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ERISA: License to Cheat, Lie, and Steal for the Disability Insurance Industry

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by Loren M. Lambert

Introduction
There is an increasingly popular notion that modern litigation is an evil that must be stamped out at all costs. This belief has not only been propounded by the uninformed, but has been championed by some of our leading legal scholars, judges, and legislators. They have sought to rarefy litigation by creating unnecessary legal complexity, stripping litigation of its essential components, gutting administrative agencies of staff and money, limiting attorneys fees, and completely eliminating adjudication of some claims.

This trend is reminiscent of individuals who desire optimum physical health without exercise or moderate consumption. All that is needed is a bit of surgery, some electrical stimulation, copious amounts of cellulite reducing cream, and the latest magic pharmacopoeia. This same approach is applied to litigation. The power brokers propose that optimum justice can be obtained through radical surgery, intellectual sophistry, copious amounts of judicial neglect, and a magic statutory bullet here or there. The problem is that, just as optimal physical health requires consistent physical activity and disciplined consumption; adequate justice also requires vigorous intellectual labor and disciplined processes. This will be true as long as imperfect beings live in a defective world.

Hence, litigation, while less than perfect, should not be a byword to be whispered in quiet places beyond the hearing of the young, weak, and uneducated. Moreover, in the long run, modern litigation is neither inefficient nor evil. Litigation is the machine of justice, exquisitely crafted, well oiled, and highly refined through centuries of evolution and fine tuning. Many of its components are necessary elements in our modern world. Contrarily, trial by ordeal, used in past centuries, though quick to churn out resolutions, was inefficient, brutal, and arbitrary. To the other extreme, the dismantling and disfigurement of our modern system of litigation into some effete, feeble but seemingly more efficient administrative or arbitrative process controlled by insurance corporations or governmental agencies, is, in the long run, as inefficient, brutal, and arbitrary as was trial by ordeal except that the deepest pocket, and not the more cunning combatant, usually wins.

As will be argued, ERISA (the acronym for the misnamed, Employee Retirement Income Security Act) has created a brutal,
arbitrary, and inefficient administrative process that is controlled by the insurance industry. ERISA governs employee welfare benefit programs, see 29 U.S.C. § 1001 et seq., that consist of "any plan, fund, or program...established or maintained by an employer," 29 U.S. C. § 1002 (1), to provide benefits through an insurance policy, *see Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982). This article concerns ERISA's application to employment short term and long term disability plans (Plans). Supposedly, Congress created ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans and to protect contractually defined benefits," *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (internal quotation marks omitted); see also 29 U.S.C. § 1001 (listing the congressional findings and declaration of policy regarding ERISA); *Dixon v. Life Ins. Co. of N. Am.*, 389 F.3d 1179, 1184 (11th Cir. 2004) ("ERISA's purpose [is] to promote the interests of employees and their beneficiaries."). However, this federal legislation would be more aptly named the "Enforcement of Revenues for Insurance Companies Security Act." The fact is ERISA does not secure employees' rights to disability benefits. Instead, it is ill-conceived legislation that gives insurance companies the opportunity to cheat, lie, and steal.

Essential Components of Modern Litigation
Adequate adjudication of a conflict has several essential fundamental components including: (1) the availability of the discovery process; (2) the right to probe the materiality, competency, and credibility of evidence; and (3) the right to present a dispute for resolution to an impartial fact finder. The elimination of any of these components in litigation invites deception and produces injustice.

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Discovery Under ERISA

Under ERISA, the insurance company has unfettered access to information regarding a claimant when evaluating his or her application for disability benefits. This information includes medical records through requests, peer-to-peer contacts, medical record reviews, medical evaluations, medical examinations, medical testing, employment record requests, Social Security record requests, and surreptitious surveillance.

Contrarily, the claimant is mostly barred from obtaining any information through discovery about the insurance company's decision-making process. A claimant challenging a denial of benefits is only permitted to obtain what the Plan Administrator, the insurance company, or both designate as the administrative file. Hence, the first disfigurement to the machine of justice in an ERISA case is its jettison of the discovery process.

Importance of Discovery

"The objectives (of discovery) are to enhance the truth-seeking process..., to eliminate surprises.... Its legitimate function is to furnish evidence, and the ultimate objective of pretrial discovery is to make available to all parties, in advance of trial, all relevant facts which might be admitted into trial." 27 C.J.S. Title Discovery § 2b (1999).

The Standard of Review in ERISA Administrative Appeals

When a claimant appeals an insurance company's denial of disability benefits under ERISA, the Federal District Court reviews the claimant's cause of action under either: (1) an arbitrary and capricious standard of review, (2) a "sliding scale/conflict of interest" arbitrary and capricious standard of review, or (3) a de novo standard of review. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that "a denial of benefits...is to be reviewed under a de novo standard unless the benefit plan gives the administrator...discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. If discretionary authority exists, which is usually the case (due to the case law established in *Firestone*, most insurance companies through the Plan Administrators have, by the stroke of a pen, granted themselves discretionary authority and it is rare that the de novo standard of review, which allow the claimant more parity, applies), then the proper standard of review is abuse of discretion. *See id.*

In *Lunt v. Metro. Life Insurance Co.*, 2007 U.S. Dist. LEXIS 47967 (D. Utah June 29, 2007), Judge Tena Campbell of the Federal District Court of Utah, in a memorandum decision, stated, "[b]ecause the Tenth Circuit has been 'comparatively liberal in construing language to trigger the more deferential standard of review under ERISA," plan language which requires a claimant to offer proof of disability satisfactory to the [P]lan [A]dministrator [and thereby the insurance company] triggers the arbitrary and capricious review." *Id.* (citation omitted). Consequently, any language in the Plan indicating that the Plan Administrator (and thereby the insurance company) has discretion to interpret and apply the Plan creates this rather lenient standard of review.

1. Arbitrary and Capricious Standard of Review

Under the arbitrary and capricious standard of review, the court's review is limited to the evidence and arguments that were presented during the administrative claim and appeal process with the insurance company, *see e.g., Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015, 1021 (10th Cir. 2004); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 823-24 (10th Cir. 1996); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380-81 (10th Cir. 1992). "In effect, a curtain falls when the fiduciary completes its review, and for purposes of determining if substantial evidence supported the decision, the district court must evaluate the record as it was at the time of the decision." *Id.* at 381. The Tenth Circuit has justified this bar to discovery, stating:

> A primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously. Permitting or requiring district courts to consider evidence from both parties that was not presented to the [P]lan [A]dministrator would seriously impair the achievement of that goal.

Id. at 380.

Consequently, when the appropriate standard of review is arbitrary and capricious, a claimant's right to discovery is limited to the administrative record, which record the claimant, the insurance company, and Plan Administrator generate prior to litigation. Most short-term and long-term disability plans have a two- to three-step administrative appeal process.

Ostensibly, one may surmise that an adequate remedy to any discovery deficiencies would be to submit any information during the administrative process that was arguably supportive of a claim for disability and to also request discovery information from the insurance company and the Plan Administrator. Although there are exceptions, in practice, this strategy is inadequate for several reasons.

Most claimants do not hire an attorney during the administrative process (to increase the probability of success, a claimant should provide all helpful medical information, obtain expert evaluations by medical and vocational specialist, submit videotaped interviews, and, when relevant, obtain employment records). They intuitively believe that, like most disputes, if they can't work it out on their own they can later hire an attorney and sue. Also, when disabled and forced to leave work on disability, many claimants quickly become bankrupt. Consequently, they cannot afford to obtain adequate medical and vocational support for their disability application and surmise that legal representation is beyond their reach even though many attorneys are willing to take these cases on a contingency basis. Claimants often have the misguided impression that, as long as they submit their own physician's opinions and a few medical records supporting their diagnosis, they will obtain benefits. Although in an obvious disability case this is true, when there is any dispute regarding a diagnosis or impairment and its disabling effects, the insurance company usually resolves that doubt in its favor. It does this by taking advantage of the claimant's naivety and by using the exclusive power ERISA has given it to exercise its discretion to develop a reasonable excuse for its denial.

Once this is done, even when claimants do obtain legal representation, it is extremely difficult to contest the insurance company's denial. While competent legal advocacy increases the chances of a successful outcome, a reasonably sophisticated and careful insurance company can summarily deny almost all appeals and immunize their decision from reversal in federal district court. This is true because under ERISA, regardless of the merits of a disability claim, to prevail a claimant must show that the insurance company's decision was unreasonable, only supported by more than a scintilla of evidence, or both.

In other words, under the arbitrary and capricious standard, "the [insurance company's] decision will be upheld so long as it is predicated on a reasoned basis." *Adamson v. Unum Life Ins. Co. of Am.*, 455 F.3d 1209, 1212 (19th Cir. 2006). In essence, "[t]he Administrators' decision need not be the only logical one nor even the best one. It need only be sufficiently supported by facts within their knowledge...." *Woolsey v. Marion Labs., Inc.*, 934 F.2d 1452, 1460 (10th Cir. 1991); *see also Adamson*, 455 F.3d at 1212 ("A lack of substantial evidence often indicates an arbitrary and capricious decision. Substantial evidence is of the sort that a reasonable mind could accept as sufficient to support a conclusion. Substantial evidence means more than a scintilla, of course, yet less than a preponderance.") (citations omitted). Courts "will not substitute [their] judgment for the judgment of the [Administrators] unless 'the actions of the [Administrators] are not grounded on any reasonable basis.'" *Woolsey*, 934 F.2d at 1460 (second and third alteration in original) (quoting *Oster v. Barco of Cal. Employees' Ret. Plan*, 869 F.2d 1215, 1218 (9th Cir. 1988)). Rather, "[t]he reviewing court 'need only assure that the administrator's decision falls somewhere on a continuum of reasonableness – even if on the low end.'" *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999) (quoting *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999)).

Under this standard during the administrative process an insurance company can usually create a reasonable, and therefore legally irrefutable explanation for its denial of benefits. This is especially the case because, if the claimant requests discovery information during the administrative process to try to uncover evidence demonstrating that the evaluation process is arbitrary, the Plan Administrator and its insurance company will deny the discovery request. It will argue that the very same federal case law prohibiting discovery in an ERISA claim during litigation, bars such requests.

Currently, except as noted below, there is scant federal case law regarding the right to discovery during the administrative process. As a consequence, attempting discovery during the administrative process does not catapult the claimant into a position to use discovery during litigation to expose shoddy, underhanded, or dishonest insurance practices that are implemented to deny claims.

2. The "Sliding Scale" Standard of Review

In two seminal cases, *Jones v. Kodak Medical Assistance Plan*, 169 F.3d 1287 (10th Cir. 1999), and *Kimber v. Thiokol Corp. Disability Benefits Plan*,196 F.3d 1092 (10th Cir. 1999), regarding actual conflicts of interest, stated, that "[b]efore applying the sliding scale, a court must decide whether there was a conflict of interest," *Jones*, 169 F.3d at 1289, and, "there must first be evidence of a conflict of interest," *Kimber*, 196 F.3d at 1092. To determine whether a conflict of interest exists, *Jones* directs the District Court to consider whether: "(1) the plan is self-funded; (2) the company funding the plan appointed and compensated the Plan Administrator; (3) the Plan Administrator's performance reviews or level of compensation were linked to the denial of benefits; and (4) the provisions of benefits has a significant economic impact on the company administering the plan." *Jones* at 1291. Jones further states that, "[i]f the court concludes that the Plan Administrator's dual role jeopardized his impartiality, his discretionary decisions must be viewed with less deference." *Id.*

In *Fought v. UNUM Life Insurance Co. of America*, 379 F.3d 997 (10th Cir. 2004), the Tenth Circuit held that where an insurer is both funding and administering claims, it is operating under an

inherent conflict of interest. Consequently, the district court is to review the plan administrator or insurance company's decision with a lesser degree of deference to the insurer's decision. The court in *Fought* stated: "The district court must take a hard look at the evidence and arguments presented to the [P]lan [A]dministrator to ensure that the decision was a reasoned application of the terms of the plan to the particular case, untainted by the conflict of interest." *Id.* at 1006. However, the Plan Administrator or insurance company's decision is to be given even less deference if the Plan Administrator is also shown to have a serious, actual conflict of interest.

Then, in *Allison v. Unum*, 381 F.3d 1015 (10th Cir. 2004), the Tenth Circuit Court stated that even though the lessened deference is required in such circumstance, "In reviewing a [P]lan [A]dministrator's decision under the arbitrary and capricious standard, we are limited to the 'administrative record' – the materials compiled by the administrator in the course of making his decision." *Id.* at 1021 (internal quotation marks omitted).

Consequently, in the Tenth Circuit, discovery is not allowed, even when there is an inherent or actual conflict of interest. This bar to discovery is in direct contradiction to additional Tenth Circuit Court pronouncements about these sliding scale reviews.

The Tenth Circuit has adopted a two-step approach for dealing with conflicts of interest in ERISA cases. (There is one medical benefits denial case in which a Utah Federal District Court judge did allow discovery in a sliding scale standard of review ERISA case.) In *Nichols v. Wal-Mart Stores, Inc.*, 259 F. Supp. 2d 1213 (D. UT 2003), the Utah federal district court allowed discovery on the issue of conflict of interest in a sliding scale arbitrary and capricious standard of review case when the plaintiff had requested discovery during the claim review process and defendant refused to answer. In *Nichols* the court stated, "Plaintiff is permitted,...to seek discovery on the narrow issue of *whether a conflict of interest exists* between the Plan Administrator of the plan and Wal-Mart Stores, Inc., the plan sponsor." *Id.* at 1221-22.

First, the court must determine whether a conflict of interest exists because "[t]he possibility of an administrator operating under a conflict of interest...changes the [arbitrary and capricious] analysis." *Fought*, 379 F.3d at 1003; *see also Adamson v. UNUM Life Insurance Co. of America*, 455 F.3d 1209, 1212 (10th Cir. 2006) ("We do note that where a 'standard' conflict of interest exists, the [P]lan [A]dministrator's decision is entitled to less deference, and the standard conflict is regarded 'as one factor in determining whether the [P]lan [A]dministrator's denial of benefits was arbitrary and capricious.'") (quoting *Fought*, 379 F.3d at 1005). As the Supreme Court noted, "if 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.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (alteration in original) (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). Second, if there is a conflict of interest, the court must decide what reduction from the arbitrary and capricious standard is warranted. "The reduction correlates with the extent to which the conflict jeopardized the administrator's impartiality." *Lunt v. Metro. Life Ins. Co.*, 2007 U.S. Dist. LEXIS 47967 (D. Utah June 29, 2007); see Fought, 379 F.3d at 1004 ("[T]he reviewing court will always apply an arbitrary and capricious standard, but the court must decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict.") (quoting *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996)).

Under this second step, the claimant bears the burden of proving that the impartiality was jeopardized. "The fact that [defendant] administered and insured the group term life insurance portion of this plan does not on its own warrant a further reduction in deference." *Adamson*, 455 F.3d at 1213. Rather, "[s]ome proof (supplied by the claimant) must identify a conflict that could plausibly jeopardize the [P]lan [A]dministrator's impartiality." *Id.*

The schematic set forth in these cases begs the question: how can a claimant, who is barred from conducting discovery, provide proof that the inherent or actual conflict jeopardized the Plan Administrator's impartiality? Granted, while there are the rare cases when evidence of a serious conflict is readily available in the administrative record as in *Flinders v. Workforce Stailization Plan of Phillips Petroleum Co.*, 491 F.3d 1180 (10th Cir. 2007), this is a rare event. Under usual circumstances, is the insurance company going to offer up, as part of the administrative record, evidence that in order to save revenues it pressures its agents to deny claims by basing their promotions, pay, and bonuses upon claim denials? Is it going to voluntarily provide information that it deliberately selects and manipulates expert witnesses so that they invariably support its denials? Is it going to divulge its procedures and protocols that indicate that certain claims are denied due to arbitrary impairment duration guidelines? No. Although this practitioner has also found evidence of such practices in the rare cases that discovery was allowed or in non-ERISA cases, this will only happen when ERISA is amended to allow discovery.

3. De Novo Standard of Review

Most circuits have adopted rules allowing the admission of additional evidence in de novo cases in limited circumstances such as when there was a conflict of interest. *See, e.g., DeFelice v. Am. Int'l Life Assurance Co. of N.Y.*, 112 F.3d 61, 65-67 (2d Cir. 1997) (allowing the use of extra evidence if

the Plan Administrator has a conflict of interest); *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 943-44 (9th Cir. 1995) (allowing the use of extra evidence where the Plan Administrator incorrectly interpreted the plan); *Casey v. Uddeholm Corp.*, 32 F.3d 1094, 1098-99 (7th Cir. 1994) (allowing a district court to consider additional evidence where the Plan Administrator has made no fact-finding himself); *S. Farm Bureau Life Ins. Co. v. Moore*, 993 F.2d 98, 101-02 (5th Cir. 1993) (allowing the admission of extra evidence with regards to plan interpretation by the administrator, but not with regards to the finding of historical facts by the administrator); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (leaving the question of whether to admit extra evidence to the discretion of the district court where there is "good cause" to admit additional information in order to provide "adequate" review); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1021-27 (4th Cir. 1993) (en banc) (leaving the question of whether to admit extra evidence to the discretion of the district court when it finds that exceptional circumstances have been met and listing some of those circumstances); *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1184-85 (3d Cir. 1991) (stating that the decision to admit additional evidence is within the district court's discretion and was permissible in this case because there was no evidentiary record). The most thorough explanation of this position has been provided by the Fourth Circuit in *Quesinberry*, see 987 F.2d 1017, which held that allowing a district court to exercise its discretion to admit additional evidence in de novo cases under certain circumstances best reconciles ERISA's competing purposes of efficiency and fairness, *see Id.* at 125-26.

In, *Jewell v. Life Insurance Co. of North America*, 508 F.3d 1303 (10th Cir. 2007), the Tenth Circuit Court of Appeals stated:

> A party seeking to introduce evidence from outside the administrative record bears a significant burden in establishing that he may do so. In particular, (1) the evidence must be "necessary to the district court's de novo review"; (2) the party offering the extra-record evidence must "demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision was made"; (3) the evidence must not be "[c]umulative or repetitive"; nor (4) may it be "evidence that `is simply better evidence than the claimant mustered for the claim review.'" *Hall [v. UNUM Life Insurance Co. of America]*, 300 F.3d [1197, 1203 (2002)] (quoting *Quesinberry*, 987 F.2d at 1027). Even then, "district courts are not required to admit additional evidence when these circumstances exist because a court `may well conclude that the case can be properly resolved on the administrative record without the need to put the parties to additional delay and expense.'"

Id. at 1309 (first alteration in original) (footnote omitted).

> For guidance in evaluating the necessity of extra-record evidence, we listed in *Hall* several examples of the "exceptional circumstances" which "could warrant the admission of additional evidence." Those situations include 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. These are not exceptions to the *Hall* rule; they are merely examples of circumstances that might militate in favor of a finding of necessity. The existence of one or more of these circumstances does not make extra-record evidence automatically admissible, for if it did, then supplementation of the record would not be limited to unusual cases or extraordinary circumstances. This would "undermin[e] the goal of not making district courts `substitute plan administrators.'" District courts must conduct analysis case-by-case to determine whether all four prongs of the test are met.

Id. (alteration in original) (citations omitted).

> [T]he term "necessary," as we used it in *Hall*, must be "harmonized with its context." We are guided by our qualification in *Hall*, following the Fourth Circuit's opinion in *Quesinberry*, that extra-record evidence may be admitted when "`necessary to conduct an *adequate* de novo review of the benefit decision.'" If, for instance, the administrator based its decision on information not in the record – perhaps on principles generally known within the medical community – the district court likely could not meaningfully review the decision without the admission of that evidence. Or if the court cannot understand abstruse medical terminology central to the issues of a case, the claimant may supplement the record with explanatory evidence. Likewise, if the administrator simply neglected to include in the record

> evidence. Likewise, if the administrator simply neglected to include in the record exhibits the claimant had submitted to it, those may be offered to the district court. (Even "necessary" evidence, however, may only be admitted if the other three prongs of the *Hall* test are satisfied. The consequences of a record insufficient to allow meaningful review will be borne by the party responsible for the insufficiency.)

Id. at 1311 (citation omitted).

In *Hall v. UNUM Life Insurance Co. of America*, 300 F.3d 1197 (10th Circuit 2002), the district court held a bench trial in which the scope of review was expanded beyond the administrative record. In its review of that decision the 10th Circuit Court of Appeals sustained the district court, stating that additional discovery is allowed, "when circumstances clearly established that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision." *Id.* at 1202.

In a similar case, the U.S. District Court for the Southern District of California allowed discovery in a de novo case on: "(1) information necessary to demonstrate 'the manner in or extent to which the conflict of interest affected UNUM's decision-making process' and 'address any shortcomings in the record or decision-making process caused by the conflict [of interest],' and (2) information regarding the independence or neutrality of the physicians utilized by Unum for medical opinions relative to [Plaintiff's] disability claim." *Waggener v. UNUM Life Ins. Co. of Am.*, 238 F.Supp.2d 1179, 1187 (S.D.Cal. 2002). The court reasoned, "These categories of information appear reasonably related to the claims and defenses in this case, and may lead to evidence that the District Judge may permit to be admitted at the time of summary judgment or trial." *Id.*

In *Leahy v. Bon, Inc.*, 801 F. Supp. 529 (1992) this Utah Federal District Court, applying a de novo standard of review stated, "[w]here the decision-maker stands to gain from a denial of benefits, there may be incentive to base the denial on less than all of the available evidence. Under such circumstances, courts should be hesitant to limit the scope of review to the evidence considered by the decision-maker." *Id.* at 540. Although it appears this case has not been directly overturned, in view of *Jewell*, its applicability is questionable.

Therefore regarding the de novo standard of review and discovery, while the authority may seem to provide a glimmer of fairness for claimants, this limited allowance of discovery is rare. This is so because the disability insurance industry has, by the stroke of the pen, quickly modified most plans to grant the plan administrators discretionary authority. Moreover, even in de novo cases, the federal judge has discretion to allow discovery. That discretion is exercised sparingly.

Essential Topics for Discovery

In summary, discovery is, for all intents and purposes, rare in ERISA cases. Discovery is, however, essential in all ERISA disability cases when disability benefits have been denied. In such cases a claimant should be allowed discovery to obtain: (a) the guidelines and other criterion used by Plan Administrators/insurance company to evaluate a claimant's disabilities and application for benefits; (b) information about the compensation and manner that medical and vocational experts are selected; (c) the qualifications and competency of selected medical and vocational experts; and (d) information regarding the way the claims adjustors are evaluated in conjunction with their denial and approval rate of claims.

1. Guidelines and Criterion

In evaluating particular illnesses, diseases, syndromes, and |injuries that are known to cause disabilities, insurance companies often use various guidelines that allegedly predict the severity and duration of particular disabling conditions. These guidelines are often applied by rote to disability claims without regard to the individual circumstances of the particular claimant. For instance, if a particular illness or disease has an average disabling duration among the general population of six months, insurance adjusters will arbitrarily apply that period of time to determine how long a claimant should receive disability benefits. Without access to this information, a claimant cannot demonstrate that a guideline is obsolete, incorrect, or does not apply in their case. Under such circumstances, this is relevant information that would demonstrate the arbitrariness of the insurance company's reliance thereon, but is nevertheless not allowed to be discovered.

2. The Compensation, Selection, and Qualifications Of Medical and Vocational Experts.

Most attorneys and legal experts recognize that if one party in a legal dispute has the exclusive ability to select experts to render opinions regarding any particular disputed matter and those selected experts are given irrefutable and controlling weight in the dispute, such a process will invariably lead to a result-oriented selection of experts with predictable outcomes. Under ERISA this is, in fact, what happens. During the administrative process, the insurance company selects the medical and vocational experts that evaluate the claimant's disability. In so doing the insurance company is able, through the power of the pocket and the protections of ERISA, to select those experts whose dispositions and philosophies are most closely aligned with the insurance company's interests and who consistently support the Plan Administrator and/or insurance company's denial. Although during the administrative process a claimant may provide their own expert's opinion rebutting the insurance company's experts' opinions, such submissions are usually futile.

This is true for several reasons. First under the arbitrary and capricious standard of review, discovery is not allowed to probe the unreliability, incompetency, or bias of the Plan Administrator and/or insurance company's experts' opinions. And second, pursuant to all standards of review in ERISA cases, so long as the Plan Administrator and/or insurance company's experts' opinions has some modicum or semblance of validity, it rules the day. As set forth above, ERISA has no mechanism to independently resolve medical disputes of fact and opinion. To the contrary, the plan administrator and insurance companies' decisions and its selected experts are given the benefit of the doubt in any dispute and therefore the district court upholds any plausible denial of benefits.

As the Supreme Court explained, "courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on [P]lan [A]dministrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003). Hence, as long as the plan administrator, insurance company, or both finds some doctor or vocational expert somewhere, no matter how competent they are or reliable their methods, that concludes the claimant is not disabled and able to work, benefits will be denied and the decision is not subject to reversal.

Empowered by this unfair schematic under ERISA, Plan Administrators
and their insurance companies have, in fact, set up their own expert witness pools that they exclusively use for result oriented denials. Often these experts cursorily review the medical evidence, cherry pick only that information which supports a denial of benefits, have underlings conduct the examinations using their signature stamp, do not physically examine or evaluate the claimant themselves, and apply outdated medical criteria and testing. Many of these experts are either directly or indirectly under the supervisory influence of the insurance company. The vast majority of these experts earn millions of dollars of income from providing these evaluations and yet supposedly have full-time jobs in the medical industry to such an extent that it is improbable they are competently and fairly conducting these expert evaluations.

The reality of human nature is that what can go wrong will go wrong. There is no human being, organization, or entity that is perfect or incorruptible. If the lights of the discovery process are therefore not shown upon the process that insurance companies use to evaluate claims, they can and will act deceptively because insurance companies are as prone to imperfection as the general population. These insurance corporations and their agents will and do commit errors because of the motive to maximize profits, bias, prejudices, human error, ego, simple slothfulness, and sometimes outright fraud. Without the indispensable cog of discovery in the machine of justice, rarely, if ever, will claimants uncover such injustices.

Right To Present Evidence in Open Court and To Conduct Cross-Examination

As set forth above, under ERISA there is no court trial of a denial of disability benefits. The claimant therefore never presents expert or lay testimony in open court about their limitations, pain, or fatigue to an independent, impartial fact finder or cross examines the insurance company's agents and experts. The judge only considers the administrative record.

Cross examination is invaluable as a test of the accuracy, truthfulness and credibility of testimony. *See Aluminum Indus. v. Egan*, 22 N.E. 2d 459, 462 (Ohio 1938). "Cross examination is a fundamental trial right in our judicial system and is an essential element of a fair trial and the proper administration of justice." 81 Am Jur 2D Title Witnesses § 771 (2004). "The right to cross examination has been called absolute and not a mere privilege. This right is also basic to our judicial system; its preservation is essential to the proper administration of justice; and it is a valuable fundamental and substantial right; to be jealously guarded." 98 C.J.S. Title Discovery § 44 (1999). Dean Wigmore characterizes cross-examination as "beyond any doubt, the greatest legal engine ever invented for the discovery of truth." 5 J. Wigmore, Evidence, § 1367 (Chadbourn Rev.1974). Moreover, since at least the time of Blackstone, it has been felt that the goal of evidentiary reliability can best be assured by testing the evidence in the "crucible of cross examination." *Crawford v. Washington*, 541 U.S. 36, 61-62 (2004).

If this is true, why do we, the American public, and we, as members of the bar, accept without a fight this gutting of our administration of justice, and blithely give in to the argument that efficiency for the insurance industry is more important than basic fairness?

Right to an Impartial Decision Maker

As set forth above, in reviewing a denial of a claim for ERISA benefits, in litigation, the Federal District Court Judge resolves the dispute through motions practice and not a trial. In reviewing these motions, "the court does not examine defendant's motion under the traditional summary judgment standard....Instead, the court acts as an appellate court and evaluates the reasonableness of a [P]lan [A]dministrator or fiduciary's decision based on the evidence contained in the administrative record." *Panther v. Synthes*, 380 F. Supp. 2d 1198, 1207 n.9 (D. Kan. 2005). Hence, the federal judge does not sit to adjudicate the case; the judge merely determines if the insurance company's denial metaphorically stinks so bad that it cannot be tolerated.

This point is highlighted when, in *Roach v. Prudential Insurance*, Civil No. 2:00-CV-00239, Utah Federal District Court Judge Dee Benson, in reviewing Prudential's request to dismiss the case stated, "I may be tempted in a case like this to find that [Ms. Roach] in my view is disabled, candidly. It seems like there is a very good case here to be made for her disability, but in light of this standard...my job is only to see if there was some rational basis to support this even if I don't agree with it....[I]t seems like this system is harsher than our judicial system...[I]t would be nice in an ideal world if someone could go back to Prudential and say 'do you want to take another look at this? I don't think she is faking it here.'"

Prudential's own attorney, Mr. Jon C. Martinson, of Fabian and Clendenin, stated, "[W]e need to remember that under [ERISA's] arbitrary and capricious standard the Court affords the administrator's discretion in their review based on the administrative record. We are not here to determine whether [Ms. Roach] was disabled under our understanding....I don't think any of us does not sympathize with [Ms. Roach]...The law requires us to make a counterintuitive decision in this case...It is not our call and it is not the District Court's call and it is not the Tenth Circuit's call. ...[T]he way [ERISA] is now we're going to have to trade unfortunate and hopefully rare situations like this for overall efficiency." (Quotes from oral argument transcript.)

Therefore, in most cases, as noted in local attorney Brian S. King's, "How ERISA Plan Administrators and Fiduciaries Make a Plaintiffs Lawyer's Life Easier," Utah Trial Journal, Volume 30, No. 3. page 6-8, in order to litigate and win a denial of benefits, it is more a matter of exploiting mistakes, and not whether "the claimant [is] disabled."

This is a curious thing. It is probable that insurance company's would never tolerate a system to resolve disputes between them and their insured in which the insured had the exclusive right to resolve the dispute and be upheld so long as the insured's decision was reasonable. Why is it then fair to allow insurance companies this same pleasure? It is hard to imagine how any person, entity or government would ever find such a system to be acceptable. It is most likely that this has been allowed under ERISA because few care about or find themselves a member of this small underclass and politically powerless group of individuals who are disabled and denied benefits.

Adding Insult to Injury

What the Plan Administrator, Insurance Company, or Both Giveth, It Taketh Away
To add insult to injury, under ERISA employers are allowed to cancel insurance programs outright even after an employee has worked for years for a company, paid premiums for disability coverage through their employment, and gone out on disability. ERISA allows companies to terminate disability benefits because they are neither vested nor accrued, *Phillips v. Amoco Oil Co.*, 799 F.2d 1464, 1471 (11th Cir.1986), cert. denied, 481 U.S. 1016 (1987). Unlike pension benefits, welfare benefit plans neither vest nor accrue. See 29 U.S.C. § 1051(1); *Vasseur v. Halliburton Co.*, 950 F.2d 1002, 1006 (5th Cir.1992); *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1160 (3rd Cir.1990). This is because Congress determined that vesting requirements for welfare plans, "would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income." H.R.Rep. No. 807, 93rd Cong., 2d Sess. 60, reprinted in 1974 U.S.C.C.A.N. 4639, 4670, 4726; S.Rep. No. 383, 93rd Cong., 1st Sess. 51 reprinted in 1974 U.S.C.C.A.N. 4890, 4935. Instead, Congress intended employers to be free to create, modify, or terminate the terms and conditions of employee welfare benefit plans as inflation, changes in medical practice and technology, and the costs of treatment dictate. *See Moore v. Metro. Life Ins. Co.*, 856 F.2d 488, 492 (2nd Cir. 1988); *see also Metro. Life Ins. Co. Arrow v. Massachusetts*, 471 U.S. 724, 732, (1985) (ERISA "does not regulate the substantive content of welfare-benefit plans").

Purchasing Swamp Land on Mars
The final injustices in ERISA disability plans are their offset provisions. Most, if not all ERISA Plans offset any benefit awarded by entitlements from other sources. For instance, if a claimant gets $1000 a month in Social Security Disability benefits, this amount will offset the monthly ERISA plan disability benefit. Consequently, if the monthly disability benefit is $1000 or less, no disability benefit will be paid unless there is a plan provision that provides for a minimum benefit. Some plans have such minimums (usually $100) but many do not. Hence, many employees' premiums may as well have been spent buying real estate on Mars.

Conclusion
It is hard to conceive of any knowledgeable advocate who would voluntarily agree to submit a client's dispute for determination in a process in which the opponent was granted all the advantages that ERISA gives insurance companies in a disability benefits dispute. So why does any respectable member of the bar, legislature, or judiciary subscribe to any notion that ERISA is anything more that an abomination and affront to our collective sense of justice and in effect a license to cheat, lie, and steal for the disability insurance industry?

Some may cry that this article sets unnecessarily alarmist tone. However, a recent Georgetown

University Health Policy Institute conducted a study found that under the arbitrary and capricious standard of review, the insured prevailed in only 28.4% and when the court applied a de novo standard of review, the insured prevailed 65.9% of the time. Also, not surprisingly, as discussed in a law review article, "Trust Law as Regulatory Law: The Scandal and Judicial Review of Benefit Denials Under ERISA," Northwestern University Law Review, Vol. 101, p. 1315 (2007), Professor John H. Langbein, Sterling Professor of Law and Legal History, Yale University, at page 1321; http://www.law.northwestern.edu/lawreview/vl01/n3/1315/LR101n3Langbein.pdf, a 1995 internal memorandum from Provident Insurance Company revealed that ERISA provided huge economic advantages to the insurance industry, especially due to the application of the deferential standard of review, and that had ERISA applied to12 claims that were settled for $7.8 million in the aggregate, Unum's liability would have been between zero and $0.5 million. There are also, hundreds of punitive damage cases that have demonstrated the insurance companies will go to great lengths to manipulate claims to defraud their insurers. None of these cases would have likely come to light under ERISA.

To restore justice to this area of law, I call upon all fair minded members of our citizenry to end that injustice before you or someone you know or love is the next victim of its efficiency.

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