TESTIMONY OF WILLIAM M. ACKER, JR.
SENIOR UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF ALABAMA
BEFORE THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
SEPTEMBER 28, 2010

It is a privilege to be able to share with you this morning some of the thoughts of a trial judge who has been grappling with ERISA for twenty-eight years. Appointed in 1982, I sweated over ERISA, and watched other courts sweat over it, until in 1998 I wrote the law review article that probably prompted this Committee to invite me. The article was entitled "Can the Courts Rescue ERISA?" A copy of that article is attached to my testimony as Exhibit "A". Although my old arguments are now somewhat dated, my answer to the question then was "NO", and since that time I have not changed my mind. The courts have not rescued ERISA. **If anything, they have dug the ERISA hole deeper**. I am not saying that the courts, including the Supreme Court, have not **tried** to make sense of ERISA, and to make it workable, but in truth, the situation is worse in 2010 than it was in 1998, and getting worse every day.

I hope that the Committee is not as interested in citations of authority to support my views as it is in the views themselves, acquired from experience as a trial judge confronted for twenty-eight years with a constantly changing ERISA.

I am assuming that except for Chairman Baucus, whose State has done away with the so-called "discretionary clause", for Senator Stabenow, whose State has done the same thing, and for Senator

Cornyn, whose State is in the process of doing it, if it has not already done so, and, who, as Texas Attorney General, was sued by Corporate Health Insurance in the case that became central to the "five-to-four" decision by the Supreme Court in *Rush Prudential v. Moran*, the other members of this Committee have no specialized knowledge about ERISA, or of the effect that the so-called "discretionary clause" (first given prominence by the Supreme Court in *Firestone v. Bruch*) has had on the ERISA courts and litigants as they plod along.

The Committee has already heard or will hear testimony from others who are my intellectual equals or my superiors, who support the continuation of the "discretionary clause", as central to ERISA benefits decision-making. I will try to explain why the "discretionary clause" is a disaster, both as a matter of economics and as a denial of "due process".

The Economic Effect of *Bruch*
"The Law of Unintended Consequences"

Bruch put the fox in the henhouse when it authorized ERISA plan administrators to operate under the now universally used provision (except for Michigan and Montana) that allows the plan administrator both to interpret the plan and to decide how to apply it to a particular disability claim. This concept not only is foreign to logic and common sense, but is unworkable and expensive. I am attaching as Exhibit "B" a copy of the initial order I routinely use in ERISA disability benefits cases. A look at it

from top to bottom will illustrate the complexity of court decision-making, something that only takes place after the already lengthy processing of the administrative claim, and after the claim has been denied upon final review by the plan administrator.

A driving force behind the idea of granting the insurer/plan administrator/plan sponsor almost unbridled discretion is the belief that the procedure will lessen costs and lessen the time spent on ERISA cases. This contention is the main argument in the *amici curiae* briefs filed in support of Standard Insurance Company's unsuccessful *certiorari* petition that sought to overturn the decision that confirmed Montana's right to eliminate the "discretionary clause".

It is, of course, true that in drafting legislation, Congress has an obligation to consider the economic impact, as well as the needs of society. This judge is willing to assume that Congress engaged in that debate before it enacted ERISA. The language it chose in 1974, if it had not, over time, been altered or obliterated by the courts, would provide for *de novo* consideration by a court of all denials of ERISA benefits. ERISA's Section 502(a)(1)(B) straightforwardly provides that any beneficiary of a plan governed by ERISA can bring a "**civil action...to recover benefits due him under the terms of his plan**". Rule 2 of the Federal Rules of Procedure provides: "There is one form of action—the **civil action**". This language recognizes nothing less

than an independent consideration by a court, a "trial on the merits". The procedure concocted by the courts in the years since 1974, now called "judicial review", based on an examination of the administrative record, while giving deference to the conflicted decision-maker who has already denied the claim, simply does not fit the scheme that Congress contemplated. Under *Bruch*, "judicial review", a phrase never used in ERISA, the burden of proof is on the plan beneficiary to prove to the court on a cold record that the denial decision was "arbitrary and capricious" or was "an abuse of discretion" (interchangeable terms used by federal courts). This burden is too great, and too time consuming.

I have found no empirical evidence to justify the argument that the costs of a trial *de novo* would be greater than the costs of so-called "judicial review". If the courts thought that they were reducing their load, they were dead wrong. I only wish that I could have brought enough steamer trunks to hold all of the trial and appellate court opinions written under the *Bruch* rule. It makes one's head swim to read the long, convoluted opinions rendered by trial and appellate courts, during the preparation of which the judges and their law clerks have labored and sometimes tossed a coin.

Before a plan beneficiary can even bring his claim to court, he will spend much energy, and probably attorneys' fees. Lawyers do not like to undertake these cases on a contingent fee basis,

because even if they win, the award of a fee is within the court's discretion. A claimant faces a structurally-conflicted decision-maker, whose self-interest not only bears on the way it looks at the claim, but provides every reason to prolong the review process. Once the case gets to court, using the *Bruch* "abuse of discretion" standard, a voluminous court opinion will eventually emerge. It will necessarily compare in detail the hearsay of opposing medical experts and vocational experts who opine on the income that can be realized from an alternative job that the plaintiff can perform, and then try to justify either an "abuse of discretion", or no "abuse of discretion". The trial judge, if he or she takes *Bruch* seriously, starts by being intimidated.

This problem was exacerbated by the Supreme Court in *Metropolitan Life v. Glenn*. In that case, the high court, which quickly acknowledged the existence of a structural conflict-of-interest, held that judges must consider the conflict-of-interest as a "**factor**" in determining whether or not there has been an "abuse of discretion". This new rule encourages plan administrators to create procedures that look like a blunting of their conflict-of-interest. It also increases the work of the trial court.

After the complaint has been filed, the court must first decide whether to limit its consideration to a review of the so-called administrative record, which may be a thousand pages, or to

allow limited discovery during which the plaintiff can seek evidence that may place more weight on the inherent conflict-of-interest. This judge does not criticize his fellow jurists, but sympathizes with them, for the head scratching they do as they decide a controversy under the instructions given in *Bruch* and *Glenn*.

Not only does *Bruch* tilt the scales against the beneficiary on questions of fact, but on the interpretation of the plan. Ordinarily, the interpretation of a contract is for a court or a jury. In one of my cases, *Oliver v. Coca Cola*, the Eleventh Circuit held that my opinion interpreting the plan to resolve an obvious ambiguity against the draftsman, was correct, but another panel of the Eleventh Circuit, in a separate case, held that the same plan was reasonably construed the other way by the Coco-Cola claims committee, meaning that Coca-Cola's claims committee did not abuse its discretion when it arrived at its favorable construction of the contract Coca-Cola had drafted. *Oliver* was remanded to me with instructions to remand it, in turn, to the Coca-Cola claims committee for its reconsideration. If the case had not been settled at that point, the courts would still be laboring over it.

What Shell is the Pea Under?

Another chore for the trial courts that needs to be removed arises from the fact that defendants don't often confess their liability, and plaintiffs don't know which entity to sue. The

funding source for the payment of monetary benefits is often obscure. I will give you an example from my personal experience. In *Florence Nightingale Nursing Service v. Blue Cross*, the only defendant named in the complaint was Blue Cross, but the truth was that the plan sponsor, who was the only obligor, was Integraph Corporation, the employer of the beneficiary. Integraph only hired Blue Cross to be its **claims administrator**. Blue Cross did not file a third-party complaint against Integraph. I accidentally flushed out the problem during a pretrial conference, and obtained the agreement of the plan sponsor and the claims administrator, who were represented by the same counsel, that if liability was found, one or the other would pay. If I had not ironed out this problem beforehand, and a judgment had not been entered against Blue Cross which was not a proper party, I do not know what would have happened.

The long and the short of it is that the "independent" consideration of an ERISA claim a contemplated by Congress would save judicial resources and clients' money. When Standard Insurance Company asserted in its petition for *certiorari* in the Montana case, that doing away with "discretionary clauses will lead to far more complex and costly litigation", it was not only wrong as a matter of fact, but was using a scare tactic.

If Congress doubts me, I recommend an experiment in which Congress will now reiterate what it said in 1974 (with no possible

misunderstanding this time) that *de novo* trials are the only appropriate procedure in ERISA cases, and wait to see the cases and judicial opinions that are produced. If I am proven wrong, I will gladly eat my words. At my age that may be a safe bet.

Justice Delayed Is Justice Denied

You have heard the cliche "justice delayed is justice denied". It has real application to ERISA. My friend and fellow district judge, Brock Hornby of the District of Maine, as recently as July 8, 2010, in *Kane v. SI Metro Services*, held that a plan beneficiary had plausibly demonstrated the futility of the final appeal to the plan administrator insisted upon by the administrator, and therefore could go directly to court to contest the lower level claim denial. As a judge, I have never been asked to go as far as Judge Hornby, although in the only case I ever argued before the Supreme Court of the United States, I did convince that Court to excuse my client's failure to exhaust remedies that were futile. If you have time, take a look at *Glover v. St. Louis & San Francisco Railroad* decided in 1969. I have had many ERISA benefits cases that, before they got to me, had bounced around the administrative process for years. By the time the matter gets to me, the beneficiary is not only administratively exhausted, but, unless he has died trying, his health has deteriorated to the point that a remand to the plan administrator for reconsideration is tempting. If the parties, to start with, understood that a denial

would shortly result in a trial on the merits, serious settlement negotiations would take place before access to the court is sought.

Plan administrators have often asked me to remand cases to them, asserting that they have uncovered something that now casts doubt on their administrative decision. Many courts remand under such circumstances. This procedure, of course, prolongs the agony. I do not remand such cases to the plan administrator unless ordered to do so by a higher court.

Until Congress grants relief, I will continue scrupulously to follow the directions given by the Supreme Court in *Bruch* and *Glenn*, that is, if there is a "discretionary clause".

Applicability of Rule 56

Attached as Exhibit "C", is an opinion I wrote on September 16, 2010, attempting to explain the impossibility of using Rule 56 as a vehicle for what Congress in 1974 described as a "civil action", but which has evolved into a "judicial review", sort of like a Social Security administrative review. If there is no real dispute of material fact, Rule 56 disposition is, of course, appropriate, but there is almost always a dispute of material fact. Competing doctors strangely see things differently, even in unsworn hearsay, and are subject to questions of credibility. If the employer/insurer/plan administrator is privileged to decide the truth of the "facts",and where those "facts" lead, as well as what the plan means, the decision is rarely for the beneficiary, that

is, unless it is a slam dunk, and not always then. It is difficult enough to read a thousand page administrative record, extensive briefs, and write an opinion that finds the decision-maker to have abused its discretion, or not to have abused its discretion, but Rule 56 does not fit this scenario. In footnote 4 of the Eighth Circuit's recent opinion in *Khoury v. Group Health Plan*, it worried over this problem, saying:

> Courts have struggled with the use of summary judgment to dispose of ERISA cases...We decline to decide the propriety of the use of summary judgment procedures in this case because the issue was not raised by the parties...If a district court rejects the ruling of the administrator, the district court would then have to independently weigh the evidence in the administrative record and render *de novo* factual determinations, contrary to the summary judgment standard of review.

The Eighth Circuit obviously had reservations about courts resolving factual disputes.

Super-Duper Preemption

In 1995, the Supreme Court of Alabama in *Weems v. Jefferson-Pilot Life*, held that Alabama courts have jurisdiction over ERISA cases, and that extra-contractual and punitive damages are recoverable because the Seventh Amendment gives the right to trial by jury. That decision still stands in Alabama, although the Alabama trial courts, unless a defendant first removes the case to federal court, dismiss an ERISA case without prejudice *sua sponte*. They are influenced by the federal courts that have suggested the complete "exclusivity" of federal courts over ERISA cases. I call

this "super-duper preemption". There is no language in ERISA, any more than in the Fair Labor Standards Act or in Title VII, that denies concurrent jurisdiction to the state courts. I do not blame the Alabama trial courts for doing what they do, although I have no reason to doubt that they can handle ERISA cases as well as I can, if not better. There is ambiguity as to whether ERISA creates this "super-duper preemption". The federal and state courts need to be on the same page on this question, and Congress should write that page in a clear hand.

Conclusion

I have covered some, if not all, of my pet peeves. ERISA jurisprudence will stay as messed up as it is, unless Congress reworks it. **The courts have not rescued ERISA**, and cannot be expected to do so. The most important legislative change that I implore you to make is to make it clear that when Congress says "civil action", as it did in 1974, it means what it said, "civil action" and not "judicial review".

Thank you for the opportunity to share these thoughts with you.