.2d 1137, 1139 (11th Cir. 1989).

\textsuperscript{250} See Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 341-42 (4th Cir. 2000) (opting for the abuse of discretion standard, not the arbitrary and capricious standard, as the “appropriate one for judicial review of a fiduciary’s discretionary decision under ERISA”). Under this standard, the Fourth Circuit will not overturn the fiduciary’s discretionary decision “if it is reasonable.” \textit{Id.} at 342.
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by substantial evidence.”  Such a standard has been described as one that affirms the plan administrator’s decision unless “totally unreasonable,” “whimsical, random, or unreasoned,” or “downright unreasonable.” In support of such a highly deferential standard, the courts note that ERISA does not permit them to substitute their decision for that of the plan administrator, provided that the administrator’s decision was reasonable. This standard is applied by the courts not only in benefit determination contexts, but also in plan interpretation contexts where the claimant’s benefits are contingent on the interpretation of the plan (e.g., benefits for “mental illness” are excluded under the plan).

The facts in the *Firestone* case involved a conflict of interest as the employer was the plan administrator under a self-funded ERISA plan, thus having a financial interest in denying the claim for benefits. While the applicable standard in that case was to be the *de novo* standard, the Court noted that if discretionary powers had been reserved to the plan administrator who was operating under a conflict of interest, such conflict would be a factor in the application of the abuse of discretion standard.

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252 Allen v. UMW of Am., 726 F.2d 352, 354 (7th Cir. 1984) (remarking that only totally unreasonable decisions will be overturned in the absence of evidence of bad faith).

253 Teskey v. M.P. Metal Prods., Inc., 795 F.2d 30, 32 (7th Cir. 1986) (describing the arbitrary and capricious standard as narrow in application).

254 See Carr v. Gates Health Care Plan, 195 F.3d 292, 294 (7th Cir. 1999) (quoting Butler v. Encyclopedia Britannica, Inc., 41 F.3d 285, 291 (7th Cir. 1994) (upholding the plan administrator’s decision as not arbitrary or capricious)).


256 See Pinto, 214 F.3d at 382; Meditrust Fin. Servs. Corp., 168 F.3d at 214; Brogan, 105 F.3d at 161; Donaho, 74 F.3d at 898; Bernstein, 70 F.3d at 788; Pagan, 52 F.3d at 442; Abnathya, 2 F.3d at 45; Millensifer, 968 F.2d at 1009; Baker, 929 F.2d at 1144. Some courts, however, have applied the state insurance law doctrine of "contra proferentem" in resolving the ambiguity in the context of determining ambiguous plan language. See Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 252 (2d Cir. 1999); Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc), cert. denied, 528 U.S. 964 (1999); Regents of the Univ. of Mich. v. Employees of Agency Rent-A-Car Hosp. Ass’n, 122 F.3d 336, 339 (6th Cir. 1997); Hughes v. Boston Mut. Life Ins. Co., 26 F.3d 264, 268 (1st Cir. 1994); Pitcher v. Principal Mut. Life Ins. Co., 870 F. Supp. 903 (S.D. Ind. 1994), aff’d, 93 F.3d 407 (7th Cir. 1996).

257 Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) (“If a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict
flurry of litigation, deciding on how best to adjust or modify the abuse of discretion standard in conflict of interest contexts. As a result, the circuits are divided as to the application of the abuse of discretion standard in conflict of interest contexts.  

Immediately after Firestone, the Eleventh Circuit decided upon a “presumptively void” (or burden shifting) standard to be used in conflict of interest cases. Under such a standard, if the claimant proves a “substantial” conflict of interest or the existence of an inherent conflict of interest, the burden shifts to the plan administrator to justify to the court that its decision was not tainted by self-interest. The Eleventh Circuit justified such standard as “prophylactic,” since it would discourage conflict of interest arrangements. Given the level of litigation involving conflict of interests, such has not been the case. The Ninth Circuit has also adopted this prophylactic theory, relying on trust law, holding that any self-interest action by a trustee is presumptively void.

Many circuits simply reformulate the abuse of discretion standard by means of a “sliding scale” approach in the presence of a conflict of interest. Such a

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259 See Brown, 898 F.2d at 1566. The majority of other circuits reject the Brown presumptively void theory. See Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 391-92 (3d Cir. 2000); Doyle, 144 F.3d at 184; Vega v. Nat'l Life Ins. Servs., Inc., 188 F.3d 287, 296-97 (5th Cir. 1999); Mers, 144 F.3d at 1019-20; Chambers v. Family Health Plan Corp., 100 F.3d 818, 826 (10th Cir. 1996); Sullivan, 82 F.3d at 1255.

260 See Brown, 898 F.2d at 1565-66 (requiring the beneficiary to show that the fiduciary placed himself/herself in a conflict of interest position, thereby shifting the burden to the fiduciary to show that his/her discretion was not tainted by self-interest).

261 Id. at 1565 (indicating that “one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises”).

262 See Atwood v. Newmont Gold Co., 45 F.3d 1317, 1323 (9th Cir. 1995) (citing GEORGE T. BOGERT, TRUSTS § 95 (6th ed. 1987) for the proposition that “under the common law of trusts, any action taken by a trustee in violation of a fiduciary obligation is presumptively void”); Lee v. Blue Cross & Blue Shield, 10 F.3d 1547, 1552 (1st Cir. 1994) (rejecting the insurer’s claim that it does not operate under a conflict of interest as it is a non-profit state-regulated entity, thereby shifting the burden to the insurer to prove its interpretation was not tainted by self-interest).

standard is then regarded as flexible, affording less deference in order to neutralize the degree of the conflict. As the standard is one that must be adjusted by the courts, the claimant will have an additional chance to challenge the plan administrator's decision if a conflict of interest can be alleged or proven. Therefore, employer self-funded plans that are also self-administered by the employer, and insured plans where the insurer is the plan administrator, present conflict of interest situations where the plan administrator's decisions may not be afforded full deference.

The recent patients' bill of rights is silent on the ERISA judicial standard of review, but negates the conflict of interest potential for health claim denials since the claimant would be given the right to independent medical review. Likewise, the impending DOL regulations are silent on the ERISA judicial standard of review, but assure the claimant of greater neutrality because the second stage of benefit review must be made de novo and by a second fiduciary, who is different than the fiduciary who made the initial determination.

Despite the regulations attempt to negate the exhaustion of administrative remedies doctrine, unless the regulations are strictly complied with, the courts will have to modify their judicial standard of review since there may be no decision to review nor an administrative record or evidence to examine. Litigation will obviously grow alongside the courts' calendars as courts conduct de novo review of benefit determinations.

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standard is "shaped by the circumstances of the inherent conflict of interest" (internal quotations omitted); Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 184 (1st Cir. 1998) (adopting the language from Doe v. Travelers Ins. Co., 971 F. Supp. 623, 630 (D. Mass. 1997)); McGraw v. Prudential Ins. Co. of Am., 137 F.3d 1253, 1258 (10th Cir. 1998) (using a less deferential standard in a conflict of interest context); Snow v. Standard Ins. Co., 87 F.3d 327, 331 (9th Cir. 1996), overruled on other grounds by Kearney v. Standard Ins. Co., 175 F.3d 597 (9th Cir. 1998); Woo v. Deluxe Corp., 144 F.3d 1157, 1160-61 (8th Cir. 1998) (requiring plaintiff to prove a conflict of interest that interfered with the administrator’s decision in order to obtain a less deferential standard of review); Chojnacki v. Georgia-Pacific Corp., 108 F.3d 810, 814-15 (7th Cir. 1997) (reshaping the arbitrary and capricious standard in the context of a conflict of interest, giving less deference the more serious the conflict becomes); Sullivan v. LTV Aerospace & Def. Co., 82 F.3d 1251, 1255 (2d Cir. 1996) (reviewing the decision de novo once a conflict of interest has been identified); Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556, 1562 (11th Cir. 1990) (holding that an inherent conflict of interest renders the use of a highly deferential standard inappropriate), cert. denied, 498 U.S. 1040 (1991).

264 See Pinto, 214 F.3d at 379 (holding that the sliding scale standard calls for more intense scrutiny to match the degree of conflict); Vega, 188 F.3d at 288 (applying less deference to offset the influence, to be determined on a case by case basis); McGraw v. Prudential Ins. Co., 137 F.3d 1253, 1259 (10th Cir. 1998) (adjusting the sliding scale in proportion to the degree of conflict present); Mers v. Marriott Int'l Group Accidental Death And Dismemberment Plan, 144 F.3d 1014, 1019-20 (7th Cir. 1998) (describing the arbitrary and capricious standard as not an “all or nothing” choice between full or no deference), cert. denied, 525 U.S. 947 (1998); Woo, 144 F.3d at 1161-62 (referring to the sliding scale as a flexible standard).

J. Evidentiary Issues at the Time of Adjudication

Another civil procedure issue that arises in benefit denial cases is whether the court is limited to the evidence that was presented before the plan administrator during the review process. The claimant would obviously prefer to offer additional evidence, which was either ignored or discovered after the review process, for the courts to review. The courts have determined that the resolution of this issue depends on the applicable judicial standard of review to be applied in the given case. In cases where the arbitrary and capricious standard is applicable, virtually all the circuits limit the evidence presented at court to that contained in the administrative record.\(^\text{266}\) If the trial court believes the plan administrator lacked sufficient evidence to make a benefits’ decision, the proper recourse is to remand the issue to the plan administrator for redetermination.\(^\text{267}\) Such result is consistent with the requirement of the exhaustion of administrative remedies doctrine applied by the courts because an administrative record is assembled for review.\(^\text{268}\)

\(^{266}\) See Elliot v. Sara Lee Corp., 190 F.3d 601, 608 (4th Cir. 1999) (noting that “an assessment of the reasonableness of the administrator’s decision must be based on the facts known to it at the time” (internal quotations omitted)); Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan, 195 F.3d 975, 981-82 (7th Cir. 1999) (concluding that it would be error for the lower courts to permit discovery into the plan administrator’s decision); Heller v. Fortis Benefits Ins. Co., 142 F.3d 487, 493 (D.C. Cir. 1998) (refusing to consider evidence that was unavailable at the time of the administrator’s initial determination); Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3d Cir. 1997) (limiting its review of the “whole” record to that of the evidence before the administrator); Miller v. United Welfare Fund, 72 F.3d 1066, 1071 (2d Cir. 1995) (rejecting the use of evidence other than the administrative record); Lee v. Blue Cross & Blue Shield, 10 F.3d 1547, 1550 (11th Cir. 1994) (limiting the courts to the facts known to the administrator at the time the decision was made); Taft v. Equitable Life Assurance Soc'y, 9 F.3d 1469, 1471-72 (9th Cir. 1993) (finding it inappropriate for the district court to examine evidence apart from the administrative record); Wildbur v. ARCO Chem. Co., 974 F.2d 631, 639 (5th Cir. 1992) (noting the Fifth Circuit’s long-standing finding that the administrator’s findings of fact findings are limited to the evidence before the administrator, citing Denton v. First Nat'l Bank of Waco, 765 F.2d 1295, 1304 (5th Cir. 1985) and Lowry v. Bankers Life & Casualty Ret. Plan, 865 F.2d 692, 694 (5th Cir. 1989)); Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 381 (10th Cir. 1992) (admonishing the lower courts to adhere to the general rule of limiting review based on the administrative record); Oldenburger v. Cent. States, SE & SW Areas Teamster Pension Fund, 934 F.2d 171, 174 (8th Cir. 1991) (limiting review to the evidence before the trustees when the final decision was made); Perry v. Simplicity Eng., 900 F.2d 963, 966-67 (6th Cir. 1990) (dictating a strict limitation to consider only the information considered by the plan administrator). But cf. Doe v. Travelers Ins. Co., 167 F.3d 53, 57 (1st Cir. 1999) (noting that the record to be considered by the court “may depend on what has been decided, by whom, based on what kind of information, and also on the standard of review and the relief sought,” thereby permitting limited discovery of extra-record evidence); Tremain v. Bell Indus., 196 F.3d 970, 976-77 (9th Cir. 1999) (permitting extra-record evidence in determining whether the administrator was operating under a conflict of interest); Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1464 (9th Cir. 1997) (permitting extra-record evidence in extraordinary cases where the plan administrator ignored relevant information); Lee, 10 F.3d at 1552 (permitting additional evidence to rebut the administrator’s bias in a conflict of interest context); Bernards v. United of Omaha Life Ins. Co., 987 F.2d 486, 489 (8th Cir. 1993) (per curiam) (deviating from its general rule of staying discovery in appropriate “emergency” cases in which irreparable harm may occur); Moon v. Am. Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989).
PERILOUS ERISA PROCEDURAL RULES

If the *de novo* standard of review is applicable, many circuits are receptive to granting discretion to the lower courts to consider evidence outside that of the administrative record as needed to make a determination.\(^{269}\) The Fourth and the Sixth Circuits take a different approach. The Sixth Circuit refuses to admit additional evidence at trial, reasoning that the courts are not to serve as substitute plan administrators and to do so would only detract from ERISA’s goal of an expedited claims process.\(^{270}\) However, if no administrative record exists and the court’s only recourse is to remand the issue for redetermination by the plan administrator, the end result for the claimant is a never-ending cycle of benefit redeterminations with no resolution. The Fourth Circuit is somewhere in the middle, permitting discretion to the lower court but only if necessary to resolve the benefit claim.\(^{271}\) In *Quesinberry v. Life Insurance Co. of North America*, the

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\(^{267}\) See *Elliott*, 190 F.3d at 609 (directing the remand to the trustees for a new determination in lieu of additional evidence submitted at the district courts, but citing Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1008 (4th Cir. 1985), for the proposition that “remand should be used sparingly”); Killian v. Healthsource Provident Adm’rs, Inc., 152 F.3d 514, 522 (6th Cir. 1998) (remanding to consider additional evidence as the administrative record was inadequate); Recupero v. New England Tel. & Tel. Co., 118 F.3d 820, 822 (1st Cir. 1997) (noting that ordinarily the appropriate form of order is to remand to the out-of-court decisionmaker); *Miller*, 72 F.3d at 1071 (instructing the district court to remand to the trustees to consider additional evidence “unless no new evidence could produce a reasonable conclusion permitting denial of the claim or remand would otherwise be a useless formality”); *Jett* v. Blue Cross & Blue Shield, Inc., 890 F.2d 1137, 1139 (11th Cir. 1989) (instructing the district court to remand as it had not limited itself to the administrative record).

\(^{268}\) See *Brown v. Seitz Foods, Inc. Disability Benefit Plan*, 140 F.3d 1198, 1201 (8th Cir. 1998) (affirming that the plaintiff’s effort to provide additional evidence outside the administrative record was “nothing more than a last-gasp attempt to quarrel with [the plan administrator’s] determination” (quoting Davidson v. Prudential Ins. Co. of Am., 953 F.2d 1093, 1095 (8th Cir. 1992))).

\(^{269}\) Several circuits permit district courts the discretion to consider outside evidence. See *Recupero*, 118 F.3d at 834 (allowing a range of discretion in admitting evidence suitable for judicial review); *DeFelice v. Am. Int’l Life Assurance Co.*, 112 F.3d 61, 67 (2d Cir. 1997) (granting the district court discretion if it finds “good cause to consider additional evidence”); *Casey v. Uddelahom Corp.*, 32 F.3d 1094, 1099 (7th Cir. 1994) (holding that *de novo* review is the correct standard for a bench trial, but not for a summary judgment); *Kirwan v. Marriott Corp.*, 10 F.3d 784, 789-90 (11th Cir. 1994) (holding that administrators’ decisions should be reviewed *de novo*); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1185 (3d Cir. 1991) (granting discretion to the district court to supplement the record when making its own independent benefit determinations); *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1571 (11th Cir. 1990). *Cf. Davidson v. Prudential Ins. Co.*, 953 F.2d 1093 (8th Cir. 1992) (holding where evidence was known or should have been known during administrative proceedings, the record may not be re-opened to allow submission of the evidence).


\(^{271}\) See *Bernstein v. Capitalcare, Inc.*, 70 F.3d 783, 790 (4th Cir. 1995) (allowing additional evidence where record was deficient on medical evidence); *Quesinberry v. Life Ins. Co.*, 987 F.2d 1017, 1026-27 (4th Cir. 1993) (permitting discretion as necessary due to the wide variety of
Fourth Circuit noted that an automatic rule requiring the scope of evidentiary review was inappropriate. Given that the trial court would be presented with such a wide variety of ERISA claim cases – cases involving plans with extensive administrative procedure and lengthy records to cases involving plans with limited administrative procedures and meager records; cases involving a conflict of interest where the plan administrator and payor are the same entity; cases involving complex medical issues and interpretation of plan terms – a more flexible approach to the scope of evidentiary review made more sense.

While the patients’ bill of rights does not specifically address these evidentiary issues, many of the problems confronting claimants on this issue will be resolved since a sharing of information with the claimant and with the independent review determiner is required, thus eliminating the need for the courts to worry whether all the evidence was considered. Similarly, the impending DOL regulations do not specifically address the evidentiary issues at trial since significant disclosure of materials considered at the various levels of the review process will be required, including disclosure of internal rules, guidelines, and protocols relied upon in making the adverse benefit determination.

K. Jury Trials

As is true with many of ERISA’s procedural rules, ERISA is silent on the issue of whether any of the causes of action permit trial by jury. However, federal courts have routinely denied jury trials to ERISA claimants denied benefits, because such claims are viewed as equitable in nature. The Supreme Court has affirmed this conclusion with the *Firestone* decision, ruling that trust law governed benefit claims determinations, and the *Mertens* decision, limiting administrative records presented to the district courts, but noting that in most cases, additional evidence would not be necessary for the court’s review). Cf. *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 943 (9th Cir. 1995) (permitting additional evidence “to enable the full exercise of informed and independent judgement”); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (requiring good cause in order to permit outside evidence). 272 987 F.2d at 1025-27.

273 *Id.* at 1025-26.


relief under ERISA section 502(a)(3) to traditional equitable remedies.\textsuperscript{278} However, in the context of benefit claims under the Taft-Hartley Act, as well as ERISA, the right to jury trial has been permitted.\textsuperscript{279} Similarly, the right to trial by jury is present if the claim arises under the Securities Exchange Act of 1934.\textsuperscript{280}

The proposed patients’ bill of rights and the impending DOL regulations are all silent on the issue of jury trial for benefit denial claims.

\textbf{IV. CONCLUSION}

Due to ERISA’s silence on a number of significant procedural issues, the courts have fashioned a federal common law in a variety of areas. In the context of causes for benefit claims, most courts implicitly presume that the plan sponsor will conform with the requirements of ERISA and, thus, deal fairly with the participant. However, due to the courts’ application of eleven specific ERISA procedural rules, a plaintiff’s rights are not protected, and any analysis of such rights is anything but straightforward. The courts seem torn between (1) ERISA’s legislative intent to protect participants’ and beneficiaries’ substantive rights under ERISA, with access to courts if necessary; and (2) the voluntary nature of employee benefit plans, delivered by the employer as settlor of the plan. ERISA recognizes that the employer sponsor, not the government, defines the type and level of benefits provided under these plans. Congress’ intent is to assure that rules of fairness govern in the delivery of these voluntary benefits.

In the arena of pension benefits, Congress has increasingly imposed restrictions on defined benefit plans to protect and strengthen participants’ and beneficiaries’ rights since the enactment of ERISA; the result, unfortunately, has led to the demise of many defined benefit pension plans in favor of defined contribution plans.\textsuperscript{281} The employers rationalize that if a fixed amount of payroll...
is desired to be attributed to retirement benefits, but a significantly greater percentage of payroll becomes needed for the expense and maintenance of defined benefit plans than for defined contributions, then the employers will shift to defined contribution plans to forestall an increase in the percentage of payroll actually used for paying and administering employees' benefits.

As health and disability benefits have been historically akin to defined benefits (i.e., the plan defines the benefits covered, as opposed to the benefits being defined by the level of contribution made to the plan), a growing concern is that continued regulation of such benefits will result in a major shift from a defined benefit approach to supplying these benefits to a defined contribution approach. Such concern arises sharply from the recent proposed legislation relating to patients' bill of rights which seeks not only to mandate certain health coverage for emergency care and clinical trials by employers, but to further strengthen the enforcement of benefits voluntarily provided by employers through employee benefit plans. While the various patients' bills of rights have been subject to great debate due to expected increase in expenses for employer health plans, practitioners predict that the mandated coverage provisions may be even more expensive than the liability provisions. For employers with only a fixed percentage of payroll to use for employee benefit plans and for small employers operating on a thin profit margin, the end result may be greater protections for participants' benefits, but an ever-shrinking level of benefits being provided via the employer. This paradoxical result might be considered, as a matter of public policy, to be the proverbial Pyrrhic Victory.

"does not fit the Canadian experience well." Robert L. Brown & Jianxum Liu, The Shift to Defined Contribution Pension Plans: Why Did it Not Happen in Canada?, 5 N.A. ACTUARIAL J. 3, 65 (July 2001). They conclude that "the difference in pension regulation and taxation in Canada and the United States has directly influenced plan sponsors in considering their pension objectives, costs, and risks." Id. at 76.

282 See comments made by attorneys at the American Bar Association's annual meeting, as recorded by BNA, Inc. e-mail update at http://subscribe.bna.com (August 9, 2001).