The Tragedies of ERISA's Unintended Preemption of State Law Remedies

Arnold R. Levinson, Esquire
Pillsbury & Levinson, LLP
600 Montgomery St. 31st Floor
San Francisco, California 94111
415-433-8000
alevinson@pillsburylevinson.com

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INTRODUCTION[1]

The Employee Retirement Income Security Act of 1974 ("ERISA") was hailed by its Senate sponsor and driving force as "the greatest development in the life of the American worker since Social Security."[2] It has instead become the genesis of massive injustice and bizarre judicial doctrines. It authorizes insurance companies to deny health, disability and life insurance claims whenever they can find any possible basis to justify the denial. This is so, because, under ERISA, an insured cannot prevail against an insurance company in court if s/he merely proves the insurance company wrongfully denied their claim. The insured must prove that there was no reasonable basis for the insurance company's denial of benefits in order to get the benefits promised under the policy. ERISA also immunizes insurance companies from all liability resulting from their actions – even if they wrongfully, intentionally or maliciously abuse their insureds. Given this unprecedented immunity, insurers have institutionalized claims operations in a manner designed to deny claims. Powerless and abused insureds have been scattered everywhere over the last 20 years. It was never intended to be this way.

The following tragedy is taken directly from the decision of the Chief United States District Judge for the District of Massachusetts, William G. Young, in the case of *Andrews-Clarke v. Travelers Ins. Co.*, 984 F.Supp. 49 (D. Mass. 1997).

On November 12, 1994 the Pelham, New Hampshire police discovered the lifeless body of Richard Clarke, a 41-year old father of four children, in a parked car

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[1] Arnold R. Levinson is a partner in the San Francisco law firm of Pillsbury & Levinson. He has represented insureds in disputes with insurance companies for 30 years. His partner Terrence J. Coleman contributed to this paper.

[2] Subcomm. on Labor of the Senate Comm. on Labor and Pub. Welfare, 94th Cong., Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print 1976) at 4747 (Remarks of Sen. Jacob Javits).

with a garden hose extending from the tailpipe to the passenger compartment. His hopes of defeating a crippling alcohol and drug addiction had come to an end after his insurer repeatedly and arbitrarily refused his desperate requests for the treatment his insurance policy specifically provided.

Six months earlier, Mr. Clarke had been admitted to St. Joseph Hospital in Nashua, New Hampshire for alcohol detoxification and medical evaluation. He was entitled to at least one 30-day treatment program under the terms of his policy. His insurer, however, only authorized 5 days. He was discharged with a diagnosis of alcohol dependence, alcohol withdrawal symptoms, elevated liver function and low hemoglobin. He remained alcohol free for 21 days but then resumed drinking. He voluntarily admitted himself to Baldpate Hospital in Georgetown, Massachusetts seeking help to stop drinking. He again asked for his 30-day stay, but was only granted eight days by the insurer.

Twenty-four hours after his discharge, Clarke drank a substantial quantity of alcohol, ingested cocaine, swallowed a handful of prescription drugs and attempted to commit suicide by locking himself in the garage with the car running. His wife saved his life, breaking through the garage door to find him slumped on the floor. She dialed 911. Although Clarke had no detectable pulse or respiration, the paramedics were able to revive him. He was then flown to Henrietta Goodall Hospital in Sanford, Maine, where he was placed in a hyperbaric chamber and successfully treated for carbon monoxide poisoning. The local court found Clarke a danger to himself and perhaps others and ordered him committed to a 30-day detoxification and rehabilitation program and requested that his insurer approve his confinement in a private hospital. When the insurer still refused the promised benefit, Clarke was committed to the Southeastern Correctional Center at Bridgewater for his detoxification and

rehabilitation. While there, he was forcibly raped and sodomized. He received little therapy or treatment.

Upon his release, his wife told him that he could return to the marital home only if he remained sober. Unable to do so, he began a three-week drinking binge. On November 10, he was admitted to the Southern New Hampshire Medical Center in full respiratory arrest with a blood alcohol level of .380 and a head injury. He received no treatment for his alcoholism. He spent the night sleeping on a stretcher because it was too cold to discharge him and there were no beds available in area shelters. Upon his release the next morning, he purchased a six-pack of beer, which he immediately began to consume. At 3:06 a.m. on November 12, he was found dead in his car clasping a 16-ounce beer can in his right hand.

Mr. Clarke's wife brought suit against the insurance company. The insurer, however, moved to dismiss the case because ERISA provided no relief to her and ERISA preempted any and all other claims which she could bring against it. Set forth below are excerpts from Judge Young's order:

> [The insurance company asks] this Court to throw her out [of court] without hearing the merits of her claim.
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> This, of course, is ridiculous. The tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief. Clarke was the named beneficiary of a health insurance policy offered through an employee benefit plan. That policy expressly provided coverage for certain medical and psychiatric treatments, including enrollment in a thirty-day inpatient alcohol detoxification and rehabilitation program. Doctors at several hospitals, and even the courts of the Commonwealth of Massachusetts, determined that Clarke was in need of such treatment, but the insurer and its agent, the utilization review provider, repeatedly and arbitrarily refused to authorize it. As a consequence of their failure to pre-approve—whether willful, or the result of negligent medical decisions made during the course of utilization review—Clarke never received the treatment he so desperately required, suffered horribly, and ultimately died needlessly at age forty-one.

Under traditional notions of justice, the harms alleged—if true—should entitle Diane Andrews-Clarke to some legal remedy on behalf of herself and her children against [the insurance company]. Consider just one of her claims—breach of contract. This cause of action—that contractual promises can be enforced in the courts—pre-dates Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it.

Nevertheless, this Court had no choice but to pluck Diane Andrews-Clarke's case out of the state court in which she sought redress (and where relief to other litigants is available) and then, at the behest of [the insurance company] . . . to slam the courthouse doors in her face and leave her without any remedy.

This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system. Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.

* * *

Thus, the practical impact of ERISA in this case is to immunize [insurers] from any potential liability for the consequences of their denial of benefits.

* * *

ERISA is a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." It is therefore deeply troubling that, in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect. What went wrong?

* * *

Although the alleged conduct of [the insurance company] . . . in this case is extraordinarily troubling, even more disturbing to this Court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.

Does anyone care?

Do you?

Andrews-Clarke at 52-53, 55, 56, 65.

What went wrong is that the Supreme Court wrongly interpreted ERISA to preempt nearly every substantive claim an ERISA beneficiary may have to protect his/her rights. Over the last half-century, states have carefully developed legal remedies which are well-suited to the resolution of disputes between vulnerable insureds and insurance companies who would take advantage of them to deny valid claims. The most basic among them is a claim for breach of contract. ERISA completely wipes out **ALL** state remedies and substitutes in their place remedial rights that are toothless, grossly inequitable and heavily biased in favor of insurance companies. An insured who has been wronged by an insurance company is left to fight a large and powerful company with the legal equivalent of two hands and a leg tied behind his/her back. Worse yet, both the language of ERISA and its extensive legislative history show that this result was never intended by ERISA's drafters. There is not a single sentence in the legislative history that would suggest an intent for such a dramatic reordering of the rights of insured and insurance companies. Indeed, the opposite is true. ERISA specifically states that "nothing [in ERISA] shall [preempt] *any* law of *any* State which regulates insurance. . . " (29 U.S.C. § 1144(b)(2)(A) (emphasis added).

Nonetheless, under current law, ERISA has essentially de-regulated the insurance industry by stripping the states of all authority to regulate these areas of traditional state governance, and by then failing to substitute meaningful federal remedies to replace the preempted state laws. In so doing, ERISA has literally created a vacuum of rights for insureds to seek benefits against wrongfully denied insurance claims and has provided insurers with *unprecedented* immunity against any meaningful

redress for the improper denial of benefits. A law without adequate remedies is a law which gives license to the powerful to abuse their power without restriction over those who depend on them. With such immunity in the hands of insurance companies, tragedies such as that experienced by Andrews-Clarke soon become the norm.

As explained below, there is no reason or rationale for this extraordinary immunity. This insurance company immunity has essentially flown under the Congressional radar without challenge for over 20 years.

The former Chief Judge of the Third Federal Appellate Circuit in Philadelphia, Edward Becker, concluding that ERISA is a "preemption nightmare," recently wrote the following in *Difelice v. Aetna U.S. Healthcare,* 346 F.3d 442 (3rd Cir. 2003):

> I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is an unjust and increasingly tangled ERISA regime.
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> [ERISA and its remedial provisions have become] virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided."
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> This "regulatory vacuum" creates situations in which plan beneficiaries have little or no recourse for even the most egregious violations of their rights . . .
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> The unavailability of extracontractual damages has effects that are perverse. . . . it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see, Pilot Life,* 481 U.S. at 54-56, 107 S.Ct. 1549, so that if an HMO wrongly denies a participant's claim even in bad

> faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else being equal, the most profitable HMOs will be those that deny claims most frequently.
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> *Difelice,* 346 F.3d at 453, 456-462.

Another prominent Federal Appellate Judge recently echoed these remarks. Judge Guido Calabresi of the Second Circuit in New York wrote in *Cicio v. Does,* 321 F.3d 83, 106 (2d Cir. 2003), " . . . the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end." (Calabresi, J. dissenting in part.)

This paper is divided into seven parts. Part 1 contains a brief summary of the standard remedies that are available under state law. Part 2 will explain how ERISA eliminated all of these remedies and replaced them with grossly inadequate remedies. Part 3 will explain that the legislative history of ERISA is unequivocal that ERISA was never intended to preempt these state remedies. Part 4 will examine the judicial decisions which lead to ERISA's preemption of state remedies. Part 5 will set forth examples of the countless tragedies which lie at the feet of ERISA preemption and will show the agony which the judicial branch has expressed over the tragedies of ERISA. Part 6 contains proposed legislation.

1. THE STATE LAW CLAIMS WHICH ARE PREEMPTED.

The most fundamental claim an insured is entitled to pursue is a simple claim for breach of contract. An insurance policy is a contract. Accordingly, a failure to pay a benefit due permits an insured the right to sue for breach of contract. As Judge Young points out, this is a basic right that has existed since the Magna Carta. This entails the basic and constitutionally protected right to a jury trial in the insured's selected state or federal forum, the right to conduct pre-trial discovery and the right to put on witnesses and other evidence to support the insured's claim. In instances of fraud and intentionally inflicted harm, traditional state torts such as causes of action for fraud or intentional infliction of emotional distress have long been available. Insureds are also generally permitted to sue for damages caused by the wrongful denial of insurance benefits. For example, if an insurance company wrongfully denied a fire loss claim thereby forcing the insured to suffer extraordinary damages, the insurance company could be sued for these damages. If a disabled insured was wrongfully denied disability benefits and thus forced into bankruptcy, the insured could sue to seek damages resulting from this bankruptcy.

Where the failure to pay insurance benefits was the result of wrongdoing on the part of a third party (such as an insurance agent who lied about the benefits of the policy when s/he sold the policy to the insured), the third party can be sued. An insurance company can also be estopped from denying benefits where it has led the insured to believe that benefits are properly payable and the insured has detrimentally relied on that fact. (For example, where an insurer has accepted premiums for many years, an insurance company would ordinarily be barred from denying a claim on the grounds that the insured never qualified for coverage in the first place.) These are all

basic, longstanding and fundamental legal rights that everyone is entitled to claim when a contractual obligation has been broken.

The most important claim is the right an insured has in many states to sue under a state law which is specifically created for the purpose of preventing insurance company abuses of those whom they insure. Basic remedies provided under such laws include an insured's right to seek (1) insurance benefits; (2) damages for harm caused by the failure to pay benefits; (3) attorneys' fees; and (4) punitive damages where the conduct was outrageous.

The development by the California courts of a claim known as the covenant of good faith and fair dealing (the violation of which is colloquially known as "bad faith") is typical of these laws. The California courts found that claims for breach of contract were insufficient to stem insurance malfeasance and that, given the great vulnerability of insureds and the great power of insurers, insurers must be responsible for compensatory damages where their conduct was unreasonable and, in addition, for punitive damages when the conduct was outrageous. The California Supreme Court has explained the genesis of this cause of action:

> The insured in a contract like the one before us does not seek to obtain a commercial advantage by purchasing the policy—rather, he seeks protection against calamity. Thus, as one commentary has noted, `The insurers' obligations are . . . rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements. . . . [A]s a supplier of a public service rather than a manufactured product, the obligations of insurers go beyond meeting reasonable expectations of coverage. The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary.'. . .
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> *Egan v. Mutual of Omaha,* 24 Cal.3d 809, 820 (1979).

The courts in California have repeatedly explained that this tort is available only against insurance companies because of the special role insurance plays in our society and the unique public policy concerns that accompany insurance. "The availability of tort remedies in the limited context of an insurer's breach of the covenant advances the social policy of safeguarding an insured in an inferior bargaining position who contracts for calamity protection, not commercial advantage." *Kransco v. International Ins. Co.*, 23 Cal.4th 390 (2000). "[T]he unequal relationship between the insured and insurers demanded special remedies for breach of the public trust . . . The significant public interest in the special relationship between the insured and insurer justifies the availability of tort remedies, and distinguishes insurance contracts from other types of contracts." *20th Century Ins. Co. v. Superior Court,* 90 Cal.App.4th 1247, 1265-66 (2001). As such, the tort of bad faith is not available in any context other than insurance.

In addition, the courts have been engaged for decades in the development of judicial standards that apply to the interpretation of insurance policies and the definition of standard insurance terms. For example, as far back as 1942, the California Supreme Court defined what is meant by the term "total disability" in the context of a total disability insurance policy.[3] An insurance company cannot place a provision in a disability insurance policy which contravenes that definition.[4] Rules of interpreting insurance contracts have been developed. An example is the rule in California that, where there is an exclusionary term in a policy which the insured would not reasonably expect, it must be set forth in conspicuous, plain and clear.[5] As noted, Courts have also applied long-held judicial doctrines, such as waiver and estoppel to the resolution of insurance disputes.

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[3] *Erreca v. Western States Life Ins. Co.*, 19 Cal.2d. 388, 394-5 (1942).
[4] *Hangarter v. Provident Life & Acc. Ins. Co.*, 387 F.3d 998, 1006-07 (9th Cir. 2004).

Unfortunately, all of these remedies have been wiped out in one fell swoop by ERISA preemption.

2. THE ERISA "REMEDY" IS GROSSLY INADEQUATE.

A. ERISA Fundamentals – The Regulation of Funds Maintained for the Benefit of Employees.

Congress enacted ERISA in 1974 to reform the private pension industry. The Act was intended to assure that workers who were relying upon promised pension benefits to provide for themselves and their families during retirement years actually received the benefits.[6] Employers were leading employees to believe that they were maintaining retirement and similar funds for their benefit, but when it came time to provide the benefits, conflicts of interest, mismanagement, and sometimes skullduggery caused plan participants to lose their retirement security when companies went bankrupt or out of business, leaving unfunded promises of pension benefits. Thus, ERISA was passed largely in an attempt to protect pension benefits by requiring proper funding and assuring proper management of pension funds. Protecting "the continued well-being and security of millions of employees and their dependents" was an express congressional declaration of policy. 29 U.S.C. §1001.

Importantly, it was the protection of pension *funds*, which ERISA's fiduciary responsibility provisions were intended to address. "ERISA was passed by Congress in 1974 to safeguard employees from the abuse and mismanagement of *funds* that had

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[5] *Haynes v. Farmers Ins. Exch.* 32 Cal.4th 1198, 1204 (2004).

[6] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). While private pensions had existed in this country since the late 19th century, the industry did not begin to boom and consequently affect a large portion of the population until during and after World War II. Congress began to study reported abuses in the private pension industry and to focus on legislation to reform the industry in the 1960s, which ultimately led to ERISA's enactment in 1975. *See* Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TULANE L. REV. 951, 964-972 (2000) and discussion in text at Part 3 below.

been accumulated to finance various types of employee benefits".[7] Indeed, the name ERISA accurately describes its purpose. ERISA is an acronym which stands for the "Employee *Retirement* Income Security Act" (emphasis added). The substantive provisions of ERISA are almost entirely directed to the protection of funds which are set aside for the benefit of employees. ERISA regulates vesting requirements, minimum funding requirements, minimum fiduciary standards, portability and disclosure requirements. It also provides a means of reinsuring these funds through the creation of Pension Benefit Guarantee Corporation.

ERISA applies to benefits which accrue to an employee pursuant to an employee benefit plan which is established or maintained by an employer with the purpose of providing benefits to its employees. For no apparent reason, ERISA included within the scope of an employee benefit plan any "plan fund or program . . . established or maintained by an employer . . . for the purpose of providing" various insurance, unemployment and vacation benefits. 29 U.S.C. §1002(1). The inclusion of insurance benefits within ERISA is quite puzzling because insurance programs generally have nothing to do with funds, which are set aside for the benefit of employees and are therefore subject to abuse by employers. Insurance is generally provided through a contract with an outside insurance company and maintained by the ongoing payment of premiums. Moreover, there is *nothing* in the legislative history to suggest that ERISA was intended to deal with *any* insurance problems and there was *nothing in ERISA as enacted to regulate insurance.* As explained below, the legislative history is, and the law as enacted was, devoted exclusively to pension issues.

One can imagine that Congress included insurance plans in order to extend ERISA's basic disclosure elements to all employee benefit plans. But it makes no sense

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[7] *Massachusetts v. Morash,* 490 U.S. 107, 113 (1989) (emphasis added).

for ERISA to preempt all state insurance remedies when ERISA provided no substantive regulation of insurance and its remedial provisions were directed exclusively to the regulation of pension funds. This would create a vacuum of insurance regulations such that neither insureds, the states, nor the federal government could hold insurance companies to their responsibilities, thereby letting insurers operate with virtual freedom from responsibility for wrongful acts.

The answer to this puzzle would seem to be found in the structure of ERISA itself. While ERISA includes insurance benefits within the definition of ERISA plans, it then "saves" from preemption all laws regulating insurance -- except for those laws which affect self-funded insurance benefits (*i.e.*, the only insurance plans which involve a fund maintained by the employer for the employees' benefit).

B. <u>ERISA's Preemption Provisions.</u>

ERISA contains a broad preemption clause, which preempts any state law relating to an ERISA employee benefit plan (sometimes referred to herein as an "ERISA plan"). Section 1144(a) provides, "[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Subsection (b) is known as the "saving" clause. It provides that "*nothing* in this subchapter shall be construed to exempt or relieve any person from *any* law of *any* State which regulates insurance . . . ." (§1144(b)(2)(A) (emphasis added).) The pertinent subchapter runs from §1001 to §1191c and includes both the remedial/enforcement provisions (§1132) and the preemption clause (§1144(a)).[8] Thus, the savings clause states unequivocally

[8] Section 1144(b)(2)(B) is known as the "deemer" clause. This "deems" that any self-funded or self-insured benefit program is not intended to qualify as an insurance policy or insurance company for purposes of the saving clause exemption from preemption for state laws that regulate insurance.

that nothing in ERISA's preemption clause or remedies provisions will preempt any state law which regulates insurance.

This is completely consistent with ERISA's legislative history, which was focused on the abuse by employers of funds supposedly set aside for the benefit of employees. It is also consistent with the McCarran-Ferguson Act, which reserves all regulation of insurance to the states and specifically prohibits federal regulation of insurance unless specifically set forth in federal legislation.[9]

Similarly, it is consistent with the fact that the federal government has long respected the tradition of the states to regulate insurance and the states' extensive and comprehensive efforts to do so over many decades. Every state has extensive insurance regulations in its insurance code, and every state has an Insurance Commissioner, whose responsibility is to oversee the state's regulation of insurance. Moreover, as explained above, many states have developed special causes of action specifically designed to address abuses in the insurance field.

Nonetheless, in 1987 the United States Supreme Court ruled in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987)[10] that ERISA's remedies are exclusive and that, regardless of the saving clause, *all* state insurance law remedies are completely preempted. The Court held that ERISA's legislative history suggests Congress intended that the enumerated remedies set forth in ERISA to be the *exclusive and only remedies* available to *any* participant in an ERISA plan, including claims for insurance benefits. This

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Consequently, while the saving clause literally saves from preemption any state laws regulating insurance, the deemer clause maintains ERISA's exclusive regulation over self-insured funds.

[9] The McCarran-Ferguson Act provides: "Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." (15 U.S.C. §1011.) Additionally, the McCarran-Ferguson Act states that "No Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance . . ." 15 U.S.C. § 1012(b).

[10] *Pilot Life* is discussed in detail in section 4 *infra*.

conclusion is directly at odds with the language of the statute itself as well as the legislative history of ERISA.

As we discuss at length below, this decision appears to have been the result of terrible briefing by the parties. In 1998, the United States Solicitor General, Seth Waxman, explained to the Supreme Court that its reasoning in *Pilot Life* was wrong. However, the Court has refused to revisit the issue. Justice O'Connor, who wrote the *Pilot Life* opinion, has twice been reported to have said that she anticipated that Congress would correct the problem shortly after her initial opinion in 1987. However, Congress has never acted.

C. ERISA's Remedies.

Fundamental to any right afforded by a statute is the ability to enforce that right. However, ERISA's remedies, as interpreted by the courts, are absurd. Under ERISA, a wronged insured has only one claim. S/he may file a lawsuit claiming the benefits that have been denied. However, this right is extremely limited and is far inferior even to a simple claim for breach of contract. Fundamental to the problem is that the Supreme Court has likened an insured's right to challenge an insurance company's denial of benefits under ERISA as akin to someone attempting to overturn a decision of a trustee or a governmental body. However, in this instance, private insurance companies are considered the trustee or governmental bodies. In essence, when making a claims decision, an insurance company is entitled to all the protections and immunities which ordinarily would be granted to an administrative body. Here are a few of the problems.

1. No Right To Jury Trial.

Extraordinary as it might seem, under ERISA, there is no right to a jury trial for an insured who sues an insurance company for failing to pay promised benefits.[11]

2. No Right To Pre-Trial Discovery.

Because the insurance decision was supposedly made by the insurance company, its claims file is considered the "administrative file." Thus, in most instances, no evidence can be presented to the Court except that which is in the insurance company's claims file. As a result, there is no right to formal discovery -- other than what is in the insurance company's claims file. The Courts sometime permit discovery to determine if the insurance company has a "conflict of interest." But discovery is never permitted on the merits of the claim.

3. No Right to Submit Evidence to the Court.

Normally no evidence is permitted except what was in the insurance company's file at the time claim was denied.[12]. The insured does not even have the right to testify about his/her claim.

4. The Insured May Not Simply Prove that the Claim was Denied Incorrectly. Normally, S/He Must Prove that the Claim was Denied Arbitrarily and Capriciously.[13]

This is really quite a shock to most people. Proving that the insurance company was wrong gets an insured nowhere. In order to obtain benefits wrongfully denied, an insured normally has to prove that the insurance company's actions were arbitrary and capricious! Therefore, if an insured proves the insurance company wrongfully denied the claim, the insurance company wins the lawsuit. It is hard to imagine what possible

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[11] *See, e.g., Tischman v. ITT/Sheraton Corp.*, 145 F.3d 561, 568 (2d Cir. 1998) *cert. denied*, 525 U.S. 963 (1998); *Adams v. Cyprus Amax Mineral Co., 149 F.*3d 1156, 1158-63 (10th Cir. 1998); *Parrino v. FHP, Inc.*, 146 F.3d 699, 706-07, *cert. denied*, 525 U.S. 101(1998).

[12] See *Kearney v. Standard Ins. Co.* 175 F.3d 1084 (9th Cir. 1999).

rationale could support such a result. This standard is so biased towards the insurance company that all an insurance company has to do is find any non-arbitrary reason to deny a claim and there is nothing an insured can do about it. It is really not that far from the "beyond a reasonable doubt" criminal standard. In other words, the insurance company wins unless the insured can prove "beyond a reasonable doubt" that s/he is entitled to benefits. That is to say that the insured must satisfy the criminal burden of proof to get insurance benefits. Imagine that -- the insurance industry gets the benefit of a criminal standard of proof before it can be required by a court to pay benefits owed to an insured.

The case of *Garcia v. Fortis Benefits Ins. Co.*, 2000 WL 92340 (E.D. Penn. 2000) is a particularly graphic presentation of the problem. In *Garcia*, the insurer denied benefits because the insured did not submit his claim on time. The United States Supreme Court, however, later ruled that an insurance company cannot deny a claim on this basis unless it can demonstrate that it suffered actual prejudice from the late filing. The court in *Garcia* agreed that, under the Supreme Court's ruling, the insurer's denial was wrong as a matter of law. Nevertheless, the court ruled against the insured and in favor of the insurance company. The reason given by the court was that the insurance company had denied the claim before the Supreme Court ruling. Thus, the court concluded, its denial was not arbitrary and capricious under the law then existing.[14] As a result, the insured in *Garcia* lost her benefits, not because she failed to prove her insurer wrongfully denied them, but because she failed to prove it was wrong enough. Only under ERISA could such a tortured result exist.

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[13] *Id.; Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).
[14] *Garcia*, at **11-12.

This standard of proof is the result of another Supreme Court decision. In *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101 (1989), the Court held that a *de novo* standard of review would apply in ERISA cases -- unless the insurance policy contained a provision providing for a discretionary standard. If the policy provided a discretionary standard, then the insurance company's decision was subject to an arbitrary and capricious standard. It didn't take the insurance industry long after *Firestone* to amend all of their policies to include the discretionary standard language. Thus, the practical result of *Firestone* is that virtually all insurance claims are subject to the arbitrary and capricious standard.[15]

To be sure, the insurance industry is diligent in classifying any claim it can under ERISA. An internal memorandum from the largest disability carrier in the world (attached hereto as **Exhibit 1**) reads:

> A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefits in question, and claims administrators may receive a deferential standard of review. As an example, Glen Felton identified 12 claim situations where we settled for $7.8 million in the aggregate. If those 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.

[15] The Supreme Court has recently held that a district court can modify the arbitrary and capricious standard if it finds that the insurance company had a conflict of interest. However, whether the insurer had a conflict sufficient to affect the insurer's decision or to alter the standard of review are decisions that have no guidelines whatsoever. They are entirely at the discretion of the district court. *Metropolitan Life Ins. Co. v. Glenn,* 128 S.Ct. 2343 (2008). Justice Scalia in dissent referred to this process as suggesting that all the circumstances should be "chucked into a brown paper bag and shaken up to determine the answer." *Id.* at 2358.

It is simply not possible to defend this ridiculous standard of review. What logic would support the conclusion that an insurance company would be required to pay $7.8 million under state law, but between zero and $.5 million under ERISA?

But it gets worse.

5. Winning Often Means Giving the Insurance Company a Second Chance to Find Some Reason to Justify a Denial.

Even if the insured is able to show from the file which the insurance company has compiled that the claim was denied arbitrarily or capriciously, that still doesn't mean the insured gets benefits. In many instances, the result is a court order merely returning the claim to the insurance company and ordering it to evaluate the claim again.[16] This result is absurd. After the Court provides all the parties with an order explaining why the insurance company was arbitrary and capricious, it then gives the insurance company another opportunity to go out and obtain information sufficient to deny the claim again, but this time to make sure that its denial is not arbitrary and capricious. In other words, after the insured wins, the Court hands the insurance company a map describing how to properly deny the claim.

6. No Right to Compensatory or Punitive Damages.

Under ERISA, an insurance company has no responsibility for any harm that it may cause to its insureds – even if that harm is intentionally caused or its actions are unreasonable, grossly reckless, deliberate or even malicious. Insurance companies have complete and total immunity against harm caused by their wrongful actions. There is simply no right to obtain any damages of any kind for any harm which may have been caused to an insured for the wrongful denial of benefits -- no matter how egregious, outrageous or intentional the conduct may be. Thus, if an insurer wrongfully denies a

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[16] *See Saffle v. Sierra Pacific Power*, 85 F.3d 455, 461 (9th Cir. 1996).

medical claim, which results in the death of an insured, the insured's family has no remedy at all. This is what happened in the *Andrews-Clarke* case. If the denial of disability benefits results in the bankruptcy of an insured, there is no remedy.

Similarly, if the denial of the claim was attributable to malfeasance on the part of third parties (such as the employer or an agent), no claim can be stated against these entities. Thus, even if an agent or employer defrauded the employee into believing that there was coverage under a policy when there wasn't, no remedy of any kind is available.

There are no punitive damages or other penalties.[17] Accordingly, there is nothing to deter an insurer from denying claims deliberately, fraudulently or maliciously.

7. Exception for Employees of Government Agencies and Religious Organizations.

There is another remarkable and inexplicable inequity of ERISA. No employee of a governmental body or church organization is subject to ERISA preemption.[18] Members of Congress and their staff are completely exempted from ERISA. So are senators, federal and state judges, state legislators and their staffs. Employees of any and every governmental body from local school districts, park districts, transit authorities and water districts all the way up to the President of the United States and his staff are completely exempted from ERISA. Thus, the local legislator and his secretary may exercise all of their state law rights without regard to the remedies set forth in ERISA, but the local maintenance worker hired by a private company to clean their offices, the grocers across the street, the truck drivers and delivery people who supply their offices, the workers at the restaurants where they eat, the salespeople at the

[17] *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

stores where they shop, the electricians, carpenters and repair people who keep their homes and offices running, and the lawyers, doctors and accountants who service them are stuck with ERISA's inadequate remedies.

Similarly, priests, bishops and rabbis, as well as their staffs and employees, are exempt from ERISA. However, all the people whom they serve and counsel and with whom they pray are stuck under ERISA.

Once again, there is no apparent answer as to why this should be in the context of insurance claims. Nothing in ERISA explains why government workers should get full state rights, but everyone else is limited to ERISA. Assume there are two secretaries living right next door to each other, one of whom works for a local city councilman and the other who works at a small accounting firm. Both develop the exact same disabling condition. Both have the exact same doctor, the exact same insurance policy with the same company and, in fact, the very same claims examiner. Both claims are denied for the same reason. The government city worker is entitled to sue the insurance company for breach of contract and all other state law remedies. But her neighbor cannot get her benefits unless she can prove to a judge, without a jury, based solely on the documents in the insurance company's file, that her insurance company was arbitrary and capricious. In addition, the local worker can sue for all compensatory damages caused by the denial of her claim and for punitive damages if the insurance company's conduct was fraudulent or outrageous. Her neighbor has no such right. If both lost their houses as a result of the denial of benefits, the government worker could seek compensation for that loss; the private sector worker could not.

There is no rhyme or reason to this arbitrary inequity. Yet this statute has been in effect for 35 years without any congressional effort to correct this inequity.

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[18] 29 U.S.C. §1003(b).

8. Subrogation.

When a person is injured, her medical insurance company is responsible for the medical bills. If that person files a suit against the party(ies) who injured her, the medical insurance company can seek reimbursement for its payments out of the proceeds of the lawsuit. However, in most states there is a "make whole" doctrine, which provides that the injured person is entitled to full compensation before the insurance company can be reimbursed. ERISA insurers have simply written their policy to eliminate the local state "make whole" law.

The recent case of *Admin. Committee of the Wal-Mart Stores v. Shank,* 500 F.3d 834 (8th Cir. 2007); *cert. denied,* 128 S.Ct. 1651 (2008) received substantial media attention because of its shocking facts. Deborah Shank, a Wal-Mart employee, suffered severe brain damage in an automobile accident, was rendered incompetent and confined to a nursing home. She also lost a child fighting in Iraq. Because her short-term memory is damaged, she breaks down whenever reminded that her son is dead as if she was hearing it for the first time. She filed suit against the responsible parties and eventually obtained a settlement of $700,000. After attorneys' fees and costs, she was left with about $417,000. The Wal-Mart health plan had paid out $470,000 in medical expenses and claimed under its ERISA policy that it was entitled to all of Ms. Shank's $417,000. The Court of Appeal for the 8th Circuit agreed and awarded Wal-Mart the entirety of Ms. Shank's settlement recovery. Under the Court's ruling, Ms. Shank's portion of the $700,000 settlement was $0. After winning the case, as a matter of public relations, Wal-Mart chose not to pursue its claims. However, the practice that would have left Ms.

Shank penniless is repeatedly applied to thousands of other insureds, whose claims don't make the newspapers.[19]

3. ERISA'S LEGISLATIVE HISTORY IS UNEQUIVOCAL IN ITS INTENT TO REGULATE PENSION BENEFITS AND WAS NOT INTENDED TO IMPACT THE FIELD OF INSURANCE.[20]

An examination of ERISA's legislative history establishes that the above results were never intended. ERISA grew directly from the explosion in private pension plans during the middle of the last century. The number of employees covered by such plans grew from approximately four million in 1940 to over 30 million by 1973.[21] The estimated assets held by such plans during this same period grew from $2.4 billion to $150 billion.[22] With this explosive growth came a similarly expansive growth in the abuses of such funds.[23] In addition, the enormous accumulation of such funds exerted a

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[19] Other inequities and inexplicable provisions abound within ERISA. We cannot explore them all in this paper. Nearly all are the results of Courts trying to apply the Supreme Court's preemption analysis. But it is the legal equivalent of trying to put a square peg in a round hole. For example, some courts, in resolving the denial of insurance claims, have held that the insured does not sue the insurance company, but is supposed to sue the ERISA "plan" itself. *Everhart v. Allmerica Financial Life Ins. Corp.*, 275 F.3d 751 (9th Cir. 2001). Suing the "plan" makes sense where there is a fund to sue. But typically, there is no fund and thus no "plan" relating to insurance claims. Thus, the Courts create a fictitious entity under ERISA which serves no purpose other than an entity to be sued. For example, if John Doe were employed by The Smith Company, which was insured by ABC Health Insurance Company, John Doe would not sue ABC Health or The Smith Company. He would sue "The Smith Company Health Insurance Plan," which is a non-existent entity.

[20] The legislative history of ERISA is largely set forth in a three volume publication of the Subcomm. on Labor of the Senate Comm. on Labor and Pub. Welfare, 94th Cong., Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print 1976) [hereinafter "Legislative History"]; see also, Special Comm. on Aging, U.S. Senate, 98th Cong., The Employment Retirement Income Security Act of 1974: The First Decade 1-25 (Comm. Print 1984) [hereinafter "The First Decade"]. The legislative history discussed herein is carefully and extensively set forth in greater detail in Bogan, *supra,* note 6, 74 Tul. L. Rev. 951; See also David Gregory, The Scope of ERISA Preemption of State Law: A Study in Effective Federalism, 48 U. Pitt. L. Rev. 427, 437-457 (1987.

[21] See S. Rep. No. 93-127, at 3, reprinted in 1974 U.S.C.C.A.N. at 4839-40, and in 1 Legislative History, *supra* note 20, at 589.

[22] See H.R. Rep. No. 93-533, at 3, reprinted in 1974 U.S.C.C.A.N. at 4641, and in 2 Legislative History, *supra* note 21, at 2350; The First Decade, *supra* note 20, at 5; James D. Hutchinson & David M. Ifshin, Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974, 46 U. Chi. L. Rev. 23, 24 (1978).

[23] *See* 120 Cong. Rec. 29,934 (1974), *reprinted in* 3 Legislative History, *supra* note 20, at 4748 (statement of Sen. Javits); The First Decade, *supra* note 20, at 6 n.22 (citing congressional hearings on abuse in pension plan administrations); *see also* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism, supra* note 21, at 443-45 (referring to the many abuses in employee pension plans listed in ERISA's legislative history).

major impact on the country's financial markets.[24] This explosion occurred without the benefit of any effective federal or state regulation.[25]

In 1954, at the request of President Eisenhower, Congress undertook an extensive study of the private pension industry.[26] This study disclosed abuses, including incompetent management of pension funds, looting, embezzlement, kickbacks, excessive administration costs and imprudent investment practices.[27] In response, Congress enacted the Welfare and Pension Plans Disclosure Act ("WPPDA") in 1958.[28] This law merely required the disclosure of certain financial information to the employees and did not provide any meaningful regulation of the funds themselves.[29]

This legislation was wholly ineffective.[30] Consequently, in 1962 President Kennedy appointed a special task force to study the problem.[31] The task force concluded that further federal regulation of private pension plans to include mandatory minimum vesting and funding requirements was necessary and that further study was required on other issues.[32] Significantly, the task force specifically did not investigate or consider any reforms of nonpension plans, such as health insurance plans.

> Although the area of investigation assigned to the Committee included welfare plans as well as retirement programs, the President's memorandum specifically raised questions about issues which arise primarily from retirement

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[24] *Id.* H.R. Rep. No. 93-533, at 3, reprinted in 1974 U.S.C.C.A.N. at 4641, and in 2 Legislative History, *supra* note 20, at 2350.
[25] See note 21 *supra.*
[26] See S. Rep. No. 85-1440, at 2-11 (1958), reprinted in 1958 U.S.C.C.A.N. 4137.
[27] *Id.* at 4137-47.
[28] Pub. L. No. 85-836, 72 Stat. 997 (1958) (repealed 1974).
[29] See H.R. Rep. No. 93-533, at 4, reprinted in 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 20, at 2351; Malone v. White Motor Corp., 435 U.S. 497, 507 (1978) (plurality opinion).
[30] See S. Rep. No. 93-127, at 4, reprinted in 1974 U.S.C.C.A.N. at 4841, and in 1 Legislative History, *supra* note 20, at 590; H.R. Rep. No. 93-533, at 4, reprinted in 1974 U.S.C.C.A.N. at 4642, and in 2 Legislative History, *supra* note 20, at 2351.
[31] See President's Comm. on Corporate Pension Funds and Other Private Retirement and Welfare Programs, Public Policy and Private Pension Programs: A Report to the President on Private Employee Retirement Plans, at vii-viii (1965) [hereinafter "President's Committee Report"]; see also The First Decade, *supra* note 20, at 8-10 (describing the formation of the committee and its findings).
[32] *Id.*

> plans. Other types of welfare plans, such as health and insurance plans, make important contributions to the economic security of American workers; they do not, however, have the impact of pension plans on accumulation of savings, labor mobility, and similar matters touched upon by the President. Consequently, the Committee has confined its efforts to an inquiry into private employee retirement plans (i.e., excluding plans for self-employed persons) without any extensive study of other types of welfare plans.").[33]

In response to these concerns, New York Senator Jacob Javits introduced legislation in 1967 to create federal funding and participation requirements for private pension plans.[34] This led to further congressional investigations and eventually ERISA. In 1970, the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare began a three-year study "undertaken to ascertain the need for statutory protections for workers' pension programs and to formulate appropriate corrective legislation."[35] Like the previous investigations, the subcommittee's hearings disclosed a morass of abusive practices resulting in the loss of retirement benefits to employees as the result of inadequate funding, mismanagement and unreasonable vesting requirements.[36] It agreed with President Kennedy's task force and recommended comprehensive regulation of the pension industry.[37] Shortly thereafter, Senator Javits introduced Senate Bill 4. It stated, "[t]he purpose of S. 4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems which

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[33] See President's Committee Report, *supra* note 31, at iv.
[34] See 113 Cong. Rec. 4650-53 (1967) (statement of Sen. Javits); see also 120 Cong. Rec. 29,933-34 (1974), reprinted in 3 Legislative History, *supra* note 20, at 4748 (remarks of Sen. Javits) (recounting his continued efforts to reform the private pension and welfare system).
[35] See S. Rep. No. 92-634, at 1 (1972); see also 119 Cong. Rec. 30,003 (1973), reprinted in 2 Legislative History, *supra* note 20, at 1598 (statement of Sen. Williams).
[36] See H.R. Rep. No. 93-533, at 5-8 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4643-46, and in 2 Legislative History, *supra* note 20, at 2355.
[37] See 120 Cong. Rec. 29,935-44 (1974), reprinted in 3 Legislative History, *supra* note 20, at 4748 (remarks of Sen. Javits).

have been determined by the Senate Subcommittee's comprehensive study of such plans."[38] A corresponding House bill was also introduced.[39]

These bills were sent to their appropriate committees, which issued their own reports. Each of these reports concerned themselves solely with abuses in and the consequent need for regulation of private pension plans.[40] The Senate Committee on Labor and Public Welfare report stated:

> The provisions of S.4 are addressed to the issue of whether American working men and women shall receive private pension plan benefits which they have been led to believe would be theirs upon retirement from working lives. It responds by mandating protective measures and prescribing minimum standards for promised benefits. The purpose of S.4 is to prescribe legislative remedies for the various deficiencies existing in the private pension plan systems. . . .[41]

The report stated that the principal issues affecting the vital and basic needs for legislative reform involve consideration of the essential elements of pensions: (1) vesting; (2) funding; (3) reinsurance; (4) portability; and (5) fiduciary responsibility and disclosure.[42] Similarly, the House Committee on Education and Labor report stated that the "primary purpose of the bill is the protection of individual pension rights" and that the legislation was designed to: (1) establish minimum fiduciary standards for retirement plans; (2) provide for enforcement and public disclosure of finances; (3) improve the equitable character and soundness of private pension plans by requiring

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[38] S. 4, 93d Cong. (1973); see S. Rep. No. 93-127 (1973), at 1, reprinted in 1974 U.S.C.C.A.N. 4838, 4838, and in 1 Legislative History, *supra* note 20, at 587.

[39] See H.R. 2, 93d Cong. (1973), reprinted in 1 Legislative History, *supra* note 20, at 3.

[40] See S. Rep. No. 93-127, at 1-36, reprinted in 1974 U.S.C.C.A.N. at 4838-89, and in 1 Legislative History, *supra* note 20, at 587-622; H.R. Rep. No. 93-533, at 1-28, reprinted in 1974 U.S.C.C.A.N. at 4639-70, and in 2 Legislative History, *supra* note 20, at 2348-75; 120 Cong. Rec. 29,933-35 (1974), reprinted in 3 Legislative History, *supra* note 20, at 4746-51 (remarks of Sen. Javits).

[41] S. Rep. No. 93-127, at 1, reprinted in 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 20, at 587.

[42] S. Rep. No. 93-127, at 8-11, reprinted in 1974 U.S.C.C.A.N. at 4844-77, and in 1 Legislative History, *supra* note 20, at 594-97 (emphasis omitted).

(a) appropriate vesting; and (b) minimum funding standards; and (4) guarantee the adequacy of the plan's assets prior to termination.[43]

ERISA's legislative history is unequivocal that it was intended as a pension reform bill. In describing ERISA, Senator Javits said, "[t]he pension reform bill is the greatest development in the life of the American worker since Social Security. For the first time in our history, most workers will be able to truly retire at retirement age and live decently on their social security and private pensions."[44] Senator Williams, Chairman of the Senate Committee on Labor and Public Welfare, described his committee's study which led to ERISA. "This study clearly established that too many workers, rather than being able to retire in dignity and security after a lifetime of labor rendered on the promise of a future pension, find that their earned expectations are not to be realized."[45] In the House, one of the principal proponents, Representative Dent, described ERISA's purpose in this way: "[W]e started out with only one aim in view and that was to give a pension participant his entitlements under the contract of the pension plan he belonged to."[46] The record is filled with tragic examples of workers deprived of pension benefits after 30, 40 and 50 years of employment because they were a few days short of vesting before retiring, the company was sold or went bankrupt, or because the employer could not afford to pay the promised retirement benefits.[47]

What is clear from this long and extensive legislative history and the statute itself is that the exclusive concern of Congress in passing ERISA was to address abuses in the

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[43] H.R. Rep. No. 93-533, at 1, 17-18, reprinted in 1974 U.S.C.C.A.N. at 4655-56, and in 2 Legislative History, *supra* note 20, at 2348, 2364-65.
[44] Legislative History, *supra* note 20, at 4747 (Remarks of Sen. Javits).
[45] Legislative History, *supra* note 20, at 4733 (Remarks of Sen. Williams).
[46] Legislative History, *supra* note 20, at 4665 (Remarks of Rep. Dent).
[47] See e.g. Legislative History *supra* note 20, at 4749-50 (Remarks of Sen. Javits on "Why Pension Reform Is Needed), (4791-96) (Remarks of Sen. Bentson), (4664-65) (Remarks of Rep. Thompson), (4710) (Remarks of Rep. McClory); Interim Report of Activities of the Private Welfare and Pension Plan Study, Subcommittee

pension field. Not a single insurance concern is expressed anywhere in the legislative history. Instead, Congress expressly saved all insurance regulation to the states. Indeed, the Supreme Court has stated that there is no legislative history discussing the relationship between the saving clause and the general preemption clause, and there is a "complete absence of evidence" to support a narrow reading of the saving clause.[48] The Supreme Court therefore "decline[d] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself . . . If a state law 'regulates insurance,' . . . it is not pre-empted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause. . . ."[49] Indeed, it is unclear even why insurance (other than self-funded plans) was included within ERISA. The legislative history tells us nothing about that.

A commentator who has extensively reviewed ERISA's legislative history reports:

> . . . ERISA's legislative history is remarkable . . . for what it does not contain. ERISA's legislative history provides no evidence that Congress seriously investigated, studied, or debated any issues or concerns with nonpension employee benefit plans.
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> There is no documentation anywhere in ERISA's legislative history of any study or investigation of the history or growth of non-pension benefit plans, or of any specific concern with the management of nonpension plan assets. Further, ERISA's legislative history fails to disclose any concerted investigation of any complaints about nonpension benefits, such as inadequate health care, accident, death or disability coverage, or problems with health, life, or disability benefits claims. In short, Congress just was not dealing with nonpension benefit plans when it enacted ERISA.
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> Bogan, *Protecting Patient Rights, supra,* note 6, at 972, 976-77.

On Labor of the Committee on Labor and Public Welfare, S. Rep. No. 92-634, 92d Cong., 2d Sess. (1972) at 67-90.

[48] *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 745-6, n.21 (1985).

Moreover, as it turns out, the broad preemption clause of ERISA was added "at the last minute"[50] and the bill was rushed through Congress in order to meet an anticipated signing date by President Ford on Labor Day, 1974. In the process, the preemption clause escaped *any* analysis by Congress. Before the matter went to the Conference Committee, both the House and the Senate versions of the bill contained a preemption provision which was expressly limited to only those matters which ERISA regulated.[51] In light of the fact that ERISA did not regulate insurance in any respect, ERISA thus preempted little, if any, state activities.

However, this situation changed dramatically with the expansion of the preemption clause. As the Supreme Court explained the situation:

> The change in the pre-emption provision was not disclosed until the [Conference] Report was filed with Congress 10 days before final action was taken on ERISA. The House conferees filed their Report, H.R.Conf.Rep. No. 93-1280, on August 12, 1974, while the Senate conferees filed their report, S.Conf.Rep. No. 93-1090, the following day. 30 Cong. Q. Almanac 252 (1974). ERISA was passed by the House on August 20, and by the Senate on August 22. 120 Cong.Rec. 29215-29216, 29963 (1974) . . . .
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> The pre-emption clause apparently was broadened out of a fear that "state professional associations" would otherwise hinder the development of such employee-benefit programs as "pre- paid legal service programs." See 120 Cong.Rec. 29197 (1974) (remarks of Rep. Dent); *Id.*, at 29933 (remarks of Sen. Williams); *Id.*, at 29949 (remarks of Sen. Javits). There is no suggestion that the pre- emption provision was broadened out of any concern about state regulation of insurance contracts, beyond a general concern about "potentially conflicting State laws." See *Id.*, at 29942 (remarks of Sen. Javits).[52]

Moreover, the Supreme Court has also characterized the preemption clause as being unusually broad[53] and poorly written by Congress.

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[49] *Id.* at 746-47.
[50] *Id.* at 745.
[51] *Id.*
[52] *Id.* at 745-6, n.23.
[53] See *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 363 (2000) (noting ERISA's "broad" scope); *Pilot Life*, 481 U.S. at 47 (describing ERISA's "expansive sweep"); *Metropolitan Life*, 471 U.S. at 739 (referring to

> The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time. [54]

Notwithstanding this unique nature of this preemption clause, it was never discussed in any depth. "There were no comments on the floor of either Chamber specifically concerning the insurance saving clause, and hardly any concerning the exceptions to the pre-emption clause in general."[55]

Thus, we are left with a preemption provision which is unusually broad and poorly written, was not debated or discussed at any length in the legislative process, was added at the last minute with little or no consideration by the full committees or entire bodies of either legislative body and which had no purpose which was related in any way to insurance. Yet this provision now sits as perhaps the most important development in insurance law in the last quarter-century.

4. <u>JUDICIAL EXPANSION OF PREEMPTION.</u>

In 1987, the Supreme Court held in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), that ERISA's remedies are the exclusive vehicle for any claim covered by ERISA, including insurance claims. Therefore, even if a state has a law which is directed solely towards the regulation of insurance companies and thus is expressly saved from preemption (such as the law of insurance bad faith), any claim under such a law is still preempted. This holding makes little sense in light of the legislative history.

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its "broad scope"); *FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990) (noting that ERISA preemption is "conspicuous for its breadth"). Of course, the Supreme Court has also said that the saving clause is equally broad. It is "phrased with similar breadth" as the preemption clause, *Ward,* 526 U.S. at 363 and "pre-emption is substantially qualified by an 'insurance saving clause,' . . . which broadly [saves state insurance laws]. . . ." *Metropolitan Life* at 733.

[54] *Metropolitan Life,* 471 U.S. at 739.

[55] *Id.* at 746.

The reason for this absurd decision might be found in the briefs, which were filed in the Supreme Court in the *Pilot Life* case. They were shockingly inadequate. The total amount of briefing on the issue of the exclusivity of ERISA's remedies was contained *only in the last three paragraphs* at the very end of the Solicitor General's *amicus* brief in which it urged the Court to accept the petition for certiorari.[56] Therein, the Solicitor General cited *only one sentence* of legislative history. No one else briefed the issue at all. The only brief filed on behalf of the insured was a *grand total of only 17 pages* and contained *no discussion* regarding the exclusivity of ERISA's remedies other than to cite the saving clause itself.

Thus, one of the most important developments of insurance law in the last 25 years was decided in Congress without any substantive debate and by the Supreme Court without any significant briefing.

The Court in *Pilot Life* identified two reasons for determining that ERISA's civil enforcement mechanisms were intended to be the exclusive vehicle for remedying the improper processing of claims under ERISA. The first reason noted by the Court was that the language and structure of the civil enforcement provisions set forth what appeared to be a carefully crafted comprehensive civil enforcement scheme. Accordingly, the Court was willing to assume that Congress did not intend to authorize any additional remedies, which were not set forth in ERISA's remedial provisions. There are, however, glaring problems with this analysis. First, as set forth above, there is no adequate remedy under ERISA for insurance claimants. Second, the "language and structure of ERISA" includes the saving clause. In 1998, the United States Solicitor General explained these flaws in Court's analysis. Addressing the precedent of *Pilot Life*, the Solicitor General said,

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[56] The Solicitor General chose not to submit any other briefs after the Court agreed to hear the case.

> . . . Congress has saved state substantive law, and it is not clear why Congress would have wanted to foreclose all access to state-created remedies or sanctions to enforce that substantive law, see, e.g., *Metropolitan Life*, 471 U.S. at 734 (suit by state Attorney General against insurer of ERISA plans to enforce provision of state insurance law), especially where the causes of action provided under Section 502 itself are not suited to that purpose.
>
> The savings clause states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A) [emphasis omitted]. "[T]his subchapter" includes Section 502, which has been construed to provide exclusive remedies under ERISA, as well as the preemption provision itself, Section 514(a). Accordingly, the savings clause by its terms directs that nothing in Section 502, which concerns causes of action and remedies under ERISA, shall be "construed" to relieve or exempt any person from "any law" of a State that regulates insurance. Thus, the insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefits laws and other prescriptive measures that do so[57].

The other reason given by the Supreme Court was that a single sentence in the Conference Report compared ERISA to the LMRA, which has a broad exclusivity provision. This analogy is also deeply flawed because ERISA has a specific clause which saves certain laws from preemption. The LMRA does not have a savings clause. Once again, the Solicitor General in 1998 attempted to explain this fallacy to the Supreme Court:

> [T]he LMRA does not bear directly on the preemption of a state-law cause of action or remedy that 'regulates insurance.' That is because LMRA Section 301 does not contain any statutory exception analogous to ERISA's insurance savings provision.[58]

Nonetheless, the holding of *Pilot Life* remains the law in effect today.

5. THE COUNTLESS TRAGEDIES OF ERISA.

Alabama Federal Judge William Acker has written, "A hyperbolic wag is reputed to have said that ERISA stands for 'Everything Ridiculous Imagined Since Adam.' This court does not take so dim a view of the Employee Retirement Income Security Act of

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[57] Br. of United States as *Amicus Curiae* in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) at 20-25.

1974. Instead, this court is willing to believe that ERISA has lurking somewhere within it a redeeming feature."[59] Its redeeming features, however, are not easily located. Where such broad immunity lies in the hands of the powerful, the ability to oppress the vulnerable who are so dependent upon insurers is unfettered and has exploded out of control. ". . . powerlessness is one of the most debilitating kinds of human oppression."[60]

The following is a list of some published and unpublished cases in addition to those referenced above, which are the tip of a very large iceberg of gross inequities spawned by ERISA's immunity for insurers.

1. *Amschwand v. Sperion Corp.*, 505 F.3d 342 (5th Cir. 2007).

While Mr. Amschwand was on medical leave for cancer, his employer switched life insurance companies. Mr. Amschwand repeatedly sought and received assurance from his employer that he was covered under the new life insurance policy. He was told that he could enroll during open enrollment. He did so and paid his premiums for the coverage. He was repeatedly told that the documentation was not yet available but not to worry about it because he was covered. As the Court stated, "Mr. Amschwand diligently sought to ensure that his wife would be provided for under the plan." When Mr. Amschwand died, his wife submitted a claim under the policy. The claim was denied because the policy contained a provision, unbeknown to Mr. Amschwand, that he had to be an active full-time employee at the time of enrollment in order to be covered. The Fifth Circuit Court of Appeal held that, under applicable Supreme Court

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[58] *Ward* Br. at 25. The Court in *Ward* found it unnecessary to directly address the Solicitor General's arguments. However, in subsequent cases, the Court has refused to disturb its holding in *Pilot Life*.
[59] *Florence Nightingale Nursing Service, Inc. v. Blue Cross & Blue Shield*, 832 F.Supp. 1456 (N.D. Ala. 1993).
[60] *Rulon-Miller v. International Business Machines Corp.*, 162 Cal.App.3d 241, 254 (1984).

precedent, Mr. Amschwand's wife was without any remedy at all. She could not sue the insurance company nor could she sue the employer.

Justice Benavides filed a concurring opinion stating,

> The facts . . . scream out for a remedy beyond the simple return of premiums. Regrettably, under existing law it is not available. I am constrained to join the court's opinion, which I find correctly applies controlling precedent.

The United States Supreme Court denied certiorari on June 27, 2008.

2. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

The Court described the facts as follows:

> Florence Corcoran, a long-time employee of South Central Bell Telephone Company (Bell), became pregnant in early 1989. In July, her obstetrician, Dr. Jason Collins, recommended that she have complete bed rest during the final months of her pregnancy. Mrs. Corcoran applied to Bell for temporary disability benefits for the remainder of her pregnancy, but the benefits were denied. This prompted Dr. Collins to write to Dr. Theodore J. Borgman, medical consultant for Bell, and explain that Mrs. Corcoran had several medical problems which placed her "in a category of high risk pregnancy." Bell again denied disability benefits. Unbeknownst to Mrs. Corcoran or Dr. Collins, Dr. Borgman solicited a second opinion on Mrs. Corcoran's condition from another obstetrician, Dr. Simon Ward. In a letter to Dr. Borgman, Dr. Ward indicated that he had reviewed Mrs. Corcoran's medical records and suggested that "the company would be at considerable risk denying her doctor's recommendation." As Mrs. Corcoran neared her delivery date, Dr. Collins ordered her hospitalized so that he could monitor the fetus around the clock.
>
> * * *
>
> In accordance with the [terms of the insurance] plan, Dr. Collins sought pre-certification . . . for Mrs. Corcoran's hospital stay. Despite Dr. Collins's recommendation, [the insurance company] determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care. Mrs. Corcoran entered the hospital on October 3, 1989, but, because [the insurance company] had not pre-certified her stay, she returned home on October 12. On October 25, during a period of time when no nurse was on duty, the fetus went into distress and died.

The court found that all of the Corcorans' claims were preempted by ERISA and they have no remedy.

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. . . . While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans' position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.

3. *Cannon v. Group Health Service of Oklahoma*, 77 F.3d 1270 (10th Cir. 1996).

The facts are described by the court as follows:

Phyllis Cannon was diagnosed with acute myeloblastic leukemia in September of 1991. She was treated with chemotherapy, and her leukemia went into remission. The insurers paid for this medical treatment. Mrs. Cannon's treating physician, Dr. Ruben Saez, recommended she undergo an autologous bone marrow transplant (ABMT), and on August 10, 1992, sought preauthorization from the insurers.

* * *

On August 11, 1992, the insurers denied preauthorization for the ABMT, contending the treatment was experimental during a first remission of leukemia. Dr. Saez requested the insurers reconsider his request and submitted medical literature in an attempt to demonstrate his proposed treatment was not experimental. Dr. Saez also informed the insurers his request needed urgent action because it was critical the ABMT be completed prior to any cancer recurrence.

On August 21, 1992, the insurers again denied preauthorization. The Cannons persisted in their request for reconsideration, and on September 21, 1992, the insurers reversed their decision and agreed to authorize ABMT. Unfortunately, Mrs. Cannon was not notified until October 10, 1992, in a letter dated September 28, 1992. By that time, her leukemia had returned and she could no longer beneficially receive ABMT, and none was ever administered. She was admitted into the hospital on October 12, 1992, and died on November 21, 1992.

The Court lamented, "although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no

choice but to affirm" the dismissal of the insurance company because all of the Cannons' claims are preempted by ERISA.

4. *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003 (9th Cir. 1998) cert. denied, 120 S.Ct. 170 (1999).

In December 1990, Rhonda Bast was diagnosed with breast cancer and she underwent a left modified radical mastectomy in January 1991. In August 1991, she was diagnosed with a secondary malignancy in her left lung. Her oncologist recommended that she undergo an autologous bone marrow transplant procedure ("ABMT") and high dose chemotherapy at the Fred Hutchinson Cancer Research Center ("the Center").

On September 9, 1991, the Center contacted Prudential to request pre-authorization for the withdrawal, processing and storage of Rhonda Bast's bone marrow. On September 13, Prudential informed the Center that the bone marrow procedure was not covered by the Plan. On December 31, 1991, Prudential issued a complete denial of coverage for the ABMT procedure.

Rhonda Bast contacted an attorney who sent letters to Prudential stating that several other insurers had paid for the ABMT procedure and that Rhonda Bast "needs her bone marrow transplant in April [1992]. Without it she will most likely die."

The court continued the tale:

> Rhonda Bast's claim was further reviewed by Prudential on February 28, 1992. On that date, Prudential's medical director informed Rhonda Bast's claim consultant that "while the protocol is clearly investigational, since it is a NCI [National Cancer Institute] sponsored trial, and according to the rules established in a recent GCLM [Group Claim Division Memorandum], it is eligible for benefits." On that same day, the claim consultant called the Center and advised it that the ABMT procedure and high dose chemotherapy would be covered under the Plan. Prudential also mailed a letter confirming the coverage, and in early March 1992, Prudential reimbursed the Basts for the costs of the harvesting and storage procedure.

Prudential's authorization of the ABMT came too late. In April 1992, Rhonda Bast underwent an MRI scan of her brain which showed that the cancer had metastasized to her brain. The spread of the cancer disqualified her from participating in the ABMT procedure. Her health declined steadily and she died in January 1993. The court said, "[a]lthough this case presents a tragic set of facts, the district court properly concluded that under existing law the Basts are left without a remedy."

5. *Dishman v. UNUM Life Ins. Co.* (C.D. Cal. 1997) 1997 WL 906146.

Mr. Dishman was severely disabled from severe migraine headaches and his claim for benefits was initially approved. However, the insurance company continued to investigate his claim. One of the insurance company's own experts wrote:

> The medical record strongly established that Mr. Dishman has been suffering from migraine headaches for a very long period of time. The medical record equally establishes that Mr. Dishman has tried numerous and varied medical treatments in order to improve his condition without success. The medical record establishes that the frequency and duration of the headaches has increased to the point that he cannot maintain a full-time work performance. As evidenced by the medical record, as well as Mr. Dishman's report, he has made numerous attempts to overcome his disability and improve his work capacity. None of these efforts have succeeded. It is unlikely that any further medical information, such as an independent medical evaluation, could render any information which would be useful in this claim.

The claim was then referred to a special unit, which purported to begin a new investigation. It found that Mr. Dishman had made three trips to visit a company in which he had an interest. It then promptly called him up and terminated his benefits. When Dishman objected that he was not employed by that company, the insurer then "suspended" his benefits. There is, however, no policy provision, nor any right to "suspend" benefits. This suspension was for the purpose of forcing Dishman to accept a settlement of his claim for less than that to which he was entitled. The insurer then

demanded grossly unreasonable documents and examinations that had nothing to do with his claim.

California Federal District Judge Letts angrily set forth his thoughts:

> [T]he facts of this case are so disturbing that they call into question the merit of the expansive scope of ERISA preemption. (The insurer's) unscrupulous conduct in this action may be closer to the norm of insurance company practice than the court has previously suspected. This case reveals that for benefit plans funded and administered by insurance companies, there is no practical or legal deterrent to unscrupulous claims practices.
>
> Absent such deterrence, the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.
>
> Insurance companies do not have the same practical incentives as employers to administer benefit plans in good faith. For self-administered and even self-insured plans, employers are motivated to act in good faith not only in order to comply with the law, but by the practical considerations of maintaining employee loyalty and morale. Employers must take into account the effects on loyalty and morale of denying or terminating legitimate claims. For many employers, trying to hold down the costs of employee plans through unscrupulous practices may undermine employee morale and loyalty even more than not having an employee plan at all. Further, the individual administrators of these plans have significant peer pressure to act in good faith, even though part of their job function may be to contain plan costs. These administrators must look the wronged employee in the eye, and face the displeasure of co-workers, associates, and friends when they unjustly deny a fellow employee's claim. . . .
>
> Without these practical incentives, there is no counter-balance to insurance companies' interests in minimizing ERISA claims. Claim minimization is a necessary part of the insurance business. It is precisely the task that claims adjustors are paid to do. . . .
>
> The Court is appalled by how UNUM handled Dishman's claim. When UNUM decided to discontinue Dishman's disability payments, it had no concrete knowledge about his financial situation. It had no reason to believe that Dishman and his wife had any means of support other than his monthly benefit. It had received no information which suggested that his medical condition or his capacity for full time employment had changed since the date upon which his disability claim was allowed. The decision to suspend payments was made on such clearly pre-textual bases, that it is impossible to avoid the conclusion that it was made in bad faith. . . .

> The fact that most people in the Dishmans' situation would have had to capitulate is the most troubling aspect of this case. The need to deter insurance companies from behaving in this matter is why "bad faith" liability exists under almost all state laws. ERISA preempts all such laws. Under ERISA, no matter how unfounded the denial of a claim may be, the only recovery permitted to the claimant is the amount of the benefit. . . .

6. *Patrick v. Unum Life Ins. Co.*, Superior Court San Mateo, California Action No. 388506.

The insured worked as a weighmaster at a rock quarry. She developed a substantial hearing loss as a result of the constant noise from the trucks. Every doctor who examined her found that her hearing loss was caused by her job and she should quit. Her insurance policy was the top of the line policy, which provided that she was entitled to benefits if she could no longer do her specific job. After paying her for a number of years, her claim went to a special unit, which was charged with finding some way out of claims. The claims person was 23 years old with two to three months of experience. He had full authority to and did promptly deny the claim without any supervision. He simply assumed that she could find another weighmaster job, which was not so loud. However, the "labor market survey" upon which he claimed to rely showed that there were no jobs available and that even if there were, it would be difficult, if not impossible, for her to obtain such a job. Still, the insurer denied the claim because its adjusters were trained that, if information was missing, they were to assume that the information pointed to the insured not being disabled. All state claims for damages were preempted by ERISA.

The trial judge was appalled at the insurer's conduct, declaring that the conduct of the insurer "shocks my conscience," contained "overwhelming evidence of bad faith," which was part of a "deliberate corporate policy" and that "this is a posterchild case for congressional hearings on why . . . [there is a] need for exemplary damages in

these cases. . . . For reasons best known to Congress, ERISA insulates insurance carriers from financial punishment for even the most egregious conduct."

7. *Nelson v. Unum Life Ins. Co. of America*, Action No. CV 96-20974 WAI (N.D. Cal.).

The insured was in a terrible automobile accident, which shattered one of her vertebrae and substantially damaged other discs in her back. She was only able to obtain partial relief of her pain after two surgeries wherein metal rods were placed in her back to hold her spine together. Thereafter, she spent much of her days on pain medication and on her back to alleviate her pain. After paying her disability benefits for a few years, the insurer learned that its insured was getting married at a private facility. It then hired investigators, who disguised themselves as wedding guests, sneaked into the event and had drinks at the bar. They attempted to watch the insured for several hours. During much of this time, she was lying on a couch in pain in one of the rooms. At nightfall, the investigators stationed themselves on the private lawn of the facility she rented and secretly videotaped her through the window. Although they attended her wedding ceremony and reception for nearly seven hours, they videotaped only about 20 minutes. The videotape depicts the insured and her husband cutting their wedding cake, kissing, talking with guests and dancing gently to music. At the end of the tape the investigator says, "Let's say goodnight to her and congratulations and thank you for letting us shoot some film."

The insurer then terminated her benefits, claiming she could work full-time and that she was faking her back pain. She had no right under state law to make any claim for the denial of her insurance benefits.

8. *Estate of Dreyer v. Premera Blue Cross Blue Shield of Alaska*, Case No. A00-367 CV (HRH) (D. Alaska).

The insured was a chiropractor who lived with his wife and two children in Anchorage, Alaska. In October 1997, he was diagnosed with a genetic disorder affecting the liver's production of protein, and which can and does affect other organs, including the heart. One of the causes of death of persons suffering from this condition is sudden cardiac death. Sudden heart death can be caused by stress and cannot be controlled by means other than transplant. Cardiac transplantation is the only known effective treatment.

The insured requested the insurer's approval for a transplant. The insurer denied approval, claiming that the recommended, and only effective treatment, was not medically necessary. When the insured requested an explanation and an alternative written treatment plan, the insurer reversed position without explanation and conditionally approved the transplant.

The transplant, however, had to take place in Washington State. Accordingly, upon getting the approval from the insurer, the insured, at the direction of the University of Washington, temporarily relocated to Washington to wait for an available heart. The insurer then promptly cancelled his coverage claiming that he was no longer an Alaska resident and thus ineligible for coverage. Five days after learning of this cancellation, the insured died from sudden cardiac death. The insured's treating physician was of the opinion that the stress caused by notice of intended cancellation, combined with the insured's medical condition, was a substantial factor in his death. His family was barred from making any claim against his insurance company because of ERISA preemption.

9. *WF and SM.*

WF and SM were both denied treatment for ovarian cancer which was specifically provided under the policy. WF was fortunate enough to be married to one of the best insurance lawyers in the state, who was eventually able to obtain coverage. Shortly thereafter, SM came to him with the same problem, but the insurer denied her care, which it clearly knew was improper as a result of the WF claim. The attorney's moving letter to me is attached hereto as **Exhibit 2.**

10. *Shemano v. Mutual of Omaha.*

Richard Shemano developed terminal cancer while working as a stockbroker and could no longer function. His company had a life insurance policy. Unbeknown to Mr. Shemano, the employer or the agent who sold the policy to his employer, the life insurance policy contained a provision which extended Mr. Shemano's coverage for only one year after he became disabled. Mr. Shemano was able to forestall his death for 18 months. The insurance company denied his wife and daughter's life insurance claim because Mr. Shemano was only insured for 12 months after his diagnosis of terminal cancer. Had he only died in 12 months instead of 18 months, his family would have been entitled to the insurance benefits.

Under state law, Mr. Shemano's family could have forced the insurance company to pay the benefits. However, his policy was covered by ERISA and he therefore had no claim.

6. PROPOSED ERISA AMENDMENTS.

Below are four proposed amendments to the language of ERISA, all of which accomplish the same thing.

Amend section 1144(b)(2)(A) as follows:

Version 1.

Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. For purposes of this statute, a law regulating banking insurance or securities shall include any state law which a claimant could rely upon in state court in connection with a claim for benefits, including remedial laws.

Version 2.

Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities. For purposes of this statute, a law regulating banking insurance or securities shall include any state law pursuant to which any remedy or claim may be asserted against an insurance company or other person responsible for the non-payment of an insurance claim.

Version 3.

Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relive any person from any law of any State which regulates insurance, banking or securities. No state law which provides any person any right, claim, or remedy [or cause of action] against an insurance company or other person responsible for the non-payment of an insurance claim shall be preempted by ERISA."

Version 4.

Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relive any person from any law of any State which regulates insurance, banking or securities. "A law regulating insurance shall include any law upon which any right, claim, or remedy [or cause of action] against an insurance company or other person responsible for the non-payment of an insurance claim may be based."

EXHIBIT 1

PRIVILEGED

Provident Internal Memorandum

Q 4/01 Looks good. See last page. comment on Ken D. 10/4/95

To: *IDC Management Group*
Glenn Felton

From: *Jeff McCall*

Date: *October 2, 1995*

Re: *ERISA*

A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.

In order to take advantage of ERISA protection, we need to be diligent and thorough in determining whether a policy is covered. Accordingly, I have attached a rough draft of questions that should be asked in our claim investigation process. I recommend that it be used for all claims. The key for determining the applicability of ERISA is whether or not the employer "sponsors" or "endorses" the plan. If the employer pays the premium, the policy would usually, but not always, be considered to be governed by ERISA. Salary allotment or payroll deduction arrangements, by themselves, do not necessarily mean that a policy is subject to ERISA. While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.

Another requirement needed in order to take advantage of the protection offered by ERISA, is to establish a formal appeal process for ERISA situations. When we deny a claim, we must include language in our letter that informs the claimant of the right to appeal our decision within 60 days. I have attached a copy of sample language. The appeal must be in writing and should be reviewed by a panel specifically established to review ERISA appeals. I recommend that the panel be composed of Chris Kinback, Bob Parks, Becky Absher, Tom Timpanaro and me.

We will be modifying the salary allotment agreements used at the point of sale to include endorsement language.

I am interested in any comments or feedback you may have on this issue.

JM:ajr

EXHIBIT 2

LAW OFFICES OF
FRIEDMAN, RUBIN & WHITE

ALASKA OFFICE

1227 W. 9th Avenue, Suite 301
Anchorage, AK 99501
907-258-0704
907-278-6449 (fax)

Jeffrey K. Rubin
Admitted in Alaska

January 20, 2009

Arnold Levinson
Pillsbury & Levinson
The Transamerica Pyramid
600 Montgomery Street, 31st Floor
San Francisco, CA 94111

Dear Arnie:

What's below comes out of my and my wife's experience with cancer treatment through the last year. I originally wrote this as part of an op-ed piece I was working on prior to the election. While it's not a horror story on par with insurance misconduct causing a death such as in *Bast v. Prudential* and in Bill Dreyer's case. It illustrates how the system is currently stacked heavily against insureds and how insurers believe they can act with impunity as they act in any manner they choose to defeat the legitimate claims of their insureds and purposefully interfere with policy holders' ability to seek redress.

Personally, it is my belief that any national health care solution that relies on the insurance industry for implementation is doomed to failure with respect to insuring coverage, the proper handling of claims and appropriate access to medical care. The failure of most political leaders to embrace this reality and to work to eliminate the health insurance market in favor of some form of single payer coverage is a failure of vision engendered by the corrupting influence of insurance company campaign contributions and lobbying, and the isolation of most political leaders from the realities that most insured Americans face. The result, among other things, is the overburdening of business with insurance costs, reducing their ability to produce, as in the case of the auto companies, and the personal and familial tragedies that you are writing about. As the country's economic difficulties increase, and employers cut payrolls any system of health insurance centered in the employment relationship will insure fewer individuals, not more, and the unemployed are in no position to purchase privately available coverage. Further, as you and I both know, any solution to the health insurance issues that rely on insurance companies without providing for effective consumer remedies in the form of compensatory and punitive damages for insurer misconduct, simply continues the

fleecing of the insured public. The opportunities and rewards for engaging in misconduct are simply too great to resist. The UnumProvident litigation establishes this point beyond argument—more than a billion dollars of benefits wrongfully withheld without substantial punishment. In any event, below are two stories, too long for your paper, but you can use all or parts as you see appropriate.

My wife, WF, was diagnosed with stage 4 ovarian cancer in August, 2000, shortly before our youngest son's fifth birthday. For eight and a half years she has fought the disease. She has undergone standard treatments and participated in clinical trials. Some treatments are more successful giving sustained periods of remission. Other treatments are much less effective and have side effects which seriously impact her quality of life, and other treatments while not constituting a cure, help keep the disease in check with few side effects, allowing her to live a more normal and productive life. When we started down this cancer journey few would have predicted that WF would still be alive today, but good science, a strong spirit and committed doctors have kept her with us and hopefully will for many years to come, unless her insurer has its way.

In 2007 WF's doctor prescribed Avastin, a new drug approved by the FDA for the treatment of colon, breast and lung cancer, but not approved for ovarian cancer. Previously, WF had participated in Avastin clinical trials and it had held the disease in check for almost two years. So we were hopeful that when her doctors prescribed the drug in October, 2007 it would be effective again. At first our insurer paid for the treatments as it should have because, while Avastin was not approved for use in treating ovarian cancer, its prior approval by the FDA made it available under the insurance policy's off-label use provision. A little explanation here is appropriate, an off label use provision in an insurance policy requires an insurer to pay for prescription medicine that has been approved by the FDA for one use if it is used for treating something else under limited circumstances. Typically, and in WF's policy, one of the circumstances was that its "off-label" use be supported by the majority of the relevant peer reviewed literature.

But, as one might expect with a new cutting edge drug, treatment is expensive, in excess of $25,000 per treatment if you were paying out of pocket. It wasn't long before the insurer which had previously paid for the treatment began denying it. Asked to explain its denial, it stonewalled. . Despite policy provisions and federal law requiring the insurer to provide a detailed explanation and the documentation in supporting an adverse claims decision the insurer refused. It provided no information and did not acknowledge that information had even been asked for. Like Bill Dryer's endless loop of voice mails, we received one non-responsive answer after another to our requests. No explanations for why the treatment paid for before had suddenly become non-compensable. Then the insurer claimed its "qualified medical reviewers" had determined the drug was experimental, ignoring the off-label use provisions of the policy. Before long we discovered that the "qualified medical reviewers" were a family practice doctor and a pediatrician; neither with expertise in oncology nor the specialty of gynecological oncology. Not knowing if or when the insurer would provide us with the information we requested, and which it was required by law to provide free of charge, we began to

prepare our appeal of the claim denials. As we put together the appeal, suddenly and with no explanation the insurer once again reversed position and said it would pay for the treatment. Weeks later it still had not paid and again denied payment for treatments it said it would pay for. We filed our appeal in which we established that use of Avastin was appropriate to treat recurrent ovarian cancer as recognized by peer reviewed literature, independent review organizations, and medical treatment guidelines established by the leading cancer institutions in the country which participate in the National Comprehensive Care Network. Ultimately the claims were paid, and having fought the battle with and for WF, I would have expected the insurer to correct its policy misinterpretation, update its data and begin to pay for the claims of other similarly situated cancer patients. Enter SM.

SM is another ovarian cancer patient, who like WF has recurrent ovarian cancer, and like WF has insurance through an employer sponsored plan. Like WF, SM's policy covers prescription drugs and has the same off-label use provision as WF's policy. SM's doctor is in the same clinic as WF's doctor. SM has the same insurer as WF. Knowing that WF's treatment was ultimately paid for by the insurer, SM's doctor sought pre-authorization to treat SM with Avastin after her 4th recurrence. Even though two months before the insurer had paid for WF's treatment, with SM, the insurer denied preauthorization, ignoring its own prior conduct, the evidence presented with WF's appeal, its own lack of basis for denying pre-authorization, and the fact that yet another means for meeting the conditions necessary for off-label use had arisen in the interim. The denial letter on SM's request for pre-authorization was signed by the same "Medical Director" who, after our extensive appeal on behalf of WF, had signed the letter approving her claims.

When SM came to our office we again requested the insurer to provide the information required to be provided any insured who is challenging a claim denial. Once again, no documents were produced. As a consequence of the company's mishandling of WF's claims, we had set up a meeting between the company, the state division of insurance, a state representative, and state senator in an effort to address our concerns. We brought the SM matter to that meeting where the company promised to make a decision within a week. No decision was forthcoming. Pressed further, the company ultimately agreed to pre-authorize the treatment. But, just as in the case of WF, the company had no explanation for its prior position, or not one that it was willing to subject to scrutiny.

In pursuing her claims against the insurer, WF was lucky, she had me and I had the legal expertise to put pressure on the company to pay. She is even luckier in that she is cared for by a compassionate university based physician who was outraged by the insurer's conduct and who had the willingness to write an extensive letter refuting the insurer's unsubstantiated position. SM was lucky, she was referred to me and, because of my prior work, I knew how to push the buttons to get her claims pre-authorized. But, these cases are illustrative of what happens every day. Insurers deny claims with no basis and unless a consumer is either sophisticated or has access to the right kind of legal

assistance the insurer gets away with the improper denial. And, it is important to note, that we are not talking about healthy consumers fighting over their claims. We are talking about people who are chronically ill with life threatening diseases. A legal system that allows insurers to take advantage of such individuals without consequence is morally offensive. A legal system that permits insurers to engage in such conduct without consequence is a system that sanctions economic terrorism of the weak by the strong. In my view, that Congress has taken no steps to fix this situation in over twenty years since *Pilot Life v. Dedeaux* raises serious questions about the competency of those elected and who they actually represent.

Thanks for asking for my input. Please let me know if I can be of further assistance.

Sincerely,

Jeffrey K. Rubin