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\*A previous version of this article was published in *For The Defense*. (See Patrick W. Begos, *Carefully Balanced by Design: Using Congressional Policy to Persuade the Court*, FOR THE DEFENSE, September 2008, at 52.) This represents the author's final version, including an analysis of the United States Supreme Court's recent decision in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008).

You're standing in a room, holding a book in your hands. Another person walks in, and shouts, "Put that book down immediately!" You turn and ask the reason for the demand. Which reason would you find more persuasive: "Because I said so!" or "It's a rare first edition and you must wear gloves when handling it or you'll damage the paper."

Unless you happen to be five years old, chances are good you'll find the second explanation more persuasive, and more likely to result in the desired outcome. Why? Because it provides a logical, persuasive explanation for the request. Nobody likes being told that they must do something just because.

The same logic applies to ERISA claim disputes. Many of the rules and procedures may be counter-intuitive to lawyers or judges who have not handled many ERISA disputes. Simply telling the judge that she has to decide the issue one way, because other courts have said so, may motivate her to look for a way around the rule.

The truth is, you can give reasons why ERISA litigation is the way it is. In many cases there is a persuasive argument that the ruling you are requesting will advance important congressional policies underlying ERISA. At the very least, educating the court on the pertinent congressional policies will allow the court to put your request in its proper context, and will lessen the possibility of a decision that actually harms those important policies.

**Congressional Policy**

In the 1950s, Congress began studying welfare and pension funds covered by collective bargaining agreements. After years of hearings, it concluded its studies and investigations with the following: "The most serious single weakness in this private social insurance complex is . . . the too frequent practice of withholding from those most directly affected, the employee-beneficiaries, information which will permit them to determine (1) whether the program is being administered efficiently and equitably, and (2) more importantly, whether or not the assets and prospective income of the programs are sufficient to guarantee the benefits which have been promised to them." S.Rep.No. 1440, 85th Cong., 2d Sess., 12 (1958); see *Malone v. White Motor Corp.*, 435 U.S. 497, 5061 (1978).

By the time ERISA was enacted in 1974, Congress still wanted to address related problems: "Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 326-27 (1997). In order to advance those goals, ERISA "established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Id.*

Though this particular congressional interest seems to say that plan administrators must be kept from harming individual participants, the truth is that this interest focused on the plan as a whole, rather than individual claimants: "A fair contextual reading of the statute makes it abundantly clear that its draftsmen were primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985). But see *LaRue v. DeWolff, Boberg & Assocs., Inc.* 128 S.Ct. 1020, 1025 (2008) ("our references to the 'entire plan' in *Russell*, which accurately reflect the operation of § 409 in the defined benefit context, are beside the point in the defined contribution context").

Regardless of whether Congress was focusing on the plan as a whole or on individual participants, one can certainly expect claimants to argue that upholding their claim in full will be advancing this policy interest.

This is only part of the Congressional policy story, however. Congress was concerned not only with ensuring that employees got the benefits they were promised, but also with encouraging employers to promise benefits in the first place by, among other things, reducing the cost of those benefits. Thus, Congress announced that ERISA was intended: "to encourage the maintenance and growth of [benefit plans]; [and] . . . to maintain the premium costs of such system at a reasonable level [.]” 29 U.S.C. § 1001b(c) (2, 5).

The Supreme Court has recognized that the important policies

underlying ERISA are in tension, and it has instructed courts “to take account of competing congressional purposes, such as Congress’ desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.” *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

It is obvious how claimants can use the congressional policy of protecting employee’s rights to benefits to argue for a “pay” decision. This is part of the difficulty facing defense counsel in such disputes. Many ERISA claim disputes evoke sympathy for the plaintiff right out of the gate, as the claimant often is sick, elderly, or widowed. The individual before the court may be suffering because of the plan administrator’s decision that he or she is not entitled to a benefit.

In contrast, the defendant is typically a large employer or an insurance company. Paying the claim will not break the defendant’s back. Moreover, most ERISA claim disputes that find their way to court are “tough” cases, with at least some facts favoring a “pay” decision. Because Congress expressly stated that it wanted to increase the likelihood that beneficiaries will receive their full benefits, it may not take much for a court to start off with an inclination to give the plaintiff the benefit of the doubt. Making them whole certainly would advance congressional policy, right?

When faced with a dispute between a sympathetic plaintiff and a deep-pocketed defendant, it can be hard to see how the congressional goal of encouraging employers to establish benefit plans is relevant. The challenge for defense counsel is to make the court see and understand that the way the court handles and decides *this* individual case can advance or harm important congressional policies that go beyond the parties in the courtroom at that moment.

A good starting point is the Supreme Court’s observation in *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993), that, in enacting ERISA, Congress “resolved innumerable disputes between powerful competing interests—*not all in favor of potential plaintiffs* [emphasis added].” This helps to start the court off at equilibrium; though Congress wanted to protect employees’ rights to benefits, it had other, equally important interests as well.

Another point to make is that courts should not permit their reaction to tough cases to create law that harms the rights of other actual or prospective plan participants. In other words, the court should be mindful of the “public interest in encouraging the formation of employee benefit plans” *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

Millions of workers benefit from plans that their employers voluntarily established. For example, employers provide disability insurance to 30 percent of the work force, and they have

purchased \$7 trillion in life insurance for employees. *Life Insurers Fact Book*, 101 (2005). Employers also provide more than 90 percent of the private health insurance in force, *Economic Report of the President 86* (2006). Most of these employers can reduce, or even discontinue, these benefits if they wish. There can be no question that an employer's decisions to establish and continue a benefit plan is based, in no small part, on the cost of the plan.

The court cannot simply focus on the individual claimant, but must be cognizant of the larger universe of employees who do not have disputed claims and who depend on benefit plans. If courts react to sympathetic plaintiffs by requiring administrators to pay benefits that should not be paid, or by insisting that administrators jump through unreasonable procedural hoops at the administrative or litigation stages, those courts certainly will make benefit plans more expensive.

A more expensive plan is one that an employer is more likely to discontinue or reduce in scope or coverage. As the Supreme Court recognized in *Egelhoff v. Egelhoff*, 532 U.S. 141, 149–50 (2001), any burden placed on employers is “ultimately borne by the beneficiaries.” So plaintiffs who are angling for sympathy, or courts who are inclined to offer it, must understand that they are not merely asking to take money from the pocket of an employer or insurer, but, ultimately, from the pockets of other employees.

With that overview, let's now look at some specific issues that arise in ERISA claim litigation, and how congressional policy can aid defense counsel in moving the court in the right direction.

### **Preemption**

Plaintiffs' attorneys often will attempt to assert state law claims against an ERISA plan administrator. It's possible they don't know any better. It's also possible, though, that they try to hammer the same point in case after case, and hope to find a judge who will agree with them. The most likely state law claims are for bad faith or unfair claim practices. Though it is easy enough to cite the broad preemption provisions in ERISA—and they are very broad—it can only help to explain the policy underlying the preemption: “[T]he detailed provisions of [ERISA] set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.” *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

As the Supreme Court reiterated in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004), “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent

to make the ERISA remedy exclusive and is therefore pre-empted.”

A plaintiff may argue that the state legislature or state court also was looking to advance important interests when it passed the consumer-protection law at issue, or when it established the common-law rule being applied. Shouldn't the state's interests be protected as well? Not according to Congress and the Supreme Court: “Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries.” *Egelhoff v. Egelhoff*, 532 U.S. 141, 149–50 (2001).

The reasoning for this conclusion is clear when viewed in light of the congressional policy. An employer that establishes a benefit plan “undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.” *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9 (1987). This is especially true when employers employ workers in several states; it would certainly increase costs, and decrease the likelihood that the employers will provide robust benefits, if they were required to vary their administration of those benefit plans depending on the residence or workplace of individual employees.

### **Litigation Procedures**

There are always plaintiffs' attorneys who live to push the envelope in ERISA benefits litigation. You know who they are. When opposing one of these attorneys, you may feel that he or she is more concerned with chipping away at ERISA procedures than in achieving a quick, favorable result for the client.

Such attorneys will fight for as much discovery as possible (even if it has no value in a particular case). They may argue, repeatedly, that courts should routinely conduct trials in ERISA matters when any fact is in dispute. They may even argue that jury trials are permissible in ERISA claims. If such lawyers can get one judge to agree, even a little, with one of their positions, they will take that decision to the next judge, and argue for another little push to the envelope.

There is no question that arguments like these have to be met head on, and on the merits. But the opposition can be made more powerful by framing it in the context of congressional policy.

As an example, the Second Circuit permits district courts to expand the administrative record on *de novo* review when it

finds “good cause” to do so. However, there arose a conflict among district courts as to when the requisite “good cause” existed. Some courts held that the presence of a “structural conflict”—*i.e.*, a single entity determining claims and paying benefits—was *per se* good cause to expand the record. Others held that more was needed to establish good cause.

The issue came to the Second Circuit in *Locher v. First Unum Life Ins. Co.*, 389 F.3d 288 (2d Cir. 2004). In presenting the issue to the court, defense counsel took care to explain that routinely expanding the administrative record in *de novo* cases would harm multiple congressional policies. It would penalize plans where the employer affirmatively chose, for reasons sufficient to it, to designate a single entity to decide claims and pay benefits. It would increase the cost of claim litigation and therefore the cost of the benefit plan. It would place the Second Circuit at odds with other circuits, harming the interest of national uniformity.

The Second Circuit accepted and endorsed the policy argument, holding that a structural conflict did not provide *per se* good cause to expand the record: “[A] *per se* rule is inconsistent with the congressional purposes and goals of ERISA. . . . [B]ecause claims reviewers and payors are often interconnected, a *per se* rule would allow additional evidence to be presented at the district court level in almost every circumstance on the basis of a presumed conflict of interest. A *per se* rule would also eliminate the appropriate incentive for a claimant to submit all available evidence regarding the claimant’s condition to the insurance company upon first submitting a claim. *Cf. Masella*, 936 F.2d at 105 (noting claimant’s obligation at the administrative level to “provide particulars regarding the claimant’s condition”). Accordingly, a *per se* rule would undermine the significant ERISA policy interests of minimizing costs of claim disputes and ensuring prompt claims-resolution procedures. *See Pilot Life*, 481 U.S. at 54; *Varity Corp. v. Howe*, 516 U.S. 489, 497, 134 L. Ed. 2d 130, 116 S. Ct. 1065 (1996) (indicating that courts should take into account Congress’s “desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans”)[.]” *Locher*, 389 F.3d at 295.

Might the Second Circuit have issued the same decision even if defense counsel had not made the policy arguments? Perhaps. But submitting policy arguments to a court makes it more likely that the court will adopt and address those policy arguments (if it agrees with your position, of course!). And decisions explaining why certain procedural rules are essential to advancing ERISA policies will certainly be helpful to defense counsel in future cases. So making policy arguments now will likely make your job easier in the future. Not to mention making it more difficult for aggressive plaintiffs’ lawyers to push the envelope in the other direction.

### Plan Design

Claimants or their attorneys sometimes will complain that specific

plan provisions are unfair. They may argue that a plan is not generous enough because it contains offset provisions that serve to reduce the benefits paid by the plan. This type of provision is common in disability plans, for example, where Social Security disability benefits are routinely offset against plan benefits.

But just as Congress permitted employers to decide whether to provide benefits *at all*, it also permitted employers to choose what benefits to provide, and under what terms: "Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). This flexibility applies to all aspects of plan design: "employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Dis. Plan v. Nord*, 538 U.S. 822, 833 (2003). In essence, when an employer chooses to provide its employees benefits that it is not obligated to give, the employee cannot complain that the benefit was not sufficiently generous or came with strings attached.

Claimants also have routinely complained about the employer's decision to grant discretionary authority to the administrator. Perhaps no aspect of plan design is more important in claim disputes than discretionary authority. Attacks on the deferential standard of review—and they have been frequent—can easily play to the well-earned sense of authority of many judges. Telling a judge that he or she *must* defer to the decision of an insurance company can be an uncomfortable message for defense counsel to deliver. Indeed, over the years, most circuits established rules permitting courts to use the existence of a conflict of interest to reduce, or even eliminate, the deference to which an administrator's determination is otherwise entitled.

The Supreme Court recently rejected those rules in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (2008), in which it held that courts must conduct a deferential review even where the administrator determines claims and pays benefits. In so holding, it explained that it did not want to "adopt[] a rule that in practice could bring about near universal review by judges *de novo* - *i.e.*, without deference - of the share of ERISA plan claims denials. Had Congress intended such a system of review, we believe it would not have left to the courts the development of review standards but would have said more on the subject." *Glenn*, 128 S. Ct. at 2350.

*Glenn* held that a conflict of interest can function as a tiebreaker when a claim determination is sufficiently close to the line between reasonable and unreasonable, but it otherwise expressly declined to establish a "detailed set of instructions" by which courts could implement this tiebreaker process. 128 S. Ct. at 2352.

The Circuits will no doubt provide their own gloss to *Glenn* in the coming months. To aid that process, defense counsel should emphasize the significance of *Glenn*'s central holding—that a court can never take away the discretionary authority that an

ERISA plan gave to the administrator. The Fourth Circuit explained, shortly before *Glenn*, how the employer's right to give deference to the administrator advances core congressional policies: the plan sponsor's power to give discretionary authority to the administrator advances core congressional policies: "Under no formulation, however, may a court, faced with discretionary language like that in the plan instrument in this case, forget its duty of deference and its secondary rather than primary role in determining a claimant's right to benefits. The abuse of discretion standard in ERISA cases protects important values: the plan administrator's greater experience and familiarity with plan terms and provisions; the enhanced prospects of achieving consistent application of those terms and provisions that results; the desire of those who establish ERISA plans to preserve at least some role in their administration; and the importance of ensuring that funds which are not unlimited go to those who, according to the terms of the plan, are truly deserving . . . Thus, the language of discretion in an ERISA plan is a message to courts, counseling not judicial abdication, to be sure, but a healthy measure of judicial restraint." *Evans v. Eaton Corp. LTD Plan*, 514 F.3d 315, 323 (4th Cir. 2008).

In that same decision, the Fourth Circuit reemphasized the "particular significance" that deferential review has in ERISA benefits litigation: "ERISA's preamble refers to the "interests of employees and their beneficiaries" no fewer than four times in three paragraphs, 29 U.S.C. § 1001 (2000); no one doubts that the statute exists to protect employees' access to benefits, *Firestone*, 489 U.S. at 113, 109 S.Ct. 948. And yet a cavalier approach to the deference owed ERISA fiduciaries who contract for it would likely disserve that purpose, whatever the call on our compassion in a particular case, for the fact is that the price of greater coverage would almost certainly be lower benefits levels and lower levels of plan formation. For more than thirty years, then, courts have balanced the need to ensure that individual claimants get the benefits to which they are entitled with the need to protect employees and their beneficiaries as a group from a contraction in the total pool of benefits available. At any point, Congress could have intervened. But the delicate balance persists. [internal quotes, brackets and citation omitted]" *Id.* at 326.

## Conclusion

There is no question that ERISA provides many litigation benefits. But it doesn't provide them as a boon to employers, administrators and their lawyers. Instead, the preemption of state laws, limited litigation, flexible plan design, and (especially) the availability of deferential review, are direct results of the careful balancing act that Congress engaged in when it created ERISA. There can be little question that the growth in employee benefits since the 1970s has been due, in no small part, to the balance that Congress chose.

As any child on a see-saw quickly learns, however, balance is something that has to be actively maintained. It is the job of

defense counsel to constantly remind courts that the plaintiff at bar is not merely an isolated individual looking for benefits, but a member of a larger class of existing and future beneficiaries whose rights can be injured *in absentia* by the court's decision. Courts cannot and should not allow a call for compassion in an individual case to supplant the goal of increased benefits across the board. By describing the relevant congressional policies to the court, defense counsel can help to ensure that the court understands what interests are really at stake, and acts to protect them.

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