No. 09-448

In the Supreme Court of the United States

BRIDGET HARDT,

Petitioner,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals for the Fourth Circuit

BRIEF OF AARP AND NATIONAL EMPLOYMENT LAWYERS ASSOCIATION, AS *AMICI CURIAE,* IN SUPPORT OF PETITIONER

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INTERESTS OF *AMICI CURIAE*[1]

AARP is the largest nonpartisan, nonprofit organization representing the interests of people age 50 and older. AARP helps people over age 50 have independence, choice, and control in ways that are beneficial and affordable to them and society. Nearly half of AARP's members are employed full or part-time, with many working for employers that provide health, pension, and disability benefit plans covered by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq*.

Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all. In its efforts to foster the economic security of individuals as they age, AARP seeks to increase the availability, security, equity, and adequacy of public and private pensions, health, and other employee benefits.

The National Employment Lawyers Association (NELA) is the largest professional membership organization in the country comprised of lawyers who represent employees in labor, employment, and civil rights disputes. NELA and its

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[1] Counsel for AARP and NELA state that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief. The parties have consented to the filing of this brief.

68 state and local affiliates have a membership of over 3,000 attorneys committed to working for those who have been illegally treated in the workplace. NELA strives to protect the rights of its members' clients, and regularly supports precedent-setting litigation affecting the rights of individuals in the workplace.[2]

Potential awards of statutory attorneys' fees protect participants' ERISA rights by enabling them to obtain the assistance of attorneys, despite the fact that the modest amounts at stake render contingent fee arrangements infeasible.[3] Moreover, such awards motivate plans and insurers to conduct full and fair reviews of benefit claims and deter them from abusing the claims procedure.[4] Accordingly,

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[2] As part of their advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP and NELA, either singly or jointly, have participated as *amicus curiae* in numerous cases in the Court and in federal appellate courts involving ERISA's preemption, civil enforcement and claims procedure provisions. *See*, *e.g.*, *Metro. Life Ins. Co. v. Glenn,* 128 S. Ct. 2343 (2008); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Great-West Life Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens v. Hewitt Assocs*., 508 U.S. 248 (1993); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

[3] The term "participants" herein also includes "beneficiaries."

[4] *Amici*'s brief focuses on the award of attorneys' fees in actions for denial of benefit claims. Many of the issues surrounding benefit claim denials do not arise in actions concerning fiduciary breach and other statutory claims. For example, remands to the plan administrator are rare in such cases for the simple reason that there is no statutory mandate that the

resolution of the issues in this case will have a significant impact on the integrity of the administration of employee benefit plans and individual participants' abilities to obtain their benefits, thereby fostering their economic security. In light of the significance of the issues presented by this case, AARP and NELA respectfully submit this brief, as *amici curiae,* to facilitate a full consideration by the Court of these issues.

SUMMARY OF ARGUMENT

Although Congress explicitly stated that the reasons for the enactment of the Employee Retirement Income Security Act (ERISA) were to protect participants' benefits and to provide access to court, judicial precedent has erected significant hurdles to those rights. Only after a participant or beneficiary has exhausted the remedies available under the plan have courts permitted a participant to go to court under ERISA to attempt to obtain their benefits that have been denied. *E.g.*, *Smith v. Sydnor,* 184 F.3d 356, 363-65 (4th Cir. 1999). Legal costs incurred during pre-trial exhaustion of the plan's review procedures are not recoverable. *E.g.*, *Parke v. First Reliance Standard Life Ins. Co.,* 368

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plan provide an pre-litigation review procedure for statutory violations of ERISA, *compare with* Section 503; adjudication of a statutory violation does not require the expertise of the plan administrator but of the judiciary; and the plan generally cannot provide the remedy the participants are seeking. *E.g., Smith v. Sydnor,* 184 F.3d 356, 363-65 (4th Cir. 1999); *Chailland v. Brown & Root, Inc.,* 45 F.3d 947 (5th Cir. 1997); *but see Mason v. Cont'l Group, Inc.*, 763 F.2d 1219, 1227 (11th Cir. 1985).

F.3d 999, 1010 (8th Cir. 2004). Once suit is brought, courts will defer to the decision of the plan administrator unless, the participant can show that, on the written record developed during the pre-litigation review procedure, the benefits were denied arbitrarily and capriciously, the plan administrator violated its fiduciary obligations under ERISA, or there is some other substantive breach of ERISA's requirements. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989). Even where a court finds that the plan administrator has arbitrarily and capriciously denied the participants' benefits, it is not uncommon for courts to remand the case to the plan administrator to redetermine the claim. *E.g., Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 31 (1st Cir. 2005).

Under the Fourth Circuit's decision, despite a finding that the plan administrator denied benefits in violation of ERISA and despite the claimant's subsequent recovery of benefits, the court nonetheless reached the remarkable conclusion that Hardt was not a "prevailing party," a judicially imposed prerequisite to an award of fees under ERISA that is entirely absent from the statute.[5] *Hardt v. Reliance Standard Life Ins. Co.*, 336 Fed. Appx. 332, 335-36 (4th Cir. 2009).

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5 *Amici* agrees with Petitioner's arguments that ERISA does not require a party to be "prevailing" in order to be considered for attorneys' fees, but, in any event, winning a remand to the plan administrator is "prevailing." *Amici* will confine their brief to the policy reasons warranting that the Court agree with Petitioner's arguments.

Instead, the Fourth Circuit requires the court to grant the participants' ultimate request – an award of benefits – in order for a participant to be a "prevailing party" under ERISA, and thus be eligible for consideration to receive discretionary attorneys' fees. *Id.*

The interaction between the Fourth Circuit's decision and existing judicial precedent limiting the § 502(a)(1)(B) and § 502(g)(1) rights of participants, coupled with both the modest benefits at issue and the limited means of most participants, will not only restrict awards of attorneys' fees in ERISA cases but, even more significantly, essentially preclude many participants from bringing a benefits claim under § 502(a)(1)(B).

ARGUMENT

I. ALTHOUGH CONGRESS ENACTED ERISA SO THAT PARTICIPANTS COULD RECEIVE THE BENEFITS TO WHICH THEY ARE ENTITLED, THE FOURTH CIRCUIT'S STRICT "PREVAILING PARTY" REQUIREMENT, WHEN CONSIDERED TOGETHER WITH EXISTING JUDICIAL PRECEDENT, WOULD DRASTICALLY LIMIT THE APPLICABILITY OF § 502(g)(1).

A. ERISA Explicitly Provides A Means To Obtain Wrongfully Denied Benefits And Attorneys' Fees.

Congress enacted ERISA to protect participants' and beneficiaries' interests in employee benefit plans by setting out substantive regulatory requirements, including standards of conduct, responsibility, and obligation for fiduciaries, and by providing for appropriate remedies, sanctions, and ready access to the courts. ERISA § 2(b), 29 U.S.C. § 1001(b); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 264 (1993).

Among the safeguards that Congress enacted was a claims procedure intended to resolve disputes over benefit claims prior to litigation. ERISA § 503, 29 U.S.C. § 1133. Section 503 provides that when a participant's claim for benefits has been denied, a benefit plan shall provide adequate written notice to the participant, setting forth the specific reasons for

the denial in a manner to be understood by the participant. *Id.* Section 503 also states that the plan shall provide the participant with a reasonable opportunity for a full and fair review of the benefit denial. *Id.*

Congress also recognized that, despite the pre-litigation plan review procedures of Section 503, plans might still deny participants the benefits to which they were entitled under ERISA. To address such situations, Congress enacted Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), which provides that a participant or beneficiary may bring a "civil action . . . to recover benefits due to him under the terms of his plan [or] to enforce his rights under the terms of the plan." *See Salovaara v. Eckert*, 222 F.3d 19, 28 (2d Cir. 2000) ("private actions by beneficiaries seeking in good faith to secure their rights under employee benefits plans are important mechanisms for furthering ERISA's remedial purpose").

In addition, Section 502(g)(1) of ERISA, 29 U.S.C. § 1132(g)(1), provides that "[i]n any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." The discretionary award of attorneys' fees under § 502(g)(1) serves an important role in the enforcement of ERISA's protections. As the Court recognized in *Alyeska Pipeline Serv. Co. v. Wilderness Soc'y*, one of the reasons Congress chooses to depart from the American Rule of recovery to permit fee-shifting in certain statutory

schemes is "to rely heavily on private enforcement to implement public policy and to allow counsel fees so as to encourage private litigation." 421 U.S. 240, 263 (1975). The policy rationales underlying Congress' decision to permit fee-shifting under certain statutes are to assure fairness, to equalize the strengths of the parties, and to provide economic incentives to encourage plaintiffs to bring actions to enforce their rights, as well as to encourage attorneys to practice in a particular area of law. *See generally* A. Bertino, *The Need for a Mandatory Award of Attorneys' Fees for Prevailing Plaintiffs in ERISA Benefits Cases*, 41 CATH. U. L. REV. 871, 877 (1992) [hereinafter "Bertino, *The Need for a Mandatory Award*"].

B. Although The Statutory Language Of ERISA Explicitly Provides Direct Access To Courts, As Well As Discretionary Attorneys' Fees, Without Regard to Whether a Party Prevails, Those Rights Have Been Circumscribed.

Despite ERISA's explicit statutory provisions, a series of judicially crafted limits on § 502(a)(1)(B) and § 502(g)(1) has significantly restricted a participant's access both to the federal courts and to attorneys' fees. *See generally* Bertino, *The Need for a Mandatory Award* at 873-74. In the context of § 502(a)(1)(B) claims challenging the denial of benefits, existing precedent generally: (1) precludes the recovery of punitive and extra-contractual damages; (2) requires plan participants to exhaust pre-litigation plan review procedures prior to gaining

access to court; (3) places heavy emphasis on the written record developed during the pre-litigation review procedure by limiting judicial consideration of the claim to a highly deferential review of the written record; (4) denies consideration for attorneys' fees during the pre-litigation plan review procedures; and (5) frequently results in relief in the form of remand to the plan administrator unless the denial of benefits is unreasonable on the face of the record or there is a substantive violation of ERISA.

1. Plan Participants Exercising Their § 502(a)(1)(B) Rights May Not Recover Punitive Or Extra-Contractual Damages.

Judicial precedent has established that, regardless of whether the benefit claims denial is made in bad faith or whether the plan or insurer engages in consistent, biased claims processing, a court cannot award compensatory, punitive or extra-contractual damages under ERISA. *See generally Great-West Life Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens*, 508 U.S. 248; *Mass Mutual Life Insurance Co. v. Russell,* 473 U.S. 134, 144 (1985). *See also* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA,* 101 NW. U.L. REV. 1315, 1321 (2007) [hereinafter "Langbein, *Unum/Provident Scandal*"] (detailing insurers aggressive claims denial policy adopted because of ERISA's preemptive effect, deferential standard of review and lack of remedies). These decisions have placed significant importance

on the availability of attorneys' fees under ERISA's fee-shifting statute, since these restrictions make contingent fee arrangements infeasible. *See infra* Section II. Consequently, many plan participants of limited means are forced to rely on attorneys' fees under 502(g)(1) in order to receive legal assistance while challenging denials of their benefits.

2. Plan Participants May Not Exercise Their § 502(a)(1)(B) Rights To Bring A Civil Action In Court Until They Have Exhausted The Plan's Pre-litigation Review Procedures.

Although "ERISA is silent as to whether exhaustion of administrative remedies is a prerequisite to bringing a civil action [for denial of benefits claims] . . . , due to ERISA's provision for the administrative review of benefits, ten federal circuits have read an exhaustion of administrative remedies requirement into the statute." *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418 (6th Cir. 1998). *See also Sydnor,* 184 F.3d at 363-65 ("the courts of appeals are in near unanimity that exhaustion of administrative remedies is required before a plaintiff can bring an ERISA action in federal court to recover benefits under a plan"). Consequently, plan participants are not able to exercise their § 502(a)(1)(B) right to bring a civil action in court until they have gone through what has now become a lengthy, costly, and contentious process of exhausting their pre-litigation review appeal.

3. The Deferential Standard Of Review The Court Has Permitted In Benefit Denial Cases Is Highly Prized By Plan Administrators Because It Precludes Participants From Obtaining Relief In Court Without First Establishing, Through The Review Procedure's Record, That The Plan Administrator's Denial Of Benefits Was Arbitrary And Capricious.

Even after plan participants have exhausted the § 503 pre-litigation review procedures, the standard of judicial review established by the Court in *Firestone,* 489 U.S. 101, significantly reduces the circumstances under which plan participants are able to achieve relief in court under § 502(a)(1)(B). Because "ERISA does not set out the appropriate standard of review for actions under [§ 502(a)(1)(B)] challenging benefit eligibility determinations," *id.* at 109, the Court held that "a denial of benefits challenged under [§ 502(a)(1)(B)] is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. In cases where benefit plans do provide the administrator with discretionary authority, courts are compelled to review decisions of the administrator under an arbitrary and capricious standard. *See Metro. Life Ins. Co. v. Glenn,* 128 S. Ct. 2343 (2008).

The consequence of *Firestone*'s standard of review is that plan sponsors and insurers merely need to

incorporate discretionary clauses in their plan or policy language to avoid *de novo* judicial review of their benefit denials. This practice has become widespread. *See also* Langbein, *Unum/Provident Scandal* at 1324. Consequently, rather than being entitled to judicial review of benefit denials under § 502(a)(1)(B), participants are limited to a deferential review of a record developed through pre-litigation plan review procedures, the creation of which pits skilled claims professionals against ordinary plan participants who have never participated in such a review proceeding, and probably never will do so again.

This disparity in skill and sophistication between the parties to the pre-litigation plan review procedures is exacerbated by the fact that many participants do not retain attorneys during these proceedings, not realizing that, more likely than not, their cases are won or lost at this stage. Indeed, even the district courts have realized that many participants do not understand these proceedings. *Cf. Herzberger v. Standard Ins. Co.*, 205 F.3d 327 (7th Cir. 2000) (language granting discretion to plan administrator must be clear and unambiguous so participants will understand their restricted coverage). Furthermore, because of the complexity of ERISA itself, the rules enforcing the statute, and an extensive web of judicial precedent implementing the statute, most individuals do not understand the significance of judicial deference to a plan administrator's decision nor do they realize that such discretion essentially means that the courts will not review their claims anew. *See Brigham v.*

Sun Life of Can., 317 F.3d 72 (1st Cir. 2003) (("[I]t seems counterintuitive that a paraplegic suffering serious muscle strain and pain, severely limited in his bodily functions, would not be deemed totally disabled. . . . [T]he undisputed facts of record do not permit us to find that Sun Life acted in an arbitrary or capricious manner in terminating appellant Brigham's benefits.").

The end result is that the ability of the vast majority of plan participants to achieve relief in courts under § 502(a)(1)(B) is predetermined by the time the plan participant has retained counsel and has an adequate understanding of the implications of the plan's pre-litigation review procedures.

4. Circuit Precedent Does Not Permit the Award Of Attorneys' Fees For Legal Work Performed During the Pre-litigation Review Procedures.

Even when plan participants understand the importance of finding knowledgeable legal representation during the plan's pre-litigation review procedures, their ability to obtain effective representation, and thus the ability to recover improperly denied benefits, is further limited by the fact that five circuits have concluded that the § 502(g)(1) attorneys' fees are not available for work performed during the plan's pre-litigation review procedures. This is true both for cases in which participants are successful, with the assistance of attorneys, in the review proceedings, s*ee, e.g.*, *Anderson v. Procter & Gamble Co.,* 220 F.3d 449,

452-56 (6th Cir. 2000)(collecting cases up to date of decision); and those in which, with the assistance of attorneys they unsuccessfully exhaust such required proceedings before filing suit. *See, e.g., Parke.,* 368 F.3d at 1010; *Peterson v. Cont'l Cas. Co.,* 282 F.3d 112, 118-21 (2d Cir. 2002); *Rego v. Westvaco Corp.,* 319 F.3d 140, 149-50 (4th Cir. 2003); *Cann v. Carpenters' Pension Trust Fund,* 989 F.2d 313, 315-17 (9th Cir. 1993), These decisions were based on the rationale that "the term 'any action' in [§ 502(g)(1)] does not extend to pre-litigation administrative proceedings." *Parke*, 368 F.3d at 1010.

Consequently, in the common scenario where a plan uses discretionary language, thus triggering *Firestone*'s highly deferential standard of review, a plan participant will be denied consideration for attorneys' fees for work during the very phase of the plan's pre-litigation review procedures, despite the fact that such procedures ultimately will determine if she will receive benefits, whether such receipt is through success in those procedures or through the development of the written record which will be the sole basis of judicial review under *Firestone*.

5. Upon A Determination That A Plan Administrator's Denial Of Benefits Was Arbitrary And Capricious, The Remedy Provided By Courts Frequently Is Remand To The Plan Administrator.

Even if a plan participant succeeds in establishing that his benefits were denied in an arbitrary and capricious manner, many courts choose to remand the claim to the plan administrator for a complete redetermination rather than provide a substantive remedy of an award of benefits. As the First Circuit has noted, "despite the fact that [§ 502(a)(1)(B)] . . . does not explicitly authorize administrative remand as a remedy . . . , numerous decisions by the Court and others have ordered, or approved in theory, remand to the administrator where arbitrariness is found in the course of [§ 502(a)(1)(B)] review . . . and we have seen none holding that remand is impermissible." *Buffonge*, 426 F.3d at 31 (citing *Cook v. Liberty Life Assur. Co. of Boston,* 320 F.3d 11, 24 (1st 2003); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 477 (7th Cir. 1998).

Some courts have recognized that the "variety of situations is so great" in ERISA cases that, after finding that the plan administrator's denial of benefits is arbitrary and capricious, the district court must have "considerable discretion" to craft an appropriate remedy, depending on the "facts and the equities." *See Buffonge*, 426 F.3d at 31; *accord*,

Elliott v. Metro. Life Ins. Co., 473 F.3d 613, 621-22 (6th Cir. 2006).

Other courts have attempted to establish bright line rules concerning when remand is appropriate. These courts generally remanded to the plan administrator to correct procedural defects where the plan administrator, who has discretion to apply the plan language, acts in an arbitrary and capricious manner by misconstruing the plan, failing to make adequate findings of fact, or failing to explain its grounds for decision. *See, e.g.*, *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455 (9th Cir. 1996) ("[R]emand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong standard to a benefits determination."); *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1288 (10th Cir. 2002) ("The remedy when an ERISA administrator fails to make adequate findings or to explain adequately the grounds of her decision is to remand the case to the administrator for further findings or explanation."). *See also Gallo v. Amoco Corp.*, 102 F.3d 918, 923 (7th Cir. 1996)**;** *Counts v. Am. Gen. Life & Accident Ins. Co.,* 111 F.3d 105, 108 (11th Cir. 1997); *Weaver v. Phoenix Home Life Mut. Ins. Co.,* 990 F.2d 154, 159 (4th Cir. 1993); *Buffonge*, 426 F.3d at 31 (1st Cir. 2005).

Courts tend to grant reinstatement of benefits as a remedy *only* where the denial of benefits was unreasonable on the face of the record or there is

another substantive violation of ERISA. *See, e.g.*, *Zervos v. Verizon New York, Inc.*, 277 F.3d 635, 648 (2d Cir. 2002) ("[A] remand of an ERISA action seeking benefits is inappropriate "where the difficulty is not that the administrative record was incomplete but that a denial of benefits based on the record was unreasonable." (quoting *Zuckerbrod v. Phoenix Mut. Life Ins. Co.,* 78 F.3d 46, 51 n. 4 (2d Cir. 1996)); *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1163 (9th Cir. 2001)("[R]etroactive reinstatement of benefits is appropriate in ERISA cases where, as here, 'but for [the insurer's] arbitrary and capricious conduct, [the insured] would have continued to receive the benefits' or where 'there [was] no evidence in the record to support a termination or denial of benefits.'" (quoting *Quinn***,** 161 F.3d at 478 (7th Cir. 1998)). "In other words, a plan administrator will not get a second bite at the apple when its first decision was simply contrary to the facts." *Grosz-Salomon*, 237 F.3d at 1163.

Consequently, even when a plaintiff has satisfied *Firestone*'s highly deferential standard of review, a court likely will decide to remand to the plan administrator "unless the case is so clear cut that it would be unreasonable for the plan administrator to deny the application for benefits on any ground." *Gallo*, 102 F.3d at 923 (quoting *Weaver,* 990 F.2d at 159 (4th Cir.1993)).

C. Within The Context Of Supreme Court And Circuit Court Precedent, The Fourth Circuit's Strict "Prevailing Party" Requirement, Along With Its Corollary Denial Of Attorneys' Fees Where The Relief Granted Is A Remand, Would Effectively Eliminate The Availability Of § 502(g)(1) Attorneys' Fees For A Large Majority Of Participants In Benefit Denial Cases.

The Fourth Circuit began its analysis of a participant's eligibility for discretionary attorneys' fees under ERISA by stating that "only a prevailing party is entitled to consideration for attorneys' fees in an ERISA action." *Hardt*, 336 Fed. Appx. at 335-36 (4th Cir. 2009). The Fourth Circuit stated that *Buckhannon* required that "to be a prevailing party, a plaintiff [must] receive at least some relief on the merits of his [or her] claim." *Id.* at 335. The Fourth Circuit then added the word "only" to conclude "*only* 'enforceable judgments on the merits and court-ordered consent decrees create the material alteration of the legal relationship of the parties necessary to permit an award of attorneys' fees.'" *Id.* (quoting *Buckhannon Bd. & Care Home, Inc. v. W. Va. Dep't of Health & Human Res.,* 532 U.S. 598, 603 (2001)). The Fourth Circuit concluded that because "remand does not constitute an 'enforceable judgment[ ] on the merits," the participant was not a prevailing party. Consequently, the Fourth Circuit held that, upon a determination that an ERISA plan arbitrarily and capriciously denied benefits, the participant is not entitled to consideration for

attorneys' fees where the remedy provided is remand to the plan administrator. *Id.* at 335-36.

A decision to affirm the Fourth Circuit's strict "prevailing party" standard would render illusory the availability of § 502(g)(1) attorneys' fees for a majority of participants who successfully challenge benefit denials under § 502(a)(1)(B), even if a participant secured significant legal relief through a determination that the plan administrator's denial of benefits was arbitrary and capricious and even if she ultimately recovered her benefits. This would frustrate a critical and explicit element of the congressional enforcement mechanism. The Fourth Circuit's rule, in conjunction with the existing precedent constraining access to courts and the availability of attorneys' fees, would mean that a plan participant would be prohibited from receiving an award of attorneys' fees when challenging the appropriateness of a benefit denial except in the unlikely scenario where: (1) he has exhausted the plan's pre-litigation review procedures, without success, thus providing him with access to court; (2) he is able to establish sufficient evidence in the review procedure's written record demonstrating that his plan administrator acted arbitrarily and capriciously, thus permitting the court to grant relief under the deferential *Firestone* review standard; and (3) the denial of benefits was unreasonable on the face of the record, thus making it more likely that the remedy would be relief on the merits rather than a remand to the plan administrator. Such a result would undermine the congressional enforcement scheme by rendering the availability of attorneys'

fees so unlikely that there no longer would be realistic economic incentives to encourage attorneys to represent plaintiffs and to enable plaintiffs to bring actions to enforce their rights to challenge improper denials of plan benefits.

II. POTENTIAL AWARDS OF ATTORNEYS' FEES PERMIT PARTICIPANTS TO ENFORCE THEIR RIGHTS AND MOTIVATE PLANS TO PROPERLY PROCESS BENEFIT CLAIMS.

Affirmance of the Fourth Circuit's decision would make the availability of attorneys' fees so uncertain that it would have a chilling effect on participants' willingness and ability to bring lawsuits to vindicate their rights. This is exacerbated by the lack of extra-contractual, compensatory or punitive remedies under ERISA. *See generally Great-West Life Annuity Ins. Co.*, 534 U.S. 204. In addition, an affirmance would give plans and insurers the green light to deny benefit claims with absolutely no consequence. *See, e.g., McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126 (2d Cir. 2008) (noting UNUM's history of biased claims handling and awarding the participant disability benefits thirteen years after his first application). *See also* Langbein, *Unum/Provident Scandal* at 1321.

A. Because Of The Limited Means Of Many Participants And The Relatively Modest Benefits At Issue, Barring The Awards Of Attorneys' Fees Where A Remand Is Attained Will Further Discourage Participants' Attempts To Enforce Their Rights.

If the Fourth Circuit's decision is affirmed thus requiring participants to always pay their own attorneys' fees where the plan administrator has violated ERISA, it would effectively reduce participants' ability to exercise their § 502(a)(1)(B) rights to recover improperly denied benefits. This is particularly important because most participants who pursue such claims are seeking only modest benefits. See *Tingey v. Pixley-Richards West, Inc.*, 958 F.2d 908 (9th Cir. 1992); *Marquardt v. North Am. Car Corp.*, 652 F.2d 715, 719-21 (7th Cir. 1981).

Indeed, in 2007 the average annual income from defined benefit retirement plans for persons age 65 and older was $15,229, with the median at $10,260. AARP, Public Policy Institute tabulation of U.S. Census Bureau's 2008 March Current Population Survey. The average 401(k) balance at year-end 2008 was $86,513, with the median amount of $43,700.[6] J. VanDerhei, S. Holden, & L. Alonso,

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[6] Determining the amount of an annuity that a lump sum amount can purchase illustrates how modest these 401(k) balances are. "For a 65-year old man retiring in April 2009, $100,000 would be sufficient to purchase a level, single life annuity that would pay income of $700 per month for life based on current rates." Patrick Purcell, *Retirement Savings and Household Wealth in 2007* at i (Congressional Research Service

Employee Benefits Research Inst., *401(k) Plan Asset Allocation, Account Balances, and Loan Activity in 2008* at 11, Fig. 5 (EBRI ISSUE BRIEF NO. 335 Oct. 2009), *available at* http://www.ebri.org/publications/ib/index.cfm?fa=ibdisp&content_id=4378.

Because a number of factors affect the calculation of private disability income benefit amounts, such as pre-disability income, income replacement ratio, and offsets from other income sources such as Social Security disability payments, there is little data on the average or median amounts of disability benefits that claimants typically receive. However, employer-sponsored disability plans typical replace sixty percent (60%) of pre-disability income. AHIP, *Disability Insurance: A Missing Piece in the Financial Security Puzzle* at 27, Figure 4.1 (Oct. 2004), *available at* http://www.ahipresearch.org/PDFs/27_AHIPDIChartBook.pdf. If one takes the median weekly earnings of men older than age 25 who work full-time in 2008, ($857), *see* Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey, Table 37 (last modified Dec. 4, 2009), *available at* http://www.bls.gov/cps/cpsaat37.pdf, multiply by 52 to obtain the median annual earnings, and then multiply by the typical replacement ratio of 60%, the typical annual long term disability benefit would be calculated as approximately $26,738.40, prior to other offsets. *E.g.*, JA 98a-99a (here Reliance offset Ms. Hardt's

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Apr. 8, 2009). All things being equal except gender, that same amount would purchase a $650 per month annuity for a woman due to women's longer life expectancy. *Id.*

disability benefits by her Social Security disability benefits).

Consequently, benefit amounts are relatively small as compared with the potential cost of litigation, thus effectively precluding the use of contingency fee agreements. The modest benefits at issue also indicate that the majority of participants are likely to have limited assets, placing a practical constraint on their ability to pay their own fees and costs, thus deterring many meritorious claims.[7] Indeed, if attorneys' fees are not awarded and the participant has to finance the litigation herself, she could actually be worse off in successfully exercising her § 502(a)(1)(B) rights than she was without the benefits.

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[7] For persons over the age of 55, the 2008 median income is $23,165, with the mean at $35,129. For persons over age 65, the 2008 median income is $18,068, with the mean at $27,886. EBRI Databook on Employee Benefits, *Sources of Income for Persons Age 55 and Over,* Table 7.2 (Updated Oct. 2009), *available at* http://ebri.org/publications/books/index.cfm ?fa=databook. The average Social Security benefit for a retired worker currently in pay status is $13,968 annually. Social Security Administration, Fact Sheet on OASDI (Jan. 6, 2010), *available at* http://www.socialsecurity.gov/OACT/FACTS/index .html.

B. Absent The Availability of Attorneys' Fees, Participants Will Have Even Greater Difficulty Obtaining The Assistance Of Knowledgeable Attorneys.

Even now participants have a difficult time finding knowledgeable attorneys to handle ERISA benefit claims, partly because the practice is not at all lucrative.[8] The ERISA bar representing individuals is extremely small. For example, 852 attorneys are members the Employee Benefit Committee of the Section of Labor and Employment Law of the American Bar Association; of those, only 101 classify themselves as representing Employee-Plaintiffs, or approximately less than twelve percent (12%) of the total membership. Illustrative of the small number of attorneys representing employees are the registration figures at the 2010 Mid-Winter Meeting of this Committee. Two hundred twenty-six (226) persons were on the registration list, with twenty-two (22) persons registered as representing Employees/Plaintiffs, or slightly less than ten percent (10%) of the registrants. *See* Employee

[8] The Department of Labor does not have authority to act as a plaintiff in benefit claim denials, *see* ERISA § 502(a)(1), and hence does not focus on benefit claims in its enforcement agenda. *See* ERISA Enforcement, National Enforcement Project, *available at* http://www.dol.gov/ebsa/erisa_enforcement .html, discussing protection of employer-sponsored plan assets. In addition, the Department of Labor does not have sufficient resources to act as counsel in benefit claim denials. *See* Department of Labor, PWBA, *Task Force on Assistance to the Public* (1992). Thus, it is imperative that there be a vibrant ERISA plaintiffs' bar to assist participants to obtain benefits to which they are entitled.

Benefit Committee of the Section of Labor and Employment Law of the American Bar Association, *available at* http://www.abanet.org/dch/committee.cfm?com=LL103000. Finally, only 150 attorneys of NELA's membership (or five percent (5%) consider themselves ERISA practitioners.

Because most plan participants have limited means, and thus are unable to retain a qualified attorney, and because the benefits at issue are typically relatively modest, thus rendering unfeasible the use of contingency fees agreements, affirmance of the Fourth Circuit's decision will dissuade the extremely limited number of knowledgeable attorneys from representing participants in the lengthy and contentious process of pursuing a benefits claim through each step necessary to eventually gain consideration for a reward of fees. *See generally* Bertino, *The Need for a Mandatory Award* at 884-86. Therefore, by affirming the Fourth Circuit's decision, the Court would be denying access to a system that is intended to be self-enforcing.

C. Awards Of Attorneys' Fees May Act As A Deterrent To Improper Processing Of Benefit Claims.

Awards of attorneys' fees also act as one of the only available mechanisms to deter arbitrary and capricious actions. This is especially true in instances where a plan or an insurer has consistently misused the benefit claim procedures. *See, e.g., McCauley*, 551 F.3d 126 (citing Unum's

history of biased claims administration); *Frederich v. Intel*, 181 F.3d 1105 (9th Cir. 1999) (finding claimant was not provided any notice of the appeal procedures and that the plan administrator failed to follow its own pre-litigation procedures, to provide medical reports to claimant, and to permit claimant to submit evidence). Plan administrators are more likely to comply with ERISA if they face a realistic risk of being assessed the participants' attorneys' fees along with paying their own attorneys. This deterrent effect benefits not only the participants but also the courts by eliminating unnecessary litigation and encouraging settlement. *E.g., Slupinski v. First Unum Life Ins. Co.,* 554 F.3d 38, 48 (2d Cir. 2009) (awarding attorneys' fees may have a deterrent effect on failure to pay benefits due to pain); *Nat'l Cos. Health Benefit Plan v. St. Joseph's Hosp., Inc.,* 929 F.2d 1558, 1675 (11th Cir.1991), *abrogated on other grounds, Geissal v. Moore Medical Corp.,* 524 U.S. 74 (1998)(in ERISA cases, "the deterrent value of an award of attorneys' fee is high" because the plan "would only be liable for what it should have covered before this litigation commenced. With nothing to lose but their own litigation costs, other ERISA-plan sponsors might find it worthwhile to force underfinanced beneficiaries to sue them to gain their benefits or accept undervalued settlements.").

Finally, because ERISA is the exclusive mechanism available to plan participants to recover improperly denied benefits, *see Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), and because there are

no compensatory, punitive or extra-contractual damages permitted under ERISA, regardless of the circumstances including bad faith claims processing, *see generally Great-West Life Annuity Ins. Co.*, 534 U.S. 204; *Mertens*, 508 U.S. 248; *Russell,* 473 U.S. at 144, the award of attorneys' fees is one of the few available tools that judges have to deter bad actors. *See, e.g., Anderson v. Unum Life Ins. Co. of Am.*, 2007 WL 604728, *6-*7 (M.D. Ala. 2007) (recognizing that with no punitive or extra-contractual damages available under ERISA insurers have little to lose if they deny benefits).

CONCLUSION

For the foregoing reasons, AARP urges the Court to reverse the decision of the Court of Appeals.

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