What is ERISA?

by Mark D. DeBosky

Introduction

ERISA, an acronym for the Employee Retirement Income Security Act of 1974,[1] is one of the most important federal laws ever passed by Congress, but hardly anyone knows what it is or what it does. Congress passed the ERISA law:

> To protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.[2]

Despite those lofty goals, ERISA seems to have taken on a new meaning which one federal judge described as "Everything Ridiculous Imagined Since Adam."[3] Judge William Acker, Jr., who came up with that whimsical replacement for ERISA's acronym in a judicial opinion, later wrote:

> Since writing Florence Nightingale, I have changed my mind. ERISA is beyond redemption. No matter how hard the courts have tried, and they have not tried hard enough, they have not been able to elucidate ERISA in ways that will accomplish the purposes Congress claimed to have in mind.[4]

This article will attempt to explain why Judge Acker was right.

ERISA's Scope

Although both the U.S. House of Representatives and Senate passed ERISA bills in 1974 after years of debate, each chamber's bill addressed only retirement benefits. The law's focus was aimed at remedying two issues that had arisen in the preceding years– the Studebaker Corporation bankruptcy and the corrupt influence of organized crime over pension funds. When Studebaker stopped making cars in 1966, the workers learned their promised pensions were gone and they had no remedy whatsoever. The recent movie, "The Irishman," with Al Pacino and Robert DeNiro, was ostensibly about Jimmy Hoffa and the Teamsters, but was really about ERISA since a main theme of the movie had to do with pension funds. Who knew?

ERISA was intended to prevent another Studebaker situation by establishing reporting and disclosure requirements, along with fiduciary standards and vesting of retirement benefits, and the creation of a new agency, the Pension Benefit Guaranty Corporation, that guaranteed workers would receive payments in the event the pension sponsor went out of business. Those requirements insured that retirement funds be held in trust for the benefit of workers; and the ERISA law also included measures to prevent pension funds from being misused by criminals.

But something big happened in Congress during the summer of 1974 that changed the scope of ERISA. No, it was not Richard Nixon's impeachment hearings. It was that the reconciliation of the House and Senate versions of ERISA in Conference Committee created a whole new type of ERISA-governed benefit, the welfare plan benefit. According to the ERISA law, a "welfare plan" was defined as:

> Any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or

unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).[5]

Obviously, employers provided health, life, and disability benefits to their employees prior to ERISA's enactment. Indeed, the concept of "welfare" benefits was well known to union employees who received union-management jointly managed welfare benefits governed by the 1947 Taft-Hartley Act as part of their collective bargaining agreements. But what was new in 1974 after ERISA's passage was that all private sector health, life, and disability benefits came under ERISA's umbrella regardless of whether the benefits were insured or self-funded by employers. The only exceptions made were plans sponsored by federal, state, and local government entities. Also exempted were plans sponsored by religious organizations for their employees, the so-called "church plan" exception, although the Internal Revenue Code allows church plans to opt in to ERISA coverage.[6]

The Impact of ERISA

Congress' decision to place welfare benefits under ERISA's umbrella has had a huge impact on personal injury litigation along with other first-party claims involving disability, life, accidental death, and health insurance. The reason can be summed up in one word – preemption. The ERISA statute contains a broad preemption provision[7] that preempts any state law that "relates to" employee benefit plans. State laws subject to ERISA preemption are not limited to statutes, but also include regulations, ordinances, causes of action, and common law. Thus, while a lawsuit against a health insurer would normally be brought as a breach of contract action, if the insurance at issue was an employer-sponsored fringe benefit, a breach of contract claim is preempted and replaced by an ERISA statutory claim.[8] Even certain aspects of divorce law, such as uniform laws enacted in most states that automatically terminate a spousal life insurance beneficiary designation upon the entry of a judgment for dissolution of marriage are preempted.[9] In addition, other well-established claims, such as the right to bring a "bad faith" claim against an insurer that denies an insurance

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claim without a reasonable basis, is preempted if ERISA is involved.[10] Even worse, the Supreme Court has even deemed incidental and consequential damages preempted.[11]

An exception to preemption is made for state laws that regulate insurance,[12] but the exception applies only to insured plans – ERISA still preempts laws regulating insurance as to self-funded plans that look identical to insured plans.[13] So, for example, anti-subrogation laws that prohibit health insurers from obtaining reimbursement from personal injury settlements and judgments are only applicable as to insured plans but have no impact on self-funded plans governed by ERISA such as union-sponsored plans.

ERISA preemption is so powerful that in some instances it is known as "field" or "complete" preemption. An illustration is a Supreme Court ruling in *Aetna Health, Inc. v. Davila* that held the Texas Patient Bill of Rights law was preempted by ERISA and precluded patients from suing their health plans for making benefit decisions that resulted in physical injury.[14] Despite a civil procedure doctrine known as the "well-pleaded complaint" rule, the Supreme Court found that regardless of the form of a pleading, if the matter relates to a claim for benefits under an ERISA plan, the cause of action is preempted. The Supreme Court has repeatedly explained the only causes of action that may be brought against an ERISA-governed plan by a claimant are the six remedial provisions contained in ERISA Section 502(a).[15]

As a result of ERISA preemption, lawsuits against group health and disability insurers, which were once garden-variety breach of contract actions, have been transformed into ERISA cases with consequences that will be discussed below. ERISA has also taken over lien resolution in personal injury cases, which will also be discussed in more detail below.

Anatomy of an ERISA Case

But wait. It gets worse. Although the ERISA statute provides for concurrent state court jurisdiction of suits seeking recovery of benefits,[16] an ERISA case is always removable to federal court[17] regardless of the amount in controversy.[18] ERISA does have a very generous venue provision that essentially allows for nationwide venue of most claims,[19] but courts have upheld choice of venue provisions contained in benefit plans that restrict venue to a specific location that may be distant from where the claimant lives.[20] To the extent state laws regulating insurance are applicable, courts have also applied choice of law provisions in ERISA plans as well, which can have the effect of precluding a resident of a state from having the protection of their home state's laws.[21]

ERISA also has quirky rules about who may be sued. For years, courts construed a section of the ERISA statute to require that plaintiffs could only sue the benefit plan itself rather than insurance companies that decide claims and pay benefits.[22] Fortunately, that misreading of the statute has now both been acknowledged and rectified; and it is permissible to sue the insurance company responsible for making the claim determination as well as paying the benefits due under the plan.[23]

Jury trials are not permitted in ERISA benefit cases. The rationale offered by courts for barring juries is an assertion that ERISA benefit claims are equitable in nature. However, there are numerous rulings describing ERISA claims as contractual in nature.[24] The Seventh Amendment to the U.S. Constitution guarantees the right to trial by jury as to breach of contract cases.[25] Yet jury trials continue to be disallowed in ERISA cases.

Before a claimant even gets to court, though, most courts require 'administrative exhaustion" of claims.[26] The basis for doing so is an ERISA statutory provision that entitles claimants to a "full and fair review" of a denied claim.[27] Claim exhaustion is excused only in limited circumstances – when the claimant is denied access to an appeal, where an appeal would be futile, and if there is a dire emergency requiring an immediate resolution.[28]

The U.S. Department of Labor has issued detailed regulations governing the claim and appeal process,[29] and there are often good reasons to pursue a pre-litigation appeal, especially since the consequences of not doing so could result in dismissal of a lawsuit. However, a recent opinion from the sixth circuit has questioned the basis for the exhaustion requirement.[30] Judge Amul Thapar authored a concurring opinion in a case involving disability benefits raising doubts about the administrative exhaustion requirement in ERISA claims because it is an extra-statutory judge-made obligation rather than one imposed by Congress. However, no court has yet invalidated the requirement

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altogether.

The biggest obstacle often faced by plaintiffs in ERISA cases, though, is the standard of judicial review. The ERISA statute does not specify a standard of review that courts must utilize in adjudicating benefit claim disputes. However, the Supreme Court found in the seminal case of *Firestone Tire v. Bruch* that the default standard or review should be the *de novo* standard.[31] The Court nonetheless permitted benefit plans to incorporate language that would trigger a deferential review standard requiring courts to give deference to the plan's determination.[32] Although there was and still remains some controversy as to what language is required, in most federal circuits, wording that requires the claimant to submit "satisfactory proof" will not suffice and there needs to be a clear, unambiguous statement in the plan document that the plan administrator has discretionary authority to interpret the plan and/or to render a benefit determination.[33] Moreover, in order for the discretionary authority to be effective, including the necessary language only in the summary plan description but not in the plan is insufficient.[34]

The difference between the *de novo* standard of review and a deferential standard is often consequential. According to a study from the Health Policy Institute compiling the outcome of ERISA benefit cases under the two standards of review, claimants won only 28 percent of the time when the court reviewed the decision deferentially but were successful in 68 percent of cases brought under *de novo* review.[35] Under the *de novo* standard, the parties come to court on an equal playing field, but when a claim is reviewed deferentially under the abuse of discretion standard of review, which, under ERISA is synonymous with an arbitrary and capricious standard, the court defers to the decisionmaker and overturns the benefit determination only if the court finds the decision was not only wrong but unreasonable as well.[36]

Another huge difference between the two standards is how the court conducts the proceedings in the case. In the seventh circuit, claimants are entitled to a trial under the *de novo* standard.[37] In other circuits, though, the court reviews a claim record without a thumb on the scale deferring to one party or the other.[38] Under the arbitrary and capricious standard of review, courts review a claim record,[39] although there is some debate over what that review consists of – whether it searches the record to find some

support for the decision or requires an examination of the entire record to determine the reasonableness of the claim determination.[40] There is also a dispute over the procedural vehicle to be used by the parties to present their cases to the court. The eighth circuit recently pointed out the inappropriateness of summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure because benefit claim records inherently contain factual disputes.[41] However, other courts view summary judgment as a "vehicle" to present a dispute to the court, while in other instances Rule 52 is utilized to essentially hold a bench trial on a stipulated record.[42]

When the Supreme Court issued its ruling in *Firestone,*[43] it acknowledged the possibility of the claim administrator deciding cases under a conflict of interest but did not offer clarity on the issue until it decided *Metropolitan Life Ins. Co. v. Glenn*[44] in 2008. That ruling found that when the same party both adjudicates a claim and is the funding source for payment of benefits, it operates under a structural conflict of interest that must be taken into consideration by a court reviewing a benefit claim denial. The court deciding the matter must consider a combination of factors that might give the conflict greater or lesser weight, such as the insurance company's history of biased claim administration in determining the adequacy of the articulated basis for the claim denial.

However, regardless of whether and how a conflict of interest is assessed, ERISA litigation is usually conducted using a quasi-administrative law framework even though there is no provision in the ERISA statute or in its legislative history that even hints at the possibility that benefit claim adjudications should be resolved on a review of a record rather than by trial. What courts have seemingly failed to grasp is that ERISA cases differ dramatically from the closest administrative parallel from which ERISA civil procedure has devolved – Social Security disability benefit disputes. Like the ERISA law, a statutory provision in the Social Security Act provides for federal court jurisdiction over cases involving benefit denials.[45] But that is where the similarity ends. Unlike ERISA cases, Social Security claims are heard by administrative law judges before reaching the federal courts. Such hearings entail sworn testimony; and claimants have the right to subpoena adverse witnesses.[46] Thus, when a federal court reviews a Social Security administrative record, the claimant

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has received due process protections. ERISA cases, in contrast, reach federal courts after a claim has been denied and typically after a claim appeal. However, an ERISA claim appeal is not made to a judicial officer or an unbiased hearing examiner. Instead, it is decided by an insurance claim adjuster, and there is no opportunity for cross-examination of adverse witnesses.

What makes the application of an administrative law type adjudication even more problematic is that ERISA cases also depart from other civil actions heard in federal court in yet another significant manner – discovery is severely curtailed. Some courts have issued a near-blanket rule precluding all discovery in cases decided under a deferential standard of review.[47] However, in cases decided under the *de novo* standard, courts will often permit more extensive discovery.[48] The *Glenn* ruling has also opened the door a crack to allowance of some discovery under the arbitrary and capricious standard of review since evidence showing a conflict of interest is rarely discernable from the record.[49]

Remedies

When the late Ohio State University football coach Woody Hayes was asked why his teams rarely threw the forward pass, he responded by saying that three things can happen when the quarterback throws a pass and two of them are bad. ERISA cases are the same. There are three potential outcomes in an ERISA case – the claimant can win, the claimant can lose, or the court can remand the claim to the party that previously denied the claim, which often results in reiteration of the denial. Remands are peculiar to ERISA and have no statutory basis whatsoever. While administrative determinations are subject to remand to administrative agencies, there is no statutory basis for remands of ERISA cases, as Judge Eric Murphy of the sixth circuit recently pointed out in a concurring opinion.[50]

The ERISA law authorizes claimants to bring a "civil action" to seek redress for a benefit denial.[51] Under the Federal Rules of Civil Procedure, there is only one form of civil action, and the Rules apply to all such cases.[52] Nowhere in the Federal Rules is there any provision for remands of civil actions from a district court to a private party. Indeed, under Article III of the U.S. Constitution, federal courts are required to issue final judgments of conclusive character, and remands run afoul of that directive. Yet courts frequently remand ERISA cases rather than issuing a clearcut determination in favor of one side or the other.

If the court rules for the plaintiff, though, victory may be pyrrhic because damages are limited to an award of benefits. As mentioned above, the Supreme Court has ruled the remedial provisions of the ERISA law do not permit any remedies that supplant or supplement the enumerated remedies. With respect to a plaintiff's recovery, therefore, the only available remedies are limited to the benefits due under the terms of the governing benefit plan. However, courts have recognized that if benefits are monetary, the recovery can include prejudgment interest,[53] but not disgorgement of profits that may have been earned by investing the money that was owed to the claimant.[54]

ERISA also contains an explicit fee-shifting provision.[55] There is no prevailing party requirement in that statute. All that is needed to trigger eligibility to recoup fees according to

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the Supreme Court ruling in *Hardt v. Reliance Standard Life Insur. Co.* is "some success on the merits."[56] Thus, even a remand can be enough to trigger a fee award,[57] although most courts require consideration of the following factors:

1) the degree of the offending parties' culpability or bad faith;
2) the degree of the ability of the offending parties to satisfy personally an award of attorney's fees;
3) whether or not an award of attorney's fees against the offending parties would deter other persons acting under similar circumstances;
4) the amount of benefit conferred on members of the pension plan as a whole; and
5) the relative merits of the parties' positions.[58]

The seventh circuit alternatively uses a "substantial justification" test borrowed from the Equal Access to Justice Act[59] to determining if fees are to be awarded, i.e., "meaning [the position taken by the losing party is] something more than nonfrivolous, but something less than meritorious—and taken in good faith, or if special circumstances make an award unjust."[60] Despite the references to "bad faith," that term has not been interpreted to mean subjective bad faith or ill will. Instead, the term has been construed to mean that a party has taken a position that is not meritorious.[61] In awarding fees, there is no requirement that fees must be proportional to the recovery in view of the ERISA statute's purpose.[62] Finally, there is a modest presumption in favor of an award of fees to the winning party.[63]

Other than the remedies enumerated above, there are no other remedies available under ERISA regardless of the egregiousness of the denial or the harm suffered by the plaintiff. Consequently, there is no significant deterrent against unreasonable behavior by insurers or plan administrators.

Issues Specific to Recoupment of Health Benefits

Since the Supreme Court has heard no fewer than four cases involving the rights of insurers to recoup payments out of personal injury settlements or judgments, and the importance of this issue to attorneys handling personal injury, products liability, and medical malpractice claims, a discussion of those cases is warranted. The first ruling addressing the issue was *Great West v. Knudson*.[64] The insurer in that case attempted to recoup medical expenses it had incurred from

monies placed into a special needs trust that was set up to provide ongoing care to a severely injured plaintiff. Much to the surprise of the health insurance industry, the Supreme Court ruled that Great West's claim was barred. The Court determined that since the benefits at issue were paid by an ERISA-governed plan, the plan's rights were cabined by the ERISA statute, and the only relief it could seek was equitable. Since the funds at issue were not specifically identifiable, the Court ruled that Great West was seeking legal, not equitable, restitution and that its claim was precluded.

Unfortunately for the plaintiffs bar, that did not end the saga. The next case to reach the Supreme Court was *Sereboff v. Mid Atlantic Medical Services, Inc.*[65] In that ruling the Court avoided the problem in *Knudson* by pronouncing the recoupment provision in the subject policy was analogous to an attorney's lien and that the payment by the insurance company to reimburse medical expenses that Sereboff incurred on account of a third-party's conduct was conditional and subject to recoupment once a settlement fund was created. *Sereboff* restored insurers' right to recoupment that was temporarily lost following the issuance of *Knudson,* but still left open the question of whether the recovery could be mitigated by other equitable considerations.

Those issues were resolved in *U.S. Airways v. McCutchen,*[66] which addressed whether the "make whole doctrine" or "common fund doctrine" could defeat the insurer's lien in whole or in part. Under the make whole doctrine, the right of reimbursement would be entirely defeated if the claimant did not receive a recovery that made him whole for his injuries, such as what occurred in *McCutchen* where the combination of the tortfeasor's liability insurance and McCutchen's underinsured motorist coverage were insufficient to fully compensate him for his severe injuries. The common fund doctrine is an equitable doctrine that requires a party who receives payment out of a fund created by another party to pay its share of the attorneys' fees and costs expended to create the fund.

In *McCutchen,* the Court determined that neither the make whole doctrine, nor any other equitable defense, was available to defeat an insurer's reimbursement claim. However, the Court found the common fund doctrine was a "gap-filler" that would apply unless the plan at issue explicitly contained language that would disallow its

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application. Finding the U.S. Airways health benefit plan did not explicitly bar the operation of the common fund doctrine, the Court ruled that U.S. Airway's reimbursement claim had to be reduced to pay the plan's share of the attorneys' fees that were incurred by McCutchen's personal injury lawyer.

Following the Supreme Court's ruling, when McCutchen's case was remanded to the district court, that court determined that while the summary plan description permitted reimbursement out of the underinsured motorist benefits McCutchen received, the underlying plan did not, which resulted in a substantial reduction in the reimbursement owed to the U.S. Airways benefit plan. What occurred on remand thus illustrates the importance of obtaining the plan document and not merely relying on the summary plan description in evaluating the plan's rights when a reimbursement claim is asserted.

Finally, in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan,*[67] the Supreme Court ruled against a benefit plan seeking reimbursement of expenses it had paid to a tort victim because the plan waited too long to seek recovery. Although the health benefit plan included language that supported its reimbursement claim, because the plan failed to take action to assert its claim until after the settlement funds had been distributed, the Court determined the plan's claim was no longer equitable since it was asserted against the plan participant's general assets. As a result, the Plan lost its right to recoup the medical expenses it had paid following Montanile's injuries.

These are all significant cases that have had tremendous impact upon personal injury litigation. Unfortunately, as a result of cases such as *McCutchen,* the common fund doctrine has been explicitly disavowed in an increasing number of plans and recoupment efforts have become more aggressive.

Conclusion

ERISA is a complex law that has been made even more incomprehensible by court rulings that have transformed a large swath of ordinary insurance litigation into federal claims that have perversely given claimants less protection than they enjoyed prior to ERISA's enactment. The original intent behind ERISA's passage was to protect employees' rights with respect to retirement benefits. However, out of concern that "welfare" benefit plans were also being mismanaged, Congress

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expanded the scope of the ERISA law at the last minute without considering of the consequences of doing so.

Through a series of subsequent Supreme Court rulings, over 100 years of legal developments with respect to insurance litigation were thrown out the window. Doctrines such as *contra proferentem,* which requires courts to construe ambiguous insurance policy provisions in favor of policyholders, are often displaced by the "discretion" accorded insurers to interpret the terms of the policy, even if the interpretation is both self-serving and not even the most reasonable reading of a contested provision. Even the idea of granting discretion to insurers' claim determinations is contrary to an understanding of the vast economic disparity between individual consumers and multi-billion-dollar insurance companies and the need to even the playing field. And without deterrents such as an award of "bad faith" damages and jury trials, insurers have little incentive to pay heed to the fiduciary obligations imposed on them by ERISA.[68] Compounding all of these deficiencies is a regime of claim adjudication that resembles judicial review of Social Security claim denials, but which lacks a key component protective of claimants' rights – a hearing before a neutral factfinder.

The good news is that a number of federal appellate judges have recently begun to take note of the anomalies present in ERISA litigation. However, unless or until the Supreme Court or Congress steps in, there is little chance of ending the current regime. The more the rising chorus of judicial criticism is heard by judges who are deciding ERISA cases, the greater the likelihood of reform. Until that happens, though, the fight goes on – one case at a time.

Endnotes

1 29 U.S.C. § 1001 *et seq.*

2 29 U.S.C. § 1001(b).

3 *Florence Nightingale Nursing Service Inc. v. Blue Cross and Blue Shield of Alabama* 832 F.Supp. 1456 (N.D.Ala. 1993).

4 Acker, "Can the Courts Rescue ERISA," 29 Cumb.L.Rev. 285 (1999).

5 29 U.S.C. § 1002(1).

6 29 U.S.C. § 1003.

7 29 U.S.C. § 1144.

8 29 U.S.C. § 1132(a)(1)(B).

9 *Egelhoff v. Egelhoff,* 532 U.S. 141 (2001).

10 *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987).

[11] *Id.*

[12] 29 U.S.C. § 1144(b)(2)(A) – known as the "savings clause."

[13] 29 U.S.C. § 1144(b)(2)(B) – known as the "deemer clause."

[14] *Aetna Health, Inc. v. Davila,* 542 U.S. 200 (2004).

[15] 29 U.S.C. § 1132(a).

[16] 29 U.S.C. § 1132(e)(2).

[17] *Metropolitan Life Insurance Company v. Taylor,* 481 U.S. 58 (1987)

[18] 29 U.S.C. § 1132(f).

[19] 29 U.S.C. § 1132(e)(2).

[20] *In re Mathias,* 867 F.3d 727 (7th Cir. 2017).

[21] *Ellis v. Liberty Life Assur. Co. of Boston,* 958 F.3d 1271 (10th Cir. 2020); but see *Curtis v. Hartford Life & Acc. Ins. Co.,* 2012 U.S. Dist. LEXIS 5423, 2012 WL 138608 (N.D. Ill. January 18, 2012) (finding choice of law provision did not control since employer was based in and only had operations in Illinois).

[22] 29 U.S.C. § 1132(d). The requirement of suing the plan itself rather than the party responsible for satisfying the judgment has led to anomalous results. In *Kirby v. Guardian Life Ins.Co.,* 231 P.3d 87 (N.M. 2010), a plaintiff who won a judgment against a "plan" had to take the case to the New Mexico Supreme Court to obtain the right to garnish the insurance company after the "plan" refused to satisfy the judgment.

[23] *Larson v. United Healthcare Ins. Co.,* 723 F.3d 905 (7th Cir. 2013).

[24] *Larson,* 723 F.3d at 911, found: "An ERISA § 502(a)(1)(B) claim is 'essentially a contract remedy under the terms of the plan.'"

[25] *Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry,* 494 U.S. 558, 564-65 (1990).

[26] *Denton v. First Natl. Bank of Waco*, 765 F.2d 1295, 1300 (5th Cir. 1985); also see *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980).

[27] 29 U.S.C. § 1133.

[28] *Powell v. A.T.T. Communications, Inc.,* 938 F.2d 823 (7th Cir. 1991).

[29] 29 C.F.R. § 2560.503-1.

[30] *Wallace v. Oakwood healthcare, Inc.,* 954 F.3d 879 (6th Cir. 2020) (Thapar, J., concurring).

[31] *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989).

[32] In Illinois, along with approximately 25 other states, insured plans that contain clauses that would trigger deferential review are invalid. *See,* 50 Ill. Admin. Code § 2001.3. In *Fontaine v. Metro. Life Ins. Co.,* 800 F.3d 883 (7th Cir. 2015), the Seventh Circuit held that the Illinois regulation was not preempted by ERISA.

[33] *See, e.g., Herzberger v. Standard Insurance Company,* 205 F.3d 327 (7th Cir. 2000).

[34] *See, e.g., Schwartz v. Prudential Ins. Co.,* 450 F.3d 697 (7th Cir. 2006).

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The Seventh Circuit ruling presaged a subsequent Supreme Court ruling in *Cigna Corp. v. Amara,* 563 U.S. 421 (2010), which explicitly held that the plan administrator's rights are derived from the plan document and not the summary plan description required to be disseminated to plan participants by 29 U.S.C. § 1022.

[35] Study available at http://www.erisa-claims.com/library/Georgetown%20Study.pdf.

[36] *Holmstrom v. Metro. Life Ins. Co.,* 615 F.3d 758 (7th Cir. 2010).

[37] *Krolnik v. Prudential Ins. Co.,* 570 F.3d 841 (7h Cir. 2009).

[38] *Noga v. Fulton Fin. Corp. Empl. Benefit Plan,* 19 F.4th 264 (3d Cir. 2021).

[39] *Perlman v. Swiss Bank Corp.,* 195 F.3d 975 (7th Cir. 1999).

[40] *See, e.g., Michael J.P. v. Blue Cross & Blue Shield of Texas,* 2021U.S. App. LEXIS 28704, 2021 WL 4314316 (5th Cir. September 22, 2021) (unpublished) (Oldham, J., concurring).

[41] *Avenoso v. Reliance Standard Life Ins. Co.,* 19 F.4th 1020 (8th Cir. 2021)

[42] *Id.*

[43] See n.31.

[44] 554 U.S. 105 (2008).

[45] 42 U.S.C. § 405(g).

[46] *Richardson v. Perales,* 402 U.S. 389 (1971).

[47] *See, Perlman,* n. 38.

[48] *See, Quesinberry v. Life Ins. Co. of N. Am.,* 987 F.2d 1017, 1027 (4th Cir. 1993) (identifying factors that would permit discovery - "claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.").

[49] *Dennison v. MONY Life Retirement Income Sec. Plan,* 710 F.2d 741 (7th Cir. 2013).

[50] *Card v. Principal Life Ins. Co.,* 17 F.4th 620 (6th Cir. 2021) (Murphy, J., concurring).

[51] 29 U.S.C. § 1132(a).

[52] Federal Rules of Civil Procedure – Rules 1 and 2.

[53] *See, e.g., Gorenstein Enterprises, Inc. v. Quality Care-USA, Inc.,* 874 F.2d 431 (7th Cir. 1989).

[54] *Rochow v. Life Ins. Co. of N. Am.,* 780 F.3d 364 (6th Cir. 2015). Although the Sixth Circuit had initially approved a disgorgement remedy (737 F.3d 415), on

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rehearing, that determination was reversed, although the Supreme Court has subsequently deemed a disgorgement remedy an appropriate equitable remedy in *Liu v. Securities and Exchange Comm.,* 140 S.Ct. 1936 (2020).

[55] 29 U.S.C. § 1132(g).

[56] *Hardt v. Reliance Standard Life Ins. Co.,* 560 U.S. 242, 256 (2010).

[57] *Gross v. Sun Life Assur. Co. of Canada,* 880 F.3d 1 (1st Cir. 2018).

[58] *Hakim v. Accenture U.S. Pension Plan,* 901 F.Supp.2d 1045, 1052 (N.D. Ill. 2012).

[59] 28 U.S.C. § 2412.

[60] *Id.*

[61] *Production and Maintenance Employees' Local 504 v. Roadmaster Corp.,* 954 F.2d 1397, 1404 (7th Cir. 1992).

[62] *Anderson v. AB Painting and Sandblasting, Inc.,* 578 F.3d 542 (7th Cir. 2009).

63 Hakim, n. 55, 901 F.Supp.2d at 1054.

[64] 534 U.S. 204 (2002).

[65] 547 U.S. 356 (2006).

[66] 569 U.S. 88 (2013).

[67] 577 U.S. 136 (2019).

[68] 29 U.S.C. § 1104(a)(1) requires that plan administrators act exclusively in the interest of plan participants and their beneficiaries. The Supreme Court emphasized those fiduciary obligations in *Glenn, supra.* n. 43, which ruled that insurers adjudicating ERISA benefit claims are required to utilize "higher-than-marketplace quality standards." 554 U.S. 105, 115.

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