
WHAT PROCESS IS DUE IN THE ADJUDICATION OF ERISA CLAIMS?

MARK D. DEBOFSKY*

INTRODUCTION

The late Senator Jacob Javits (Republican-New York), one of the main sponsors of the Employee Retirement Income Security Act of 1974 (“ERISA”)¹ heralded the law as “the greatest development in the life of the American worker since Social Security.”² Governing retirement benefits, as well as health, life, and disability insurance provided by employers,³ at least fifty million Americans participate in ERISA-governed employee benefit plans.⁴ However, there is reason to believe that employee benefit claimants have been stripped of many of the rights and protections they enjoyed both before, and even for a period of time after, the ERISA law was enacted. Prior to ERISA, when disputes arose regarding employees’ entitlement to benefits, the parties would litigate their claims as they would any other breach of contract action before courts and juries.⁵ The passage of the ERISA law did not immediately change the status quo, because Congress granted plan participants a right in § 502 of the statute to bring a “civil action” without any constraints upon the civil procedures accorded to such cases. As the result of the Supreme Court’s 1989 watershed ruling in *Firestone Tire & Rubber Co. v. Bruch*,⁶ however, plan sponsors were permitted to write language into benefit plans giving plan administrators the discretion to

* Partner, Daley, DeBofsky & Bryant, Chicago, Illinois and adjunct professor, The John Marshall Law School, Chicago, Illinois. The author gratefully acknowledges the contributions of Donald Bogan, Jon Holder, Robert June, and Robert Liebross to this article.

1. 29 U.S.C. §§ 1001-1461 (2000).
2. 120 CONG. REC. 29, 933 (1974) (statement of Sen. Javits).
3. 29 U.S.C. §§ 1002(1), 1002(2) (2000).
4. JAMES A. WOOTEN, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 – A POLITICAL HISTORY 2 (U. Cal. Press 2005).
5. See Brief for the United States as Amicus Curiae Supporting Respondents at 10 n.7, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)(No. 87-1054), 1988 WL 1025997 (arguing for application of contract law rather than trust law in analyzing ERISA claims).
6. 489 U.S. 101 (1989).

interpret the plans' provisions or to determine the claimants' eligibility to receive benefits.⁷

The impact of *Firestone* has been dramatic. Although the Supreme Court's ruling focused solely on the standard of review applied to litigation of ERISA claims - for example, whether, and under what circumstances, a court should give deference to a benefit plan's determination - the lower courts have interpreted *Firestone* to justify the imposition of a quasi-administrative summary adjudicative process to ERISA civil actions. Without any discussion of the due process implications inherent in such a regime, courts have precluded claimants seeking reimbursement for lifesaving medical treatments, disability insurance, or life insurance benefits from conducting discovery or presenting any evidentiary challenge to the "administrative record" assembled by the claim administrator.

While many commentators have discussed the standard of review applicable to litigation of ERISA claims,⁸ little has been written about the impact of *Firestone* upon the procedure utilized to adjudicate employee benefit disputes. This article will explore that topic and will focus on how the courts have increasingly failed to protect claimants' procedural due process rights.

I. THE FIRESTONE STANDARD OF REVIEW

The major result of the *Firestone* ruling is that if a benefit plan incorporates appropriate language reserving discretionary authority,⁹ it triggers a deferential standard of court review: the benefit plan's determination will stand undisturbed unless a court finds the decision arbitrary and capricious or an abuse of discretion.¹⁰ To evaluate whether a benefit determination meets

7. *Id.* "Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115.

8. See, e.g., Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U.L. REV. 1083, 1096-1107 (2001) (discussing the various standards of review applied to ERISA claims).

9. There has been a significant amount of litigation over what plan language is adequate to reserve discretionary authority. See Kennedy, *supra* note 8, at 1114-16 (observing the lack of language reserving discretionary authority in *Firestone*); see also Diaz v. Prudential Insur. Co. of Am., 424 F.3d 635, 639 (7th Cir. 2005) (finding that absence of specific language reserving discretion abrogated application of deferential standard of review); Feibusch v. Integrated Device Tech. Inc. Employee Benefit Plan, 463 F.3d 880, 884 (9th Cir. 2006).

10. The terms are used interchangeably. See Gallo v. Amoco, Corp., 102 F.3d 918, 921 (7th Cir. 1996) (referring to abuse of discretion and arbitrary and capricious standards as equally deferential). "[T]here is only a 'semantic, not a substantive, difference' between the arbitrary and capricious and the

that standard, the court must consider whether the decision-maker “entirely failed to consider an important aspect of the problem [or] offered an explanation for its decision that runs counter to the evidence.”¹¹ The degree to which the court is to undertake such an analysis varies, however, from court to court. The Seventh Circuit has explained:

Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action.¹²

However, that approach may be too lenient, and other courts have taken the position that even a deferential review:

inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator’s decision as long as the plan was able to find a single piece of evidence-no matter how obscure or untrustworthy-to support a denial of a claim for ERISA benefits.¹³

The high water mark of due process protection of ERISA claimants, even under a deferential standard of review, is exemplified by two rulings: *Miller v. United Welfare Fund*¹⁴ and *Bedrick v. Travelers Insurance Co.*¹⁵ Both decisions demonstrate the effectiveness of pretrial discovery in revealing significant defects in the claim determination. In *Miller*, a disability benefit dispute, the parties involved in deciding the claim were shown to lack appropriate expertise,¹⁶ while in *Bedrick* a denial of medical

abuse of discretion standards in the ERISA benefits review context.” Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc., 168 F.3d 211, 214 (5th Cir. 1999) (quoting Wildbur v. Arco Chem. Co., 974 F.2d 631, 635 (5th Cir. 1992)).

11. Motor Vehicle Mfr. Ass’n v. State Farm Mutual Auto. Ins. Co., 463 U.S. 29, 43 (1983).

12. Pokratz v. Jones Dairy Farm, 771 F.2d 206, 209 (7th Cir. 1985).

13. McDonald v. Western-Southern Life Ins. Co., 347 F.3d 161, 172 (6th Cir. 2003) (citation omitted).

14. 72 F.3d 1066 (2d Cir. 1995).

15. 93 F.3d 149 (4th Cir. 1996).

16. *Miller*, 72 F.3d at 1069; see also Luby v. Teamsters Health, Welfare and Pension Trust Funds, 944 F.2d 1176, 1183 (3d Cir. 1991) (stating:

Plan administrators are not governmental agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting or other training preparing them for their responsible position, often without any expertise in or understanding of the complex problems arising under ERISA, and, as this case demonstrates, little knowledge of the rules of evidence or legal procedures to assist them in factfinding [sic].)

benefits was overturned based both on evidence of bias and insufficient clinical expertise on the part of the medical consultants to the plan.¹⁷ Yet another significant ruling on this issue is *Crocco v. Xerox Corp.*,¹⁸ a health benefit case, which pointed out the need for the plan administrators to consider the evidence presented by both sides. Depositions taken in that case established that the plan administrator only credited the opinions of a consultant hired by the plan rather than weighing all of the evidence as the ERISA law requires.¹⁹

Cases such as these have prompted at least one court to note:

[A]s the arbitrary and capricious standard requires courts to scrutinize, although deferentially, decisions by plan fiduciaries for lack of reasonableness, including the absence of substantial evidence, such deficiencies in the administrative review function can be significantly illuminated through the reasonable exercise of standard discovery devices available in federal civil practice.²⁰

However, other courts have taken a much more lenient approach to ERISA cases. For example, in *Perlman v. Swiss Bank Corp. Comprehensive Disability Plan*,²¹ the court barred the parties from examining the underlying basis for the decision, or potential biases inherent in the decision-making process while concluding:

It follows from the conclusion that review of UNUM's decision is deferential that the district court erred in permitting discovery into UNUM's decision-making. There should not have been any inquiry into the thought processes of UNUM's staff, the training of those who considered Perlman's claim, and in general who said what to whom within UNUM—all of which Perlman was allowed to explore at length by depositions and interrogatories, and on some of which the district judge relied. Deferential review of an administrative decision means review on the administrative record.²²

17. *Bedrick*, 93 F.3d at 153-54.

18. 956 F.Supp. 129 (D. Conn. 1998), *aff'd*, 137 F.3d 105 (2d Cir 1998).

19. *See id.* at 140 for the court's reasoning.

The court is not impressed by Nazemetz's claim that she lacked the medical knowledge to make an independent review of Crocco's case. The fact of the matter is she did make a medical decision: She listened to the medical opinion of one side, decided that "all the facts . . . seemed to point out that medical necessity was not proven," and denied the claim. There is no reason why she could not have sought similar information from Crocco and her psychiatrist and then made an informed and fair "medical" decision, as required by ERISA. It is exactly this type of choice, between the conflicting opinions of experts, that judges, juries, and patients must make every day in courtrooms and hospitals.

Id. (citation omitted).

20. *Nagele v. Electronic Data Sys. Corp.*, 193 F.R.D. 94, 104 (W.D.N.Y. 2000).

21. 195 F.3d 975 (7th Cir. 1999).

22. *Id.* at 981-82.

The court then added:

[W]hen there can be no doubt that the application was given a genuine evaluation, judicial review is limited to the evidence that was submitted in support of the application for benefits, and the mental processes of the plan's administrator are not legitimate grounds of inquiry any more than they would be if the decisionmaker were an administrative agency.²³

The difficulty in accepting the Seventh Circuit's analysis²⁴ is that its reasoning is circular. A court has no means of knowing whether "the application was given a genuine evaluation" absent discovery or an evidentiary proceeding. Nor does it necessarily follow that deferential review ineluctably leads to review of an administrative record. Trust law cases, which the Supreme Court cited in *Firestone* as the basis for applying the arbitrary and capricious standard of review to ERISA cases,²⁵ traditionally allow for plenary proceedings.²⁶

Those concerns have not gone entirely unnoticed. Dissenting from the majority in *Perlman*, Judge Diane Wood began by stating:

[T]he majority has misapplied the standard of review established in *Firestone Tire & Rubber Co. v. Bruch*, and has effectively precluded as a matter of law any procedural challenge to an ERISA plan administrator's decisions, thereby giving those decisions a uniquely privileged position in the entire field of administrative or quasi-administrative law.²⁷

The dissent further pointed out that the distinctions between a publicly funded program such as Social Security and a privately funded program militate against "import[ing] wholesale a body of administrative law"²⁸ and which, "in order to give content to the

23. *Id.* at 982.

24. Other courts have also deemed deferential review to mandate review on an "administrative record." See, e.g., Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 617-20 (6th Cir. 1998); DeFelice v. Am. Int'l Life Assurance Co., 112 F.3d 61, 65 (2d Cir. 1997); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993); Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1021-27 (4th Cir. 1993) (en banc); Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 380 (10th Cir. 1992); Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176, 1184-85 (3d Cir. 1991).

25. ERISA "abounds with the language and terminology of trust law." *Firestone Tire & Rubber Co.*, 489 U.S. at 110.

26. See, e.g., Barnett v. Ross, 3 A.2d 923, 925 (Pa. 1939) (in an action for breach of implied trust by fiduciary, plaintiff beneficiary may seek a bill of discovery in equity to support a claim of existence of trust and misconduct by alleged trustee); Phelps Dodge Corp. v. Brown, 540 P.2d 651 (Ariz. 1975) (jury trial conducted); Matthews v. Swift & Co., 465 F.2d 814 (5th Cir. 1972) (plenary bench trial of pension and disability claim despite arbitrary and capricious standard of review).

27. 195 F.3d at 983 (Wood, J., dissenting) (citation omitted).

28. *Id.* at 985 (Wood, J., dissenting).

rights conferred by § 1132," require exploration of the "process by which the administrator came to its conclusion."²⁹

Recent revelations have validated Judge Wood's observations by raising serious concerns about whether the ERISA law has led to wholesale deprivation of full and fair claim evaluations. Following on the heels of several judicial findings critical of the claims procedures utilized by UnumProvident Corporation, the largest disability insurer in the world,³⁰ as well as other judicial criticism of insurers' practices in adjudicating benefit disputes under ERISA,³¹ the insurance regulators of 49 states and the United States Department of Labor issued a stinging indictment of UnumProvident. The California Department of Insurance issued a similar report shortly thereafter.³² A leading ERISA-law scholar, Professor John Langbein of Yale Law School, has taken note of this situation and commented:

Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga lacks legal policy implications. On this view, a rogue insurance company behaved exceptionally badly; it got caught and sanctioned; and its fate should deter others. My reading of the events is less sanguine . . . a self-interested plan decisionmaker will take advantage of its license under *Bruch* to line its own pockets by denying meritorious claims. Unum turns out to have been a clumsy villain, but in the hands of subtler operators such

29. *Id.* at 986 (Wood, J., dissenting).

30. See Radford Trust v. First Unum Life Ins. Co. of Am., 321 F. Supp. 2d 226, 247-48 n.20 (D. Mass. 2004) (cataloguing such cases); Dishman v. UNUM Life Ins. Co. of Am., No. 96-0015 JSL, 1997 WL 906146 (C.D. Cal. May 9, 1997) (criticizing insurer's bad faith conduct in disability benefit denial).

31. See Loucks v. Liberty Life Assurance Co. of Boston, 337 F. Supp. 2d 990, 991 (W.D. Mich. 2004) (vacated following settlement) (describing court's dissatisfaction with effect of ERISA on disability insurance claims). The court began its opinion with the following observation:

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

Id.

32. *Multistate Market Conduct Study on UnumProvident* performed by the insurance commissioners of 49 states and by the United States Department of Labor, <http://www20.insurance.ca.gov/ePubAcc/Graphics/66713.pdf> (last visited June 15, 2007).

misbehavior is much harder to detect.³³

Yet the courts, for the most part, have failed to take note of this criticism and remedy the current situation in any meaningful way.

II. CONFLICT OF INTEREST

Some courts approach concerns about whether self-interested decision-making is compatible with a deferential standard of court review by giving content to a key sentence found in the *Firestone* ruling: “[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a ‘facto[r]’ in determining whether there is an abuse of discretion.”³⁴ That admonition was reiterated in *Rush Prudential HMO, Inc. v. Moran*,³⁵ an ERISA health benefits claim, where the Court stated that the abuse of discretion review should “home in on any conflict of interest on the plan fiduciary’s part,” and added, “[i]t is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest.”³⁶

Although the Supreme Court has never specified the circumstances and manner in which a conflict of interest is to be considered, there has been some recognition that when an insurer acts both as plan administrator and as the payor of benefits, this structural conflict of interest should give courts pause before granting unfettered deference to the benefit determination. Recently, the Ninth Circuit attempted to formulate a workable standard to evaluate conflicts of interest in *Abatie v. Alta Health & Life Insurance Co.*,³⁷ a life insurance case, suggesting that a conflict should be given little regard if there is no evidence of malice, self-dealing, or “a parsimonious claims-granting history.”³⁸ On the other hand, the conflict might be weighed more heavily if the plan administrator provides “inconsistent reasons for denial,” “fails adequately to investigate a claim or ask the plaintiff for necessary evidence,” “fails to credit a claimant’s reliable evidence,” or “has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record.”³⁹ The Ninth Circuit analogized conflict-weighing to a judge’s evaluation of a witness’s

33. John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, N.W. U. L. REV., 101 N.W. U. L. REV. 1315, 1321 (2007).

34. 489 U.S. at 115 (quoting RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)).

35. 536 U.S. 355 (2002).

36. *Id.* at 384 n.15.

37. 458 F.3d 955 (9th Cir. 2006) (en banc).

38. *Id.* at 968.

39. *Id.*

credibility, and suggested that extrinsic evidence beyond the claim file may be considered in order to decide "the nature, extent, and effect on the decision-making process of any conflict of interest."⁴⁰

However, even within the Ninth Circuit, differing viewpoints exist. In a concurring opinion to *Abatie*, one member of the court observed that the mere existence of the arbitrary and capricious standard of review can have deleterious consequences:

"Discretion" is not just a means by which courts can easily get rid of complicated ERISA cases. What it means in practical affairs is that, if the administrator could reasonably decide either way, then it can decide against the claimant and there is no recourse. That means a lot of people who ought to get life insurance proceeds, disability benefits, or medical expense coverage will not get the coverage they should and, under a sounder reading of the evidence, would...⁴¹

Moreover, there is substantial disagreement among the other federal courts of appeals as to how conflicts of interest are to be considered, if at all. For example, *Rud v. Liberty Life Assurance Co.*,⁴² which involved a claim for disability benefits, represents the opposite viewpoint from *Abatie*. In *Rud*, the Seventh Circuit refused to consider the structural conflict, present when an insurer serves as both administrator and funding source for the benefit payments, as grounds for diminishing deference and finding:

The ubiquity of such a situation makes us hesitate to describe it as a conflict of interest. There is no contract the parties to which do not have a conflict of interest in the same severely attenuated sense, because each party wants to get as much out of the contract as possible. How serious the conflict is depends on circumstances. If Liberty Life refuses to honor meritorious claims, it will obtain windfall profits in the short run, assuming that the premium that Andersen paid it was calculated on the expectation of a normal claims experience. But Andersen will be dismayed - it has no interest in conferring such profits on Liberty Life, thereby incurring its employees' ill will with no offsetting financial benefit to itself - and so may refuse to renew the policy when it expires, or demand a much lower premium. The latter option suggests a theoretical basis for suspecting a long-run conflict of interest: the chintzier the insurance company is in responding to benefits claims, the lower (given a competitive insurance market) the premium that Andersen will have to pay, whether to Liberty Life or to a competitor of Liberty Life, to obtain insurance.⁴³

While acknowledging that every other court outside of the Seventh Circuit has expressed concern about the conflict of interest that exists "whenever an insurer is being asked to dip into

40. *Id.* at 970.

41. *Id.* at 975 (Kleinfeld, J., concurring).

42. 438 F.3d 772 (7th Cir. 2006).

43. *Id.* at 775 (citation omitted).

its own pocket to pay a claim for benefits,”⁴⁴ the Seventh Circuit has consistently rejected that argument. The Seventh Circuit found “their acceptance would destabilize large reaches of contract law, of which ERISA is, after all, a part, since it neither requires employers to establish welfare and pension plans nor prescribes the terms of such plans.”⁴⁵ Further, despite the paternalistic nature of the ERISA statute, the court pointed out, “it is hard to see why, if the plan unequivocally authorizes the insurance company to make the conclusive determination of eligibility, the courts should rewrite the provision.”⁴⁶

While the Seventh Circuit is indeed correct that insurance arrangements are ubiquitous in the ERISA benefit world, that merely heightens the threat of such conflicts, particularly because fiduciary obligations owed by insurance companies to their shareholders are in considerable tension with ERISA’s exclusive benefit rule.⁴⁷ This rule mandates that plan fiduciaries act exclusively in the interest of plan participants and their beneficiaries for the purpose of paying benefits. Consequently, because of inconsistencies in when and how the conflict of interest is applied, a more universal solution is required.

44. *Id.* (citing *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 387-89 (3d Cir. 2000); *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561-62 (11th Cir. 1990)).

45. *Id.* at 776. The Seventh Circuit has also stated:

When the administrator is a large corporation, the firm has a financial interest, but the award in any one case will have only a trivial effect on its operating results.

* * *

We have no reason to think that UNUM’s benefits staff is any more “partial” against applicants than are federal judges when deciding income-tax cases.

Perlman, 195 F.3d at 981. See also *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 408 (7th Cir. 2004) (holding that the Chicago Mercantile Exchange may have reason to approve borderline claims in order to appease workers and attract potential employees). But see *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir. 2000) (holding that an insurance company both funding and administering benefits acts under a conflict of interest that may mitigate the arbitrary and capricious standard of review depending on the degree to which the conflict infected the claim determination).

46. *Rud*, 438 F.3d at 776.

47. 29 U.S.C. § 1104(a)(1). This provision was derived from the RESTATEMENT (SECOND) OF TRUSTS § 170 (1959), which set forth the duty of loyalty by requiring the trustee to administer the trust only for the beneficiary’s interest.

III. DOES THE ERISA STATUTE LIMIT CLAIMANTS' RIGHT TO DUE PROCESS?

A. Are ERISA Cases Review Proceedings?

Although the Seventh Circuit recently concluded, “[w]here an insurance plan gives discretionary authority to a plan administrator, ERISA provides a limited Article III review,”⁴⁸ and further found that “[l]ike a suit to challenge an administrative decision, a suit under ERISA is a review proceeding, not an evidentiary proceeding,”⁴⁹ there is significant reason to doubt the soundness of those statements. When Congress enacted the ERISA law in 1974, it authorized plan participants and their beneficiaries to bring civil actions in accordance with § 502⁵⁰ “to recover benefits due . . . under the terms of [a] plan.”⁵¹

In analyzing whether the scope of a statutorily created civil action invokes a review proceeding rather than an evidentiary hearing, the Supreme Court’s guidance in *Chandler v. Roudebush*⁵² is instructive. *Chandler* involved a claim brought by a federal employee alleging discrimination in employment pursuant to § 717(c) of the Civil Rights Act.⁵³ The lower courts had split over whether the civil action authorized by that statute was limited to a review of administrative proceedings conducted prior to suit. The Supreme Court resolved the dispute by holding that federal employees were entitled to discovery and a trial. The Court explained, “[n]othing in the legislative history indicates that the federal-sector ‘civil action’ was to have this chameleon-like character, providing fragmentary de novo consideration of discrimination claims where ‘appropriate,’ and otherwise providing record review.”⁵⁴ The Court added:

In most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like “substantial evidence,” which has

48. *Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 813 (7th Cir. 2006), *cert. denied*, 127 S. Ct. 53 (2006). In contrast, the Seventh Circuit recently ruled that when the de novo standard applies, “the district courts are not reviewing anything; they are making an independent decision about the employee’s entitlement to benefits.” *Diaz v. Prudential Ins. Co.*, 499 F.3d 640, (7th Cir. 2007)(emphasis in original).

49. *Id.* at 815 (quoting *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7th Cir. 1997)).

50. 29 U.S.C. § 1132(a).

51. 29 U.S.C. § 1132(a)(1)(B).

52. 425 U.S. 840 (1976).

53. 42 U.S.C. § 2000e-5 (2000).

54. *Chandler*, 425 U.S. at 861 (citation omitted).

"become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court."⁵⁵

Like the Civil Rights Act, nowhere in the ERISA statute itself or in its legislative history is the term "substantial evidence." Nor is the oft-cited language that the ERISA law was enacted to provide "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously"⁵⁶ a basis for foreclosing meaningful judicial review. That quotation is derived from an early version of the ERISA law that would have afforded pension claimants the opportunity to pursue a grievance or arbitration proceeding before the Secretary of Labor. However, that portion of the bill was ultimately dropped,⁵⁷ leaving claimants without administrative redress when benefit claims are denied.

Nor does the ERISA statute's inclusion of a pre-litigation appeal providing for a "full and fair review" of claim determinations⁵⁸ substitute for a hearing in benefit claims, particularly when the claim regulations⁵⁹ are compared to other ERISA provisions, such as 29 C.F.R. §§ 2560.502i-1, 2570.7, and 2570.11 (2000),⁶⁰ which explicitly provide for administrative hearings before the Secretary of Labor in other types of ERISA disputes, such as prohibited transaction claims. Thus, in the words of Professor Jay Conison, an early critic of how the courts have applied ERISA law:

Yet even if there were some basis for believing that the treatment of a benefit suit as an evidentiary proceeding would interfere with

55. *Id.* at 862 n.37 (citation omitted) (referencing 5 U.S.C. § 706 (scope-of-review provision of Administrative Procedure Act); 12 U.S.C. § 1848 (scope-of-review provision applicable to certain orders of the Board of Governors of the Federal Reserve System); 15 U.S.C. § 21(c) (scope-of-review provision applicable to certain orders of the Interstate Commerce Commission, the Federal Communications Commission, the Civil Aeronautics Board, the Federal Reserve Board, and the Federal Trade Commission); 21 U.S.C. § 371(f)(3) (scope-of-review provision applicable to certain orders of the Secretary of Health, Education, and Welfare)).

56. S. REP. NO. 93-383, at 1179 (1973) *reprinted in* 1974 U.S.C.C.A.N. 4639, 5000 (*cited in Semien*, 436 F.3d at 815; *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990)).

57. Senator Jacob Javits, one of ERISA's main sponsors, explained that opposition was raised "on grounds it might be too costly to plans and a stimulant to frivolous benefit disputes, and at their insistence it was dropped in conference." 3 LEGISLATIVE HISTORY OF ERISA, 4769 at n.4.

58. 29 U.S.C. § 1133.

59. 29 C.F.R. § 2560.503-1 (2000).

60. Also contrast 20 U.S.C. § 1415 (Individuals with Disabilities Education Act – IDEA) where despite the existence of an explicit administrative hearing procedure, courts may to consider new evidence *de novo*. While a new trial is not to be held, courts are not required to give extreme deference to the administrative determination and may consider extrinsic evidence. *Alex R. v. Forrestville Valley Cmtys. Unit Sch. Dist. # 221*, 375 F.3d 603, 611-612 (7th Cir. 2004).

“prompt resolution of claims by the fiduciary,” the rationale would still fail. For it to be plausible, one would have to add two premises: that “prompt resolution of claims” is something Congress intended for the protection of sponsors and fiduciaries; and that such protection of sponsors and fiduciaries is more important than protection of the participants’ right to receive benefits due. Merely to state these premises is to reveal their untenability.⁶¹

More recently, Professor John Langbein expressed similar concerns:

It is indeed more time-consuming to decide a case than to presume the correctness of somebody else’s self-serving decision. Because, however, Congress determined to subject ERISA-plan benefit denials to federal judicial review, and because ERISA’s celebrated [draconian] preemption provision suppresses the state law causes of action that existed for many such cases before ERISA, the proper role of the federal courts is to decide these cases fairly, and not to slough them off to biased decisionmakers.⁶²

Furthermore, ERISA’s legislative history makes it clear that civil actions brought pursuant to § 502 “are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947.”⁶³ According to *Textile Workers Union of America v. Lincoln Mills*,⁶⁴ LMRA § 301⁶⁵ requires the federal courts to “fashion from the policy of our national labor laws” a federal common law governing the interpretation of collective bargaining agreements which includes plenary proceedings that even encompass trials before juries.⁶⁶

The *Firestone* case itself further dispels any basis for interpreting the ERISA statute in a manner that excludes plenary proceedings. The Court explained, “Unlike the LMRA, ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans.”⁶⁷

61. Jay Conison, *Suits for Benefits under ERISA*, 54 U. PITTS. L. REV. 1, 57-60 (1992).

62. Langbein, *supra* note 33, at 1334.

63. H.R. REP. NO. 93-1280, at 5107 (1974) (Conf. Rep.).

64. 353 U.S. 448 (1957).

65. 29 U.S.C. § 185 (2000).

66. *Textile Workers Union*, 853 U.S. at 456; see also Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry, 494 U.S. 558, 558-60 (1990) (holding that employees’ claims of breach of collective bargaining agreement are analogous to actions for breach of contract, thus entitling the employees to a jury trial).

67. *Firestone*, 489 U.S. at 110 (citation omitted); see also 29 U.S.C. § 186(c)(2) (2000) (providing an exception to liability upon settlement). Proceedings under 29 U.S.C. § 186 of the LMRA are quite different than cases brought under the statutory section immediately preceding. Cases such as *Beam v. Int'l. Org. of Masters, Mates and Pilots*, 511 F.2d 975, 977-99 (2d Cir. 1975), have characterized LMRA proceedings as seeking review of trustees’

Perhaps the Supreme Court was also alluding to the necessity of meaningful judicial review when it commented in *Rush Prudential HMO, Inc. v. Moran*:

[ERISA] requires plans to afford a beneficiary some mechanism for internal review of a benefit denial, and provides a right to a subsequent judicial forum for a claim to recover benefits. Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations.*⁶⁸

Yet despite the foregoing, the present regime is, in the majority of courts, one of extremely lenient reviews, and not one of evidentiary hearings.

B. Are ERISA Cases Administrative Proceedings?

The root of claimants' frustration with the fairness of benefit claims litigation has been the courts' application of an administrative law framework to ERISA litigation.⁶⁹ It is easy to understand how that process has evolved. Between the importation into the ERISA law of the doctrine of administrative exhaustion in cases such as *Amato v. Bernard*,⁷⁰ and the use of terminology familiar from administrative law (such as the arbitrary and capricious standard of review) it is not surprising that courts have concluded that ERISA cases mandate administrative review procedures.

However, some courts have questioned the appropriateness of the use of an administrative law paradigm in ERISA litigation. For example, in *Van Boxel v. Journal Co. Employees' Pension Trust*⁷¹ the court warned:

determinations; however, such actions are based on disputes arising under benefit trusts where both management and labor appoint trustees. Even then, however, due process is preserved because the procedures are required to include "elemental requirements of fairness" which encompass notice, a hearing, and an opportunity to present evidence. *Sturgill v. Lewis*, 372 F.3d 400, 401 (D.C. Cir. 1966).

In contrast, the decision-maker in many ERISA claims is often an insurer. Hence, the Second Circuit marked the distinction between the LMRA and disputes relating to non-union benefit plans by explaining that "review in this case is not the examination of a dispute between an insurance company with a boilerplate contract on one hand and a consumer on the other." *Beam*, 511 F.2d at 980.

68. 536 U.S. 355, 385 (2002) (citations omitted) (emphasis added).

69. See generally Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727 (2004) (discussing the use of an administrative law paradigm in ERISA cases).

70. 618 F.2d 559 (9th Cir. 1980).

71. 836 F.2d 1048 (7th Cir. 1987).

Pension fund trusts are not administrative agencies and most of the decisions they make are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers. Certainly in a case such as the present one, pension fund trustees are not policy-makers; they are interpreters of contractual entitlements.⁷²

Likewise, in *Ramsey v. Hercules, Inc.*,⁷³ a disability benefit dispute, the Seventh Circuit acknowledged:

Crucial differences exist between findings of fact made by a private entity such as a plan administrator, and findings made by duly authorized administrative law judges, agencies, or federal district courts. Underlying the deferential review that fact findings of the latter bodies enjoy is a well established set of procedural protections that stem from the Constitution and individual statutes. Plan administrators, in contrast, neither enjoy the acknowledged expertise that justifies deferential review for agency cases, nor are they unbiased fact finders like the courts. Indeed, when the initial decision in an agency lacks the crucial procedural safeguards, the Administrative Procedure Act requires the federal courts to review both fact and law *de novo*.⁷⁴

The Eleventh Circuit reached a similar conclusion in *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*,⁷⁵ a case involving hospitalization benefits. There too, the court warned about the misuse of administrative law concepts:

Because we have restated the standard as arbitrary and capricious, the temptation exists to consult precedent regarding the use of that standard to review administrative agency decisions. We express caution, however, at wholesale importation of administrative agency concepts into the review of ERISA fiduciary decisions. Use of the administrative agency analogy may, ironically, give too much deference to ERISA fiduciaries. Decisions in the ERISA context involve the interpretation of contractual entitlements; they "are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers." Moreover, the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies. We therefore concentrate on the common law trust principles to evaluate the application of the arbitrary and capricious standard.⁷⁶

72. *Id.* at 1050.

73. 77 F.3d 199 (7th Cir. 1996).

74. *Id.* at 205 (citation omitted).

75. 898 F.2d 1556 (11th Cir. 1990).

76. *Id.* at 1564 n.7 (quoting *Van Boxel*, 836 F.2d at 1050) (citations omitted). The Seventh Circuit reiterated that finding in *Herzberger v. Standard Ins. Co.*, which also involved disability benefits. 205 F.3d 327 (7th Cir. 2000). Chief Judge Richard Posner, who also authored *Van Boxel*, pointed out the basis for the deviation of ERISA litigation into administrative law:

Application of an administrative law model is also attractive because the ERISA law provides for a “full and fair review”⁷⁷ of claims prior to suit which, as pointed out above, has led courts to require that claimants exhaust pre-suit appeals prior to resorting to litigation. In *Amato*, the court explained that ERISA’s full and fair review requirement was “apparently intended by Congress to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned.”⁷⁸ Critics have countered that the use of the word “apparently” conveys that the foregoing rationales are pure “speculation” and are without support in the statutory history of the ERISA law.⁷⁹ Thus, there is neither textual support, nor legislative history pointing to a requirement of administrative exhaustion.

Nonetheless, the push toward application of administrative law principles in ERISA cases was hastened by an influential decision issued by the Sixth Circuit. In *Perry v. Simplicity Eng’g*,⁸⁰ a disability benefits dispute, the court determined its role in adjudicating ERISA cases was limited to conducting a review of the claim “based on the record before the administrator.”⁸¹ That principle was reiterated in *Wilkins v. Baptist Healthcare System, Inc.*,⁸² where the court explained:

[W]e are satisfied that a district court should not adjudicate an ERISA action as if it were conducting a standard bench trial under Rule 52. Such a proceeding would inevitably lead to the introduction of testimonial and/or other evidence that the administrator had no opportunity to consider. A district court’s evaluation of such

What may have misled courts in some cases is the analogy between judicial review of an ERISA plan administrator’s decision to deny disability benefits and judicial review of the denial of such benefits by the Social Security Administration . . . Judicial review of the latter sort of denial is of course deferential, and it is natural to suppose that it should be deferential in the former case as well. But the analogy is imperfect, quite apart from its having been implicitly rejected by the Supreme Court in [Firestone Tire & Rubber Co. v.] *Bruch* when it determined that the default standard of review in ERISA cases is plenary review, and quite apart from the fact that the social security statute specifies deferential (“substantial evidence”) review. The Social Security Administration is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by plan administrators.

Id. at 332 (citation omitted).

77. 29 U.S.C. § 1133(2) (2000).

78. *Id.* at 567.

79. Conison, *supra* note 61, at 29.

80. 900 F.2d 963 (6th Cir. 1990).

81. *Id.* at 967.

82. 150 F.3d 609.

evidence would contravene *Perry's* mandate confining the district court's *de novo* review to the evidence contained in the administrative record. Moreover, the disposition of an ERISA action in a standard bench trial is inconsistent with ERISA's goal of providing an inexpensive and expeditious method of resolving benefits disputes.

The only exception to the above principle of not receiving new evidence at the district court level arises when consideration of that evidence is necessary to resolve an ERISA claimant's procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part.⁸³

In addition to the absence of statutory support for that conclusion, the Sixth Circuit's reasoning suffers from circularity because one cannot meaningfully mount a due process challenge unless the claimant can first investigate the fairness of the claim process through discovery proceedings.

Thus, the Eleventh Circuit's viewpoint, expressed in *Moon v. American Home Assurance Co.*,⁸⁴ appears more consistent with both the statute and with commonly held notions of civil procedure in its finding:

[Any] contention that a court conducting a *de novo* review must examine only such facts as were available to the plan administrator at the time of the benefits denial is contrary to the concept of a *de novo* review. During oral argument, American Home's counsel conceded that absent ERISA, there would be no deferential standard of review of the denial of coverage. Thus, what the Supreme Court said of a similar contention advanced in *Firestone* is equally applicable to this contention: "Adopting [this] reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than [they enjoyed] before ERISA was enacted."⁸⁵

Nonetheless, *Perry's* view of the procedures to be accorded to ERISA benefit claimants appears to have won.

83. 150 F.3d at 618 (Gilman, J., concurring) (citations omitted); see also *DeFelice*, 112 F.3d at 65-66 (2d Cir. 1997) (allowing consideration of evidence beyond the administrative record); *Koons v. Aventis Pharm., Inc.*, 367 F.3d 768, 780 (8th Cir. 2004) (stating that a trial court may hear evidence beyond the scope of that considered by a plan administrator so long as there is "good cause"); *Panther v. Sun Life Assurance Co. of Can.*, 464 F. Supp. 2d 1116, 1121 (D. Kan. 2006) (noting that the court does not apply a summary judgment standard when reviewing a denial of benefits, but rather considers evidence in the administrative record in analyzing the reasonableness of a plan administrator's decision) (citing *Olenhouse v. Commodity Credit Corp.*, 42 F.3d 1560 (10th Cir. 1994)).

84. 888 F.2d 86 (11th Cir. 1989).

85. *Id.* at 89 (quoting *Firestone*, 489 U.S. at 114).

C. Are Claimants' Due Process Rights Being Violated?

If, indeed, an administrative law model for adjudication of ERISA benefit claims is appropriate, other than the tangential comment from *Wilkins* quoted above, the due process protections inherent in administrative proceedings are entirely missing from ERISA claims and have been entirely overlooked by the courts. In his landmark article dissecting the fundamentals of administrative law, *Some Kind of Hearing*,⁸⁶ Judge Henry Friendly described the essential due process requirements in administrative adjudications: 1) an unbiased tribunal; 2) notice of the proposed action and the grounds asserted for it; 3) an opportunity to present reasons why the proposed action should not be taken; 4) the right to call witnesses, subject to reasonable limits on the number of witnesses and scope of examination, including the right to cross-examine adverse witnesses;⁸⁷ 5) the right to know the evidence at issue; 6) the right to have a decision based on the evidentiary record; 7) the right to counsel; 8) a record; 9) articulated reasons for the decision; 10) public attendance; and 11) judicial review.⁸⁸

Although practical limitations make it clear that procedural protections may vary depending on the value of the interest sought to be protected,⁸⁹ when it comes to employee benefits, the issue at stake often involves a life or death determination. In *Peruzzi v. Summa Medical Plan*,⁹⁰ a health benefit claim brought under the ERISA law, the plaintiff died after her health insurer refused to agree to reimburse the cost of cancer treatment. The court concluded the insurer had rational grounds for refusing to pay for the treatment, however, no evidentiary hearing was held to determine whether the basis for the benefit denial was supported by substantial evidence. Indeed, the court refused to even consider testimony from medical specialists establishing both the appropriateness and efficacy of the procedure at issue on the

86. Judge Henry Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267 (1975).

87. Judge Friendly cites *Greene v. McElroy* for the proposition that the right to confront adverse witnesses applies not only to criminal proceedings, but also is necessary "in all types of cases where administrative and regulatory actions were under scrutiny." Friendly, *supra* note 86, at 1283 (citing *Greene v. McElroy*, 360 U.S. 474, 497 (1959)). However, he also identifies practical limits on cross-examination in every case and suggests investigation into other models such as a board of independent physicians. *Id.* at 1285-86.

88. *Id.* at 1279-95.

89. See *Mathews v. Eldridge*, 424 U.S. 319, 348 (1976) (stating that "[a]t some point the benefit of an additional safeguard to the individual affected by the administrative action and to society in terms of increased assurance that the action is just, may be outweighed by the cost").

90. 137 F.3d 431 (6th Cir. 1998).

ground that the evidence was taken only after SummaCare rendered its final denial. Because only the materials considered by the plan administrator in making the challenged determination may be considered on appeal, we may not consider these depositions in deciding whether SummaCare's denial of coverage was arbitrary and capricious.⁹¹

Although the stakes in disability benefits disputes are arguably not as high as they were in *Peruzzi*, there can be little doubt that "decisions whether and how to ensure that disability does not lead to poverty are obviously of great societal importance,"⁹² and therefore, demand significant procedural protections.

The courts' conclusion, in the absence of discovery or any evidentiary hearing, that opinions from doctors hired by insurers "demonstrate a thorough consideration of the available information"⁹³ represents a significant deprivation of claimants' due process rights. Absent legislative authority, the courts have effectively suspended the applicability of the Federal Rules of Civil Procedure. Rule 1 of the Federal Rules of Civil Procedure mandates applicability of the Rules to all federal civil actions other than those enumerated in Rule 81, with no exception made for ERISA cases. Indeed, in *New Hampshire Fire Ins. Co. v. Scanlon*,⁹⁴ the Supreme Court explained the universality of the Federal Rules of Civil Procedure:

Summary trial of controversies over property and property rights is the exception in our method of administering justice. Supplementing the constitutional, statutory, and common-law requirements for the adjudication of cases or controversies, the Federal Rules of Civil Procedure provide the normal course for beginning, conducting, and determining controversies. Rule 1 directs that the Civil Rules shall govern all suits of a civil nature, with certain exceptions stated in Rule 81 none of which is relevant here. Rule 2 directs that "There shall be one form of action to be known as 'civil action.'"⁹⁵

Likewise, the Federal Rules of Evidence, which apply to all federal court actions,⁹⁶ are ignored. The Federal Rules of Evidence require that witnesses may only testify based on their personal knowledge⁹⁷ unless they are testifying as expert witnesses, which requires that: "1) the testimony is based upon sufficient facts or

91. *Id.* at 434 (citation omitted).

92. *Radford Trust v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 226, 240 (D. Mass. 2004).

93. See, e.g., *Semien*, 436 F.3d at 812.

94. 362 U.S. 404 (1960).

95. *Id.* at 406.

96. FED. R. EVID. 101, 1101.

97. FED. R. EVID. 602.

data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.”⁹⁸ Without evidentiary proceedings, courts have no means of discharging their gatekeeper function to ascertain whether the requirements of Rule 702 have been met.⁹⁹ Nor are courts able to fulfill the Supreme Court’s requirement set forth in *Black & Decker Disability Plan v. Nord*,¹⁰⁰ that plan administrators base their benefit determinations on *reliable* evidence. Because cross-examination is regarded as “beyond any doubt the greatest legal engine ever invented for the discovery of truth,”¹⁰¹ its disallowance in ERISA cases creates a huge void in the truth-seeking process.

Quite plainly, pre-suit appeals brought pursuant to Section 503 of the ERISA statute fail to substitute meaningfully for administrative proceedings. Such proceedings involve nothing more than the continuation of claim adjustment and lack even the basic fundamental protection inherent in an administrative proceeding—a neutral decision-maker.

Nor can the wholesale admission of medical reports adverse to claimants in ERISA claims be countenanced when comparison is made to the standards under which such reports may constitute substantial evidence in Social Security proceedings. The Supreme Court’s ruling in *Richardson v. Perales*¹⁰² is revealing in that it points out the due process protections claimants receive when medical reports are admitted into evidence:

[A] written report by a licensed physician who has examined the claimant and who sets forth in his report his medical findings in his area of competence may be received as evidence in a disability hearing and, despite its hearsay character and an absence of cross-examination, and despite the presence of opposing direct medical testimony and testimony by the claimant himself, may constitute substantial evidence supportive of a finding by the hearing examiner adverse to the claimant, when the claimant has not exercised his right to subpoena the reporting physician and thereby provide himself with the opportunity for cross-examination of the physician.¹⁰³

Richardson represents a departure from the legal residuum rule, a longstanding evidentiary principle that precludes admission of hearsay in administrative proceedings both as a

98. FED. R. EVID. 702.

99. See *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993); see also *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999) (holding that courts are required to fulfill a gate-keeping responsibility to assure the trustworthiness of scientific and expert testimony).

100. 538 U.S. 822, 832(2003).

101. 5 J. WIGMORE, EVIDENCE 1367 (J. Chadbourn ed. 1974).

102. 402 U.S. 389 (1971).

103. *Id.* at 402.

matter of procedural due process as well as fundamental fairness.¹⁰⁴ It did so, however, only after identifying the following underlying factors that “assure underlying reliability and probative value”¹⁰⁵ of such evidence. First, there were five reporting physicians who were independent and who all examined the claimant. Second, the Social Security system “make[s] for reliability and impartiality in the consultant reports.”¹⁰⁶ The system is designed to operate “as an adjudicator and not as an advocate or adversary.”¹⁰⁷ Third, the physicians’ reports were detailed, and “were based on personal consultation and personal examination and rested on accepted medical procedures and tests.”¹⁰⁸ The Court also characterized the reports as “routine, standard, and unbiased medical reports by physician specialists concerning a subject whom they had seen.”¹⁰⁹ Fourth, the reports covered a gamut of medical specialties, leading to a conclusion “that the claimant received professional examination and opinion on a scale beyond the reach of most persons and that this case reveals a patient and careful endeavor by the state agency and the examiner to ascertain the truth.”¹¹⁰ Fifth, the reports were consistent with one another and were “reached by independent examination in the writer’s field of specialized training.”¹¹¹ Sixth, the claimant was given the opportunity to subpoena the witnesses; his failure to do so precludes him “from now complaining that he was denied the rights of confrontation and cross-examination.”¹¹² Seventh, although the reports are hearsay, the “reliability and probative worth of written medical reports” is well recognized.¹¹³

104. See Leonard M. Simon, *The Weight To Be Given Hearsay Evidence By Administrative Agencies: The “Legal Residuum” Rule*, 26 BROOK. L. REV. 265, 267 (1959-60); see also B. Schwartz, ADMINISTRATIVE LAW TREATISE § 7.4 at 376 (3d ed. 1991) (stating “[t]he rules of evidence cannot be so relaxed in administrative proceedings as to disregard due process and fundamental rights. There is a fundamental distinction between the *admission* of incompetent evidence and *reliance* upon it in reaching a decision.”) (emphasis in original); John Gedid, *Hearsay Evidence in Administrative Proceedings - Pro and Con Views on the “Legal Residuum” Rule: The “Legal Residuum” Rule Should be Retained in Pennsylvania Because of Its Function to Insure Fundamental Fairness and Due Process*, 75 PA. BAR ASSN. QTLY. 1 (2004) (surveying several states’ refusal to allow hearsay evidence in administrative proceedings). But see Kenneth Culp Davis, *Hearsay in Administrative Hearings*, 32 GEO. WASH. L. REV. 689, 697 (1964) (criticizing the rule).

105. 402 U.S. at 402.

106. *Id.* at 403

107. *Id.*

108. *Id.*

109. *Id.* at 404.

110. *Id.*

111. *Id.*

112. *Id.* at 405.

113. *Id.*

Eighth, past rulings have recognized the value of such reports.¹¹⁴ Ninth, from a pragmatic standpoint, there is a necessity to allow the admission of such reports.¹¹⁵

*Gehin v. Wisconsin Group Insurance Board*¹¹⁶ is a more recent discussion of these issues. The Wisconsin Supreme Court highlighted the due process considerations necessary to assure procedural fairness in benefit disputes. *Gehin* involved a state disability benefit program and followed *Perales* in ruling:

The harm to claimants in having their income continuation insurance benefits terminated on the basis of controverted written hearsay medical reports, without an opportunity to cross-examine the authors of the reports, exceeds the burden on the Group Insurance Board to call a witness to corroborate those hearsay medical reports.¹¹⁷

Gehin also cited a Mississippi Supreme Court decision holding that the bench and bar would likely be scandalized if the Court received *ex parte*, unsworn statements of persons other than doctors, even in Workmen's Compensation cases.

While doctors occupy an important role in our scheme of things, they are, after all, merely human, and may not be considered wholly free from the frailties that beset the rest of us. There is nothing, therefore, in the fact that a witness may be a member of the medical profession that reasonably may be said to justify his exemption from the requirements and restriction which would apply to others giving testimony in an adversary proceeding. The admission of the reports constitutes reversible error.¹¹⁸

In contrast, most courts have taken an exceptionally lenient tack with respect to ERISA cases and have disregarded the legal residuum rule altogether. For example, in *Davis v. Unum Life Insurance Co. of America*¹¹⁹ reports generated by non-examining physician-employees of a disability benefit insurer were deemed sufficient to sustain a benefit denial under a deferential standard of review. The court concluded that without direct evidence of bias,¹²⁰ "[i]t is enough, in situations such as this, for the doctors to

114. *Id.* at 405-06.

115. *Id.* at 406.

116. 692 N.W.2d 572, 590 (Wis. 2005).

117. *Id.* at 590.

118. *Id.* at 589 (citing *Georgia-Pacific Corp. v. McLaurin*, 370 So. 2d 1359, 1362 (Miss. 1979)).

119. 444 F.3d 569 (7th Cir. 2006), *cert. denied*, 127 S. Ct. 234 (2006).

120. Placing the burden on the claimant to show specific bias is inconsistent with the trust law principle that when it is possible to question the trustee's duty of loyalty, no further inquiry is necessary to set aside the trustee's actions. See Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry Into Conflicted Plan Administrator Claim Denials*, 58 OKLA. L. REV. 637, 640 (2005). The recent *Abatie* ruling appears to address this issue in part. *Abatie*,

review the file and render a professional, medical opinion.”¹²¹ However, undermining the *Davis* court’s presumption of physician independence, *Bennett v. Unum Life Insurance Co. of America*¹²² recited sworn testimony from a former Unum physician describing how Unum’s “[m]edical advisors . . . are offered bonuses at a level of 25% base pay determined, in part, on company earnings. Medical advisors are also eligible to participate in stock option grants with the company upon management’s recommendation and the Compensation Committee’s approval.”¹²³ Consequently, it appears the very employees whose opinions are used to decide claims stand to profit from claim denials.¹²⁴

Nor is bias limited to situations where employees of the plan administrator are consulted in claim disputes. In *Denmark v. Liberty Life Assurance Co. of Boston*,¹²⁵ the defendant insurer failed to identify a single instance where a frequently utilized claim reviewer found a claimant to be disabled.¹²⁶ However, when courts

458 F.3d at 972-73. However, while the Ninth Circuit did not adopt a “no further inquiry” rule, the court permitted the parties to develop extrinsic evidence that would expose potential bias. *Id.* at 970.

121. *Davis*, 444 F.3d at 579.

122. 321 F. Supp. 2d 925, 933-34 (E.D. Tenn. 2004).

123. *Id.*

124. See also *Multistate Market Conduct Study*, *supra* note 32 (citing government investigations of the UnumProvident Corporation). In addition, *Moon v. UnumProvident Corp.* cautioned against judicial deference to insurers’ benefit determinations based solely on in-house staff physician file reviews. 405 F.3d 373, 381 (6th Cir. 2005). This includes a review from the same physician involved in the *Davis* case: Dr. Feagin’s role was not as a neutral independent reviewer, but as an employee of Unum. It is not enough for Unum to offer an explanation for the termination of benefits; the explanation must be consistent with the “quantity and quality of the medical evidence” that is available on the record. *Id.* *Moon* further held, in direct conflict with the Seventh Circuit’s observations, that “[w]hen a plan administrator’s explanation is based on the work of a doctor in its employ, we must view the explanation with some skepticism.” *Id.* at 381-82. See also *Evans v. UnumProvident Corp.*, 434 F.3d 866, 877 (6th Cir. 2006) (questioning file reviews in the face of critical credibility questions); *Sheehan v. Metro. Life Ins. Co.*, 368 F. Supp. 2d 228, 255 (S.D.N.Y. 2005) (finding file reviews in psychiatric claims particularly inappropriate because, “[u]nlike cardiologists or orthopedists, who can formulate medical opinions based upon objective findings derived from objective clinical tests, the psychiatrist typically treats his patient’s subjective symptoms . . .”). This evidence also illuminates Upton Sinclair’s observation: “It is difficult to get a man to understand something when his salary depends upon his not understanding it.” UPTON SINCLAIR, I, CANDIDATE FOR GOVERNOR: AND HOW I GOT LICKED (University of California Press ed., 1994) (1935).

125. No. 04012261-DPW, 2005 U.S. Dist. LEXIS 27180, at *84-86 (D. Mass. 2005).

126. See, e.g., *Gunn v. Reliance Standard Life Ins. Co.*, 399 F. Supp. 2d 1095, 1105 (C.D. Cal. 2005) (noting that the disability insurer’s claim reviewer was not an “independent” physician, but rather was a “man with a mission – to find a way to justify a denial of benefits”) vacated and remanded for

limit their review to the claim record and disallow discovery into such practices,¹²⁷ evidence of bias is impossible for claimants to obtain when they are given no means to challenge the validity of the evidence presented.

These cases therefore illustrate the need for a closer examination of whether, and to what extent, claimants seeking employee benefits are receiving fundamental due process. An examination of the Supreme Court's procedural due process jurisprudence is instructive, although not necessarily decisive because of fundamental differences between "rights" granted under the ERISA statute and rights that have been adjudicated before the high Court. For example, in *Gibson v. Berryhill*,¹²⁸ the Alabama Board of Optometry brought charges seeking to revoke the professional licenses of optometrists employed by a corporation offering discount eyeglasses. In response, the optometrists sought an injunction against the Board on grounds of bias because the members of the Board were individual optometrists whose personal livelihoods were at stake. The Supreme Court sided with the optometrists, finding it "sufficiently clear from our cases that those with substantial pecuniary interest in legal proceedings should not adjudicate these disputes."¹²⁹

Building on that precedent, *Schweiker v. McClure*¹³⁰ further defined procedural due process requirements in a quasi-judicial context. *McClure* involved a challenge to a denial of benefits under Medicare Part B that had been adjudicated by a private insurance carrier administering Medicare benefits. The Court rejected the petitioner's due process argument on the ground that the claimant was unable to rebut a presumption of neutrality by the decision-maker. The Court determined the due process challenge "would be relevant only if the carriers themselves are biased or interested."¹³¹ The court reasoned that such a conclusion could not be drawn because the federal government paid the benefits rather than the carriers' themselves, and because the United States paid the hearing officers' salaries.¹³² In contrast, the manner in which ERISA benefits are paid and adjudicated is just the opposite and is tainted by insurers' self-interest and bias.

The Supreme Court's subsequent ruling in *Concrete Pipe and Products of California, Inc. v. Construction Laborers Pension Trust for Southern California*¹³³ further establishes a basis for raising a

reconsideration, 235 Fed. Appx. 553 (9th Cir. August 9, 2007).

127. *Semien*, 436 F.3d at 813-16.

128. 411 U.S. 564 (1973).

129. *Id.* at 579 (citations omitted).

130. 456 U.S. 188 (1982).

131. *Id.* at 196.

132. *Id.*

133. 508 U.S. 602 (1993).

due process challenge as to the manner in which ERISA claims are adjudicated. *Concrete Pipe* dealt with the assessment of pension withdrawal liability under the Multiemployer Pension Plan Amendments Act of 1980.¹³⁴ An employer objected to the manner in which the actuary employed by the plan initially assessed liability. However, the Supreme Court ruled that a subsequent adjudication before an arbitrator cured any due process infirmities in the initial assessment.

Concrete Pipe's discussion of procedural due process is revealing when contrasted with the adjudication of benefits under the ERISA law. In Part III of the opinion, the Court considered *Concrete Pipe's* challenge that the trustee's assessment of liability violated its due process rights. Acknowledging the possibility of trustee bias despite ERISA's fiduciary duty of loyalty,¹³⁵ the Court explained:

“Justice,” indeed, “must satisfy the appearance of justice, and this stringent rule may sometimes bar trial [even] by judges who have no actual bias and who would do their very best to weigh the scales of justice equally between contending parties.” This, too, is no less true where a private party is given statutory authority to adjudicate a dispute, and we will assume that the possibility of bias, if only that stemming from the trustees' statutory role and fiduciary obligation, would suffice to bar the trustees from serving as adjudicators of *Concrete Pipe's* withdrawal liability.¹³⁶

Nonetheless, that conclusion did not save the day for *Concrete Pipe* because the subsequent arbitration cured the taint of bias by affording the employer the opportunity to challenge the withdrawal liability determination made by the trustee's actuary. However, the Court did note “[w]here an initial determination is made by a party acting in an enforcement capacity, due process may be satisfied by providing for a neutral adjudicator to ‘conduct a *de novo* review of all factual and legal issues.’”¹³⁷

The Court then addressed *Concrete Pipe's* argument that the arbitration itself was constitutionally infirm. The employer (*Concrete Pipe*) contended that its burden of overcoming the determination of withdrawal liability was so onerous it would be impossible to meet. The Court thus framed the due process issue presented by that argument:

134. Pub. L. No. 96-364, 94 Stat. 1208 (1980) (codified as 29 U.S.C. §§ 1381 to 1461 (2000)).

135. 29 U.S.C. § 1104(a)(1).

136. *Concrete Pipe*, 508 U.S. at 618 (quoting *Marshall v. Jerrico, Inc.*, 446 U.S. 238, 243 (1980)) (citations omitted).

137. *Id.* (citations omitted). *Cf. Withrow v. Larkin*, 421 U.S. 35, 58 (1975) (stating “[c]learly, if the initial view of the facts based on the evidence derived from nonadversarial processes as a practical or legal matter foreclosed fair and effective consideration at a subsequent adversary hearing leading to ultimate decision, a substantial due process question would be raised”).

[I]f the employer were required to show the trustees' findings to be either "unreasonable or clearly erroneous," there would be a substantial question of procedural fairness under the Due Process Clause. In essence, the arbitrator provided for by the statute would be required to accept the plan sponsor's findings, even if they were probably incorrect, absent a showing at least sufficient to instill a definite or firm conviction that a mistake had been made. In light of our assumption of possible bias, the employer would seem to be deprived thereby of the impartial adjudication in the first instance to which it is entitled under the Due Process Clause.¹³⁸

The Supreme Court resolved the problem, though, by construing the statute to allow the arbitrator authority to independently consider any factual issue. Thus, the claimant's rights were protected by a *de novo* proceeding before a neutral, unbiased decision-maker.

Both *McClure* and *Concrete Pipe* therefore establish a framework against which the adjudication of ERISA claims must be measured. However, the issue is not without controversy. Legal scholars, such as Frank Easterbrook, who now sits as Chief Judge of the United States Court of Appeals for the Seventh Circuit, maintain that how much procedure is due is a function of what the legislature has ordained.¹³⁹ At the opposite pole is Professor Martin Redish, who takes a more fundamentalist approach.¹⁴⁰ Redish asserts that the position of "positivists" such as Easterbrook is undermined by the Supreme Court's first ruling on the due process clause, *Murray's Lessee v. Hoboken Land & Improvement Co.*,¹⁴¹ where the Court pointed out:

It is manifest that it was not left to the legislative power to enact any process which might be devised. The [due process] article is a restraint on the legislative as well as on the executive and judicial powers of the government, and cannot be construed as to leave congress free to make any process "due process of law," by its mere will.¹⁴²

Without getting into the details of the debate, which includes Judge Easterbrook's exegesis of the origins of procedural due process in the Magna Carta and its development in the writings of Lord Coke and Blackstone, the Supreme Court has undoubtedly recognized a constitutionally based right to procedural due process, albeit one without clearly defined parameters.

138. *Id.* at 626 (citations omitted).

139. Frank H. Easterbrook, *Substance and Due Process*, 1982 SUP. CT. REV. 85 (1982).

140. Martin H. Redish & Lawrence C. Marshall, *Adjudicatory Independence and the Values of Procedural Due Process*, 95 YALE L.J. 455 (1986).

141. 59 U.S. 272 (1855).

142. *Id.* at 276.

Redish maintains the core value in procedural due process is the right to an independent adjudicator, and all other procedural safeguards aimed at accuracy in the determination process such as notice, hearing, counsel, and cross-examination are subordinate:¹⁴³

Judge Henry Friendly has noted that as the independence of the decisionmaker [sic] increases, the need for other procedural safeguards decreases. Of course, the use of traditional procedural guarantees can enhance the accuracy of the decision of a well-intentioned and independent adjudicator. But if the costs of such procedures in a particular situation are prohibitive, the use of an independent adjudicator can at least assure that a good-faith effort to achieve an accurate conclusion will be made. The converse is not true.¹⁴⁴

Yet, in ERISA cases, claims are first decided by a biased source whose findings are presumed correct and given deference by the district court without the claimant having any tools to meaningfully challenge the basis for the denial. Under the framework of *Concrete Pipe*, that presents a significant constitutional question about the current regime.

However, before that issue can be addressed, there remains a further impediment to the application of Constitutional due process considerations to the ERISA law. As Professor Paul Verkuil recently pointed out:

In American law, the term private due process is an oxymoron. Under our Constitution, there must be a “state action” to trigger the Due Process Clause of the Fourteenth Amendment or a comparable federal action to invoke the Fifth Amendment. Therefore, process is only *due* when the public sector, rather than the private, takes action. Without such action, process is theoretically a matter of choice or discretion.¹⁴⁵

That principle, along with the Supreme Court’s ruling in *American Manufacturers Mutual Insurance Co. v. Sullivan*¹⁴⁶ rejecting a due process challenge due to a lack of “state action,” raises a significant question about the availability of a procedural due process challenge to claim determinations made by ERISA plan administrators. In *Sullivan*, a private insurer’s withholding of medical cost reimbursements in workers’ compensation disputes, while seeking a determination of medical necessity, was upheld against a due process challenge. The Court also questioned whether there was even a property interest at stake since payments were preconditioned on two extrinsic factors that had

143. Redish & Marshall, *supra* note 140, at 476-77.

144. *Id.* at 477 (citing Friendly, *supra* n.86).

145. Paul R. Verkuil, *Privatizing Due Process*, 57 ADMIN. L. REV. 963, 964 (2005) (emphasis added).

146. 526 U.S. 40 (1999).

not yet been met: that the injury was work-related, and that the expenses were reasonable and necessary. Thus, the Court could find no due process issue.

Similarly, in *Black v. Unumprovident Corp.*,¹⁴⁷ a district court rejected a due process challenge to a disability benefit claim brought under the ERISA law, explaining:

Generally, the Constitution's procedural due process safeguards are triggered only by conduct that constitutes state action. Conduct of a private entity amounts to state action when it acts in a judicial or quasi-judicial capacity pursuant to a legislative delegation of authority. Here, however, ERISA does not delegate any adjudicative functions to an otherwise private party. Namely, ERISA does not mandate that a particular entity perform any specific task or create presumptions with regard to any entity's determination. Rather, ERISA merely establishes "minimum standards" on those performing reviews of initial adverse benefit determinations. Absent the requisite legislative delegation of adjudicative authority, Defendant's conduct remains that of a private, rather than state, actor. Accordingly, the Court rejects Plaintiffs' constitutional argument and finds Defendant is entitled to judgment on its Motion to Dismiss Count II.¹⁴⁸

*Downs v. Liberty Life Assurance Co.*¹⁴⁹ likewise rejected an argument that the denial of a disability benefit claim brought pursuant to the ERISA statute violated due process. The court found a lack of state action, citing *DeShaney v. Winnebago County Department of Social Services*,¹⁵⁰ where the Supreme Court explained the purpose of the due process clause "was to protect the people from the State, not to ensure that the State protected them from each other. The Framers were content to leave the extent of governmental obligation in the latter area to the democratic political processes."¹⁵¹ The court concluded, "ERISA does not specifically delegate any adjudicative functions to an otherwise private party."¹⁵² The court also found no property interest in the claim since Downs lacked an unconditional right to the benefits he was seeking.¹⁵³

The major flaw in both *Black* and *Downs* is in the courts' findings that "ERISA does not specifically delegate any adjudicative functions to an otherwise private party."¹⁵⁴ On the contrary, whether or not Congress intended such a delegation, the

147. 245 F. Supp. 2d 194 (D. Me. 2003).

148. *Id.* at 199 (citations omitted).

149. No. 3:05-CV-0791-R, 2005 U.S. Dist. LEXIS 22531, (N.D. Tex. Oct. 5, 2005).

150. 489 U.S. 189 (1989).

151. *Id.* at 196.

152. *Downs*, 2005 U.S. Dist. LEXIS 22531, at *18.

153. *Id.* at *24.

154. *Id.* at *18.

manner in which courts give deference to the findings of ERISA plan administrators that internally review their own decisions¹⁵⁵ is indistinguishable from the adjudicative functions granted to administrative agencies under laws such as the Social Security Act¹⁵⁶ and the Administrative Procedure Act.¹⁵⁷ Hence, under the Court's analysis in both *McClure* and *Concrete Pipe*, the delegation under ERISA of adjudicative authority to a biased private actor has created a significant due process deprivation of the right to a statutorily guaranteed full and fair review.

Moreover, a point missed in both *Black* and *Downs* is that the claimed due process violation in ERISA litigation is not directed against the specific actions of private insurers or plan administrators. As the Seventh Circuit explained in *Rud*,¹⁵⁸ "each party wants to get as much out of the contract as possible."¹⁵⁹ Instead, the due process issue that arises in litigation of ERISA claims is, as it was in *Concrete Pipe*, derived from the rights the statute itself created, such as the right to a "full and fair review"; or, more properly, from the courts' interpretations of the statute.

A significant caveat in the *Sullivan* ruling supports such a conclusion. The Court left open the possibility that a property right claim could be dependent on the cause of action itself.¹⁶⁰ The Supreme Court's decision in *Logan v. Zimmerman Brush Co.*,¹⁶¹ which found a due process violation where an employment discrimination claimant was deprived of the opportunity to adjudicate his claim due to a procedural shortcoming beyond his control. The Court reasoned that the Due Process Clause protects the right to meaningfully pursue a cause of action, finding "[a] claimant has more than an abstract desire or interest in redressing his grievance . . ."¹⁶² Moreover, the Court expressly determined that the cause of action itself was a substantially protected property interest. The Supreme Court's *Firestone* decision, therefore, cannot be read to have constitutionally granted deference to a non-Article III, or even to a non-Article I, decision-maker without retaining claimants' basic due process rights when

155. 29 U.S.C. § 1133.

156. 42 U.S.C. § 401 *et seq.* (2000).

157. 5 U.S.C. § 553 (2000).

158. See 438 F.3d at 778 (holding that the defendant insurance company failed to comply with its duties as an ERISA fiduciary).

159. *Id.* at 775.

160. The Supreme Court noted, "Respondents do not contend that they have a property interest in their claims for payment, as distinct from the payments themselves, such that the State, the argument goes, could not finally reject their claims without affording them appropriate procedural protections. We therefore need not address this issue." *Sullivan*, 526 U.S. at 61, n.13 (citations omitted).

161. 455 U.S. 422 (1982).

162. *Id.* at 430.

the decision-maker is biased, and traditional notions of a fair and impartial adjudication are absent. Under the canon of statutory construction set forth in *Concrete Pipe*, courts are to construe unclear statutory language in a manner that comports with constitutionality.¹⁶³ Given an explicit congressional intent that the ERISA law was enacted for the protection of plan participants and their beneficiaries,¹⁶⁴ any construction of the civil action right granted by § 502 of the ERISA statute that presumes a delegation of adjudicatory authority to private actors, without constitutional guarantees of due process in ensuing court proceedings is entirely misplaced.

CONCLUSION

The Supreme Court made it clear in *Firestone* that benefit claimants should not receive less protection “than they enjoyed before ERISA was enacted.”¹⁶⁵ However, that is precisely what has resulted from *Firestone* due to the lower courts’ interpretations of that ruling as allowing the imposition of an administrative law paradigm to the adjudication of ERISA claims without the corresponding due process protections inherent in administrative proceedings. If, indeed, the pre-litigation appeal brought pursuant to ERISA § 503 substituted in a meaningful way for an administrative determination, claimants would be afforded much greater protection. However, the bare minimum requirement of a neutral decision-maker is absent from that process, and claimants also lack the right of cross-examination, as well as the other protections identified in *Richardson v. Perales* that promote evidentiary reliability and protect against inaccurate claim determinations. In its place, medical judgments and disability determinations are made by fact-finders who lack neutrality and whose decisions are based on unchallengeable hearsay from consultants whom the Supreme Court has acknowledged “may

163. 508 U.S. at 628-29.

164. 29 U.S.C. § 1001(b).

165. 489 U.S. at 114. Prior to ERISA’s enactment, pension and welfare benefit claims were litigated as breach of contract actions. *See, e.g., Matthews v. Swift & Co.*, 465 F.2d 814, 816 (5th Cir. 1972) (stating that non-contributory pension plan rights are contractual rights); *Stopford v. Boonton Molding, Co.*, 265 A.2d 657, 667 (N.J. 1970) (stating promises to pay a pension upon performance should not be in an employer’s contract); *Cox v. Washington Nat'l Ins. Co.*, 520 S.W.2d 76, 80 (Ct. App. Mo. 1974) (interpreting one claim pursuant to contract laws); *Antram v. Stuyvesant Life Ins. Co.*, 287 So. 2d 837, 839-40 (Ala. 1973) (noting most insurance policies are akin to contracts).

have an ‘incentive to make a finding of “not disabled” in order to save their employers money and to preserve their own consulting arrangements.’¹⁶⁶

There are several potential remedies, however. First, Congress may need to be called upon to expressly guarantee a trial *de novo* in ERISA claims, which may even include jury trials.¹⁶⁷ To the extent due process is defined by the statute itself, the absence of specific procedures in the ERISA law arguably justifies the current regime in the eyes of those who view due process from a positivist viewpoint. While the need for such a fix is more evident in cases adjudicated under the arbitrary and capricious standard of review, its necessity is also required under the *de novo* standard because many courts have also deemed cases adjudicated under that standard as review proceedings.¹⁶⁸ Thus, so long as courts are applying an administrative law approach to deciding ERISA cases, claimants must be given the opportunity to have their claims fully and fairly resolved.

Absent a legislative solution, just as the problem was created by the Supreme Court’s *Firestone* ruling, the resolution is within the power of that tribunal. Accepting a case for review that presents the issues raised in this article will give the Court an opportunity to set the lower courts back on a path that maintains due process protections for benefit claimants. To be sure, the Supreme Court made it clear in *Firestone* that a deferential standard of review is permissible in ERISA cases. But *Firestone* never directed any limitation upon the scope of the evidence and procedures available under the arbitrary and capricious standard or any other available standard of review for that matter.¹⁶⁹ The Supreme Court needs to make that clear and expand upon its comment in *Rush Prudential* that the ERISA law was never

166. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 832 (2003) (quoting Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130, 1139 (C.D. Cal. 2001)).

167. See *Lamberty v. Premier Mill Work & Lumber Co., Inc.*, 329 F. Supp. 2d 737 (E.D. Va. 2004) (denying a motion to strike the jury demand); *Bona v. Barasch*, No. 01 Civ 2289 (MBM), 2003 U.S. Dist. LEXIS 4186, at *103 (holding that ERISA plaintiffs are entitled to jury trial where they seek money damages).

168. See, e.g., *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 518 (1st Cir. 2005), cert. denied, 546 U.S. 937 (2005) (stating that “the fact that judicial review is *de novo* does not itself entitle a claimant to a trial or to put on new evidence”).

169. See, e.g., *Head v. Lutheran Gen. Hosp.*, 516 N.E.2d 921, 926 (Ill. App. Ct. 1987) (finding that despite application of an arbitrary and capricious standard to a hospital’s termination of a physician’s staff privileges, the case was decided by a jury which was instructed as to the meaning of the term “arbitrary and capricious”).

intended to create a “lenient regime of reviewing benefit determinations.”¹⁷⁰

Any effort to call upon the Supreme Court to rectify the current situation will, however, no doubt trigger fears of a tidal wave of ERISA litigation that could swallow up the entire workload of the federal courts. As noted earlier in this article, many courts have justified the application of an administrative law model by seeking refuge in ERISA’s legislative history for the proposition that ERISA cases were to be resolved “inexpensively and expeditiously.”¹⁷¹ Nonetheless, fear of increased litigation was rejected by the Supreme Court in *Firestone* as a justification to impose an arbitrary and capricious standard of review as a default rule.¹⁷² Nor is there a rational basis for such concern. As a matter of economics, claimants face a strong deterrent against pursuing wide-ranging expensive discovery and a jury trial when a claim has modest value, as in most cases. Furthermore, the Federal Rules of Civil Procedure contain a mechanism in Rule 16 that gives district judges the authority to maintain tight control over pretrial proceedings to expedite litigation and discourage wasteful pretrial activities. Consideration should also be given to the likelihood that the availability of discovery and the possibility of trials would promote more settlements and less litigation if plan administrators were faced with more careful scrutiny as to the accuracy of their claim decisions.

Moreover, the vast majority of cases could be resolved through trials on the papers, a procedure recommended by several courts of appeals¹⁷³ as a creative means of balancing the cost of litigating a smaller value claim against the economics of a full-blown jury trial.¹⁷⁴ Presumably, both plan administrators and claimants share a common goal of compensating claimants who present meritorious claims. However, the current system removes any incentive for plan administrators to perform a thorough and objective claim analysis. Nor do claimants have any means of exposing deficiencies and inaccuracies in the claim determination.

Therefore, due process must be restored to the ERISA law in order to make meaningful the protections promised by Congress in the law’s preamble:

170. *Rush*, 536 U.S. at 385.

171. *Perry*, 900 F.2d at 967.

172. 489 U.S. at 114-15.

173. See, e.g., *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1094-95 (9th Cir. 1999) (declaring that a district court may use a record containing exhibits and documents to try the case giving significance to the administrator’s internal review process).

174. See Morton Denlow, *Trial on the Papers: An Alternative to Cross-Motions for Summary Judgment*, 46 FEDERAL LAWYER 30, 30-34 (Aug. 1999) (exploring a trial on the papers as a time and work-saving judicial device).

It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions,¹⁷⁵ and ready access to the Federal courts.

175. 29 U.S.C. § 1001(b).