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A Call for the Overhaul of ERISA: How the Employee Retirement Income Security Act of 1974 Rewards Employers for Bad Faith Denials of Legitimate Claims for Employee Disability Benefits, A Multi-Case Study Involving One Philadelphia-Based Insurance Carrier

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A CALL FOR THE OVERHAUL OF ERISA: HOW THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 REWARDS EMPLOYERS FOR BAD FAITH DENIALS OF LEGITIMATE CLAIMS FOR EMPLOYEE DISABILITY BENEFITS

A MULTI-CASE STUDY INVOLVING ONE PHILADELPHIA-BASED INSURANCE CARRIER

By Thomas P. Kelly III*

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INTRODUCTION

This paper examines whether the unavailability of extraordinary damages for willful and knowing violations of the Employee Retirement Income Security Act ("ERISA")[1] actually incentivizes plan administrators to knowingly deny legitimate claims for employee disability benefits. The paper will explore this issue, at least in part, from a policy perspective, to determine whether the public interest warrants an overhaul of ERISA's recovery scheme. Specifically, a multiple-case analysis involving one Philadelphia-based disability carrier suggests that ERISA's current framework tends to result in a financial windfall for offending benefit plan sponsors and a corresponding underpayment of state and federal taxes by disabled plan participants to the detriment of society as a whole.

I. Overview of ERISA

A. Civil Recovery Available to Plan Participants Under ERISA

Originally passed by the Ninety-Third Congress in 1974, ERISA defines an "employee welfare benefit plan" as any plan, fund, or program maintained by an employer for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, benefits in the event of sickness, accident, disability, death or unemployment.[2] Under ERISA's civil enforcement scheme, an aggrieved plan participant or beneficiary may recover the following damages: benefits due to him under the benefits plan; enforcement of rights under the terms of the plan; or clarification of rights to future

[1] 29 U.S.C. § 1001 (2012).
[2] 29 U.S.C. § 1002(1) (2012).

benefits under the terms of the plan.[3] Beyond those benefits actually due under the plan, the availability of additional recovery has been the focus of much litigation throughout ERISA's history.

B. Availability of Attorney Fees for ERISA Violations

ERISA expressly provides that a court may allow recovery of a reasonable attorney's fee and costs of suit to either party.[4] In a recent landmark case, the United States Supreme Court ruled that a fee claimant in an ERISA matter need not even be a "prevailing party" to be eligible for an attorney fee award.[5] In *Hardt v. Reliance Standard Life Ins. Co.*, the Court held that a successful fee claimant need only show "some degree of success on the merits."[6] Distinguishing *Hardt* from typical fee-shifting ERISA matters was the district court's finding that although it was "inclined to rule in Ms. Hardt's favor" on her benefits claim, the insurer should first be given "the chance to address the deficiencies" in its required "full and fair review" of that claim.[7] Therefore, even though the case had merely been remanded to the insurer for further adjudication without an order to pay damages, the Supreme Court believed that the plaintiff had achieved more than "trivial success on the merits" or a "purely procedural victory" and was thus eligible to recover attorney fees under 29 U.S.C. §1132 (g)(1).[8]

Having first determined that an aggrieved plan participant is eligible to recover attorney fees, a district court must next consider several factors before determining whether a fee award is appropriate.[9] The Third Circuit set forth the relevant factors to be considered in *Ursic v. Bethlehem Mines*.[10] They include: "(1) the offending parties' culpability or bad faith; (2) the ability of the offending parties to satisfy an award of attorneys' fees; (3) the deterrent effect of an award of attorneys' fees against the offending parties; (4) the benefit conferred on members of the [benefit] plan as a whole; and (5) the relative merits of

[3] 29 U.S.C. § 1132(a) (1) (B) (2012).
[4] 29 U.S.C. §1132(g) (1) (2012).
[5] Hardt v. Reliance Standard Life Ins Co., 130 S.Ct. 2149, 2156 (2010).
[6] *Id*. (citing Ruckelhaus v. Sierra Club, 463 U.S. 680, 694 (1983)).
[7] *Hardt*, 130 S. Ct. at 2158.
[8] *Id*.
[9] *In re* Unisys Corp. v. Retiree Med. Benefits ERISA Litig., 579 F.3d 220, 239 (3d Cir. 2009).
[10] 719 F.2d 670 (3d Cir. 1983).

the parties' position."[11] A party seeking attorney fees in an ERISA action need not prove each and every one of the *Ursic* factors, but rather, they are all elements to be considered during the exercise of the Court's discretion.[12]

C. ERISA's Preemption of State Law Claims

Section 502(e) (1) of ERISA provides that federal district courts shall have exclusive jurisdiction over lawsuits brought by a participant to recover the benefits due them under the terms of an employee welfare benefit plan.[13] ERISA's "pre-emption clause" (§ 514(a)) provides that the Act supersedes all state laws insofar as they "relate to any employee benefit plan," but ERISA's "saving clause" (§ 514(b) (2) (A)) excepts from such preemption any state law that "regulates insurance."[14] Therefore, ERISA generally preempts state law claims that are related to the employee benefit plan at issue.[15] This often results in an aggrieved plaintiff's inability to truly be made whole, even in cases of bad faith or intentional misconduct, because punitive awards and consequential damages are unavailable to the injured party.[16] A state law claim relates to an employee benefit plan if "the existence of an ERISA plan [is] a critical factor in establishing liability' and 'the trial court's inquiry would be directed to the plan.'"[17] To avoid preemption by ERISA, the state law being applied "must be 'specifically directed' toward the insurance industry."[18] It is not enough that a statute merely has a "significant impact" on the insurance industry.[19]

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[11] *Id*. at 673.

[12] Fields v. Thompson Printing Co., 363 F.3d 259, 275 (3d Cir. 2004).

[13] 29 U.S.C. § 1132(e)(1)(2012).

[14] Pilot Life Ins. Co. v. Dedeaux,481 U.S. 41 (1987).

[15] 29 U.S.C. § 1144(a) (2012); *see also* Egelhoff v.Egelhoff, 532 U.S. 141, 147-48 (2001); Metro. Life Ins. Co. v. Price, 501 F.3d 271, 275 (3d. Cir. 2007).

[16] An exception to this general rule, not applicable for the purposes of this article, resulted when ERISA was amended by the Retirement Equity Act of 1984, which included an exception for qualified domestic relations orders. 29 U.S.C. § 1144(b)(7); Retirement Equity Act of 1984, Pub. L. No. 98–397, Stat 1426; *see* Boggs v. Boggs, 520 U.S. 833, 846-47 (1997).

[17] Stanley v. Int'l Bhd. of Electrical Workers, 207 Fed.Appx. 185, 189-90 (3d. Cir. 2006) (quoting 1975 Salaried Ret. Plan for Eligible Emp. of Crucible, Inc. v. Nobers,968 F.2d 401, 406 (3d. Cir. 1992).

[18] Levine v. United Healthcare Corp., 402 F.3d 156, 166 (3d. Cir. 2005).

[19] *Id*.

D. Punitive and Consequential Damages Unavailable Under ERISA

To the dismay of many disabled plan participants, the Supreme Court has determined that extra-contractual, compensatory and punitive damages are not available under ERISA.[20] Basing its holding on perceived congressional intent, the Court has ruled that the express enforcement provisions set forth in §502(a) suggests that Congress never intended to authorize other unmentioned remedies.[21] This conclusion is based, at least in part, on the fact that an early version of the statute in both the Senate and House Committee Reports had included a provision for "legal or equitable" relief, permitting "the full range of legal and equitable remedies available in both state and federal courts."[22] In determining that punitive and other damages were not intended under ERISA, the Court observed that in the bill finally passed by the House of Representatives and ultimately adopted by the Senate the reference to legal relief had been deleted.[23]

E. Judicial Review of Civil Actions Brought Under ERISA

Although plan participants are legally permitted to bring a civil action to recover damages under ERISA, before doing so they must first exhaust the administrative remedies available under the plan.[24] This policy is, at least ostensibly, "to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a non-adversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned."[25] When a dispute does find its way to federal court, the sitting judge is tasked with determining whether a plan administrator improperly denied benefits to one or more of the plan's participants in violation of ERISA's claim provisions. The narrow scope of the court's review is limited to the

---

[20] Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985).

[21] *Russell*, 473 U.S. at 146.

[22] *Id*. (citing H.R.Rep. No. 93-533, at 17 (1973) , U.S. Code Cong. & Admin. News 1974, pp. 4639, 4655, 2 Leg.Hist. 2364.)

[23] *Russell*, 473 U.S. at 146.

[24] Harrow v. Prudential Ins. Co. of America, 279 F.3d 244, 249 (3d Cir. 2002) (internal citations omitted); Weldon v. Kraft, Inc., 896 F.2d 793, 800 (3d Cir.1990) (internal citations omitted); Robyns v. Reliance Standard Life Ins. Co., 130 F.3d 1231, 1235 (7th Cir. 1997) (internal citations omitted).

[25] *Harrow*, 279 F.3d at 249 (citing Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980)).

administrative record that was available to the plan administrator at the time when the final decision was made.[26]

The Supreme Court has established three distinct standards for evaluating a plan administrator's decision to deny benefits under a plan governed by ERISA: (1) *de novo* where the plan does not grant the administrator discretion [to determine eligibility for benefits]; (2) arbitrary and capricious where the plan grants the administrator such discretion; and (3) heightened arbitrary and capricious where the plan grants the administrator discretion but the administrator operates under a conflict of interest.[27] The Court has held that "a denial of benefits challenged under §1132(a)(1)(B) must be reviewed under a *de novo* standard unless the benefit plan expressly gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms."[28]

To determine whether an administrator is given discretionary authority to determine eligibility for benefits, a court must look to the language of the plan.[29] Where an administrator or fiduciary has been given discretion to make such determinations, her decisions are reviewed under an "abuse of discretion" or "arbitrary and capricious" standard, meaning they will not be disturbed if reasonable.[30] The Court of Appeals for the Third Circuit substantially modified the standard of review for ERISA cases in *Pinto v. Reliance Standard Life Insurance Company*, adopting a "sliding scale" approach to ERISA claims involving an employer who shifts the burden of plan administration by paying an insurance company to fund, interpret, and administer a plan.[31] The Third Circuit noted the obvious conflict of interest involved whenever an insurance company both funds and administers a plan; that is, the insurance company has a clear incentive to deny even legitimate claims because it is paying those claims out of its own coffers.[32] A long-

[26] Kovach v. Zurich American Ins. Co., 587 F.3d 323, 340 (6th Cir. 2009) (quoting Marks v. Newcourt Credit Group Inc., 342 F.3d 444, 457 (6th. Cir. 2003).

[27] Shahpazian v. Reliance Standard Life Ins. Co., 388 F. Supp. 1368, 1373 (N.D. Miss. 2005) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)).

[28] Firestone Tire & Rubber Co.v. Bruch, 489 U.S. 101, 102 (1989).

[29] *See id*. at 115. ("[T]he validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue.")

[30] Mitchell v. Eastman Kodak Co., 910 F. Supp. 1044, 1047 (M.D. Pa. 1995), *aff'd*,113 F.3d 433 (3d Cir. 1997) ("The 'arbitrary and capricious' standard is essentially the same as an 'abuse of discretion' standard . . .").

[31] 214 F.3d 377 (3d Cir. 2000).

[32] *Id*. at 388-89.

term disability benefits policy creating this type of conflict of interest might read as follows:

> [Insurance Company] shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.[33]

Under the sliding scale or "heightened arbitrary and capricious" analysis established in *Pinto*, the district court was required to examine each case on its facts, taking into account "the sophistication of the parties, the information accessible to the parties, and the exact financial arrangement between the insurer and the company."[34] However, the holding in *Pinto* was superseded by *Metropolitan Life Insurance Company v. Glenn*, which held that the mere existence of a conflict is not sole justification for heightening the level of scrutiny, but may nevertheless be considered as a factor.[35]

In *Metropolitan Life*, the Supreme Court suggested that it had not previously set forth a detailed list of instructions for courts to follow when applying the relevant factors in ERISA cases.[36] In an effort to offer some guidance, however, the Court noted the following approach, originally set forth in *Firestone Tire and Rubber v. Bruch*:

> In determining the appropriate standard of review, a court should be guided by principles of trust law; . . .
>
> Principles of trust law require courts to review a denial of plan benefits under a *de novo* standard unless the plan provides to the contrary.
>
> Where the plan provides to the contrary by granting the administrator *discretionary authority* to determine eligibility for benefits a more *deferential standard* of review may be appropriate.
>
> If a benefit plan gives discretion to an administrator who is *operating under a conflict of interest*, that conflict must be weighed as a *factor* in determining whether there is an abuse of discretion.[37]

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[33] *See e.g.*, RELIANCE STANDARD, GROUP LONG TERM DISABILITY INSURANCE PROGRAM, 5-6 (March 6, 2008), *available at*, http://www.fordham.edu/images/campus_resources/admin_offices/hr/fordham%20university%20-local%20805%20ltd%20booklet%20-final.pdf

[34] *Pinto* at 392.

[35] 554 U.S. 105, 117-18 (2008).

[36] *See generally Id.*

[37] *Id.* (internal citations omitted).

Therefore, although technically superseded by *Metropolitan Life*, the approach set forth by the Third Circuit in *Pinto* remains essentially unchanged. Where plan administrators have both the ability to determine eligibility for benefits and also an obligation to pay those benefits, the conflict may be properly considered in determining whether a denial was arbitrary and capricious.

F. Public Policy Considerations Related to ERISA Violations

As suggested above, the denial of ERISA-based claims may result in public policy implications that affect all taxpayers. This is so, at least in part, because a corporate employer may enjoy an annual tax deduction for payment of disability insurance premiums for the benefit of employees.[38] Likewise, the premium payment is generally not includable in the income of the employee.[39] However, in the event that the employee becomes disabled, payment of benefits by the insurance company may become taxed as ordinary income to the employee.[40] There are caveats to these rules such as where a partner or member of the employer pays premiums for himself, but as a general matter the tax rules are straightforward.[41]

In light of these tax implications, this author suggests that where a claim for disability benefits is wrongly denied by an employer or its plan administrator, society pays the price for such wrongdoing by virtue of an underpayment of both corporate and personal income taxes. That is, employers enjoy a tax deduction for their provision of employee disability benefits, presumably because the deduction encourages businesses to provide such benefits. But where a disabled employee cannot work and is wrongfully denied disability income that would ordinarily be taxable, such a deduction is meaningless and the purpose underlying the corporate tax deduction is thwarted.

Accepting as true that an administrator's wrongful refusal to pay disability income (or any welfare benefit for that matter) results in a reduction of income taxes paid then it must likewise be accepted that public tax policy should encourage corporate compliance with ERISA's provisions. With that in mind, this Article turns its attention toward one

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[38] *See* 26 U.S.C. § 162(a)(1) (2012).
[39] 26 U.S.C. § 106(a) (2012).
[40] 26 U.S.C. § 105(a) (2012).
[41] *See generally* Alson R. Martin & David Michael D. Carson, *Choice of Business Entity: Business, Tax, and Other Non-Fringe Benefit Considerations*, 2000 ALI-ABA COURSE OF STUDY, SE66 ALI-ABA 525 (Feb. 17, 2000).

Philadelphia-based insurance company that has been repeatedly held liable in federal court for knowing and deliberate violations of ERISA throughout the last decade.

II. Lasser v. Reliance Standard Life Ins. Co.[42]

A. Overview

Reliance Standard Life Insurance Company ("RSL") is an Illinois corporation headquartered in Philadelphia, Pennsylvania.[43] In 1999, RSL was the insurer, underwriter and claims administrator for a long-term disability benefit policy issued for the benefit of employees of a small medical practice called Townsquare Orthopedic Associates, with offices located in Dover, New Jersey.[44] Dr. Stephen Lasser was an orthopedic surgeon employed by Townsquare.[45] Pursuant to the employer's disability insurance policy, disabled employees would receive "long term disability benefits" equal to "66 2/3% of Covered Monthly Earnings" with a "maximum monthly benefit of $15,000."[46] The policy further provided: " 'Totally Disabled' and 'Total Disability' mean . . . that as a result of an injury or [s]ickness, during the [e]limination period and thereafter an insured cannot perform the material duties of his/her regular occupation."[47] Similarly, the policy provided that "'Partially Disabled' and 'Partial Disability' mean that as a result of injury or [s]ickness an insured is capable of performing the material duties of his/her regular occupation on a part-time basis or some of the material duties on a full-time basis."[48] Dr. Lasser's medical record revealed a history of heart problems.[49] Specifically, in 1986 Dr. Lasser was diagnosed with coronary artery disease, and underwent

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[42] 146 F.Supp.2d 619 (D.N.J. 2001).

[43] RELIANCE STANDARD LIFE INSURANCE CO., ANNUAL STATEMENT FOR THE YEAR ENDED DECEMBER 31, 2011. (2011), *available at* http://www.reliancestandard.com/SiteData/docs/RSL2011Ann/4cbb327d757df91a/RSL_2011_Annual_Statement.pdf. (last visited Apr. 13, 2013).

[44] Lasser v. Reliance Standard Life Ins. Co., 146 F.Supp.2d 619, 620 (D.N.J. 2001), 146 F.Supp.2d at 620.

[45] *Id*.

[46] Amended Complaint at ¶8 and Exhibit A, *Lasser*, 146 F. Supp. 2d 619 [hereinafter Amended Complaint].

[47] *Id*.; *see also Lasser*, 146 F.Supp. 2d at 623-24.

[48] *Lasser*, 146 F. Supp. 2d at 624.

[49] *Id.* at 620.

bypass surgery at age forty-six.[50] A decade later, on July 16, 1996, he was admitted to the hospital with a diagnosis of "acute inferior wall myocardial infarction," otherwise known as a heart attack, which required cardiac catheterization on July 18, 1996 and coronary angioplasty on July 22, 1996.[51] Dr. Lasser's treating physician prescribed a change of diet and additional exercise and placed him on medication.[52] Dr. Lasser was also instructed to reduce his stress level, including work-related stress.[53] In September 1996, Dr. Lasser returned to work on a reduced basis, lessening his patient load by 50%, avoiding on-call duty at night or on weekends, and refraining from emergency surgery.[54] With these medical restrictions and a reduced workload in place, RSL approved Dr. Lasser's application for long-term disability benefits on December 26, 1996.[55]

One year later, RSL reviewed Dr. Lasser's claim and terminated his collection of benefits under the disability policy.[56] RSL based its decision to terminate benefits primarily on the opinion of an independent medical examiner that reviewed the claim file.[57] The company terminated Dr. Lasser's benefits on the basis that he was not totally disabled, as defined in the policy, and that he could therefore perform the material duties of his regular occupation.[58] Dr. Lasser invoked the disability plan's administrative review process, after which RSL affirmed its decision to deny benefits.[59] Pursuant to the provisions of ERISA, Dr. Lasser filed a civil complaint in the United States District Court for the District of New Jersey.[60] Applying the appropriate "moderately heightened arbitrary and capricious" standard of review, the district court held that RSL's determination was arbitrary and capricious and that Dr. Lasser was entitled to receive benefits.[61]

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[50] Amended Complaint, *supra* note 47 at ¶9.
[51] *Id*.
[52] Lasser v. Reliance Standard Life Ins. Co., 344 F.3d 381, 383 (3d. Cir. 2003).
[53] *Id*.
[54] *Id*.
[55] *Id*.
[56] *Id*.
[57] *Id*.
[58] *Lasser*, 344 F.3d at 383.
[59] *Id*. at 384.
[60] Amended Complaint, Lasser v. Reliance Standard Life Ins. Co., No. 99-4131, 146 F. Supp 2d. 619 (D.N.J. 2000).
[61] *Id*. Note that *Lasser* was decided before *Metropolitan Life* overruled the *Pinto* standard of review and thus technically superseded this form of review. Nevertheless, the

Unhappy with the court's decision, RSL appealed the matter to the United States Court of Appeals for the Third Circuit.[62]

The Third Circuit's analysis of *Lasser* turned on the meaning of the term "regular occupation," as it was used in the disability policy.[63] The policy expressly stated that an applicant is disabled if, *inter alia*, "as a result of injury, illness or disease he is capable only 'of performing the material duties of his/her regular occupation on a part-time basis or some of the material duties on a full-time basis.'"[64] The term "regular occupation," however, was not defined in the insurance policy.[65] In support of its decision to terminate benefits, RSL argued that the term was broad and generic. In its benefit denial letters, RSL included boilerplate language regarding its own interpretation of the term stating, "regular occupation is not your job with a specific employer, it is not your job in a particular work environment, nor is it your specialty in a particular occupational field . . . [i]n evaluating your eligibility for benefits, we must evaluate your inability to perform your own or regular occupation as it is performed in a typical work setting for any employer in the general economy."[66]

The Third Circuit noted that, under the "arbitrary and capricious" standard of review, if the term "regular occupation" was vague or ambiguous, then RSL's definition would be entitled to deference.[67] To the contrary, the *Lasser* court flatly rejected RSL's interpretation of the term, holding that an employee's "'regular occupation' is the usual work that the insured is actually performing immediately before the onset of the disability."[68] The Third Circuit concluded that it was "unreasonable for [RSL] to define 'regular occupation' differently from its plain meaning . . . without explicitly including that different definition in the Policy."[69]

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holding in *Lasser* remains good law.

[62] *See* Lasser v. Reliance Standard Life Ins. Co.,, 344 F.3d 381 (3d Cir. 2003).

[63] *Id*. at 385.

[64] *Id*.

[65] *Id*.

[66] *Id*.

[67] *Id*. (citing Skretvedt v. E.I. DuPont de Nemours & Co., 268 F.3d 167, 177 (3d Cir. 2001) ("insurer's interpretation of an ambiguous insurance provision is entitled to deference unless it is contrary to the plan's plain language")).

[68] *Lasser*, at 386.

[69] *Id*. at 386-87.

Both the district court and the circuit court held that such an interpretation violated ERISA, stating:

> [W]e believe that "regular occupation" is not ambiguous. The Policy states that it protects the insured from inability to "perform the material duties of his/her regular occupation." Both the purpose of disability insurance and the modifier "his/her" before "regular occupation" make clear that "regular occupation" is the usual work that the insured is actually performing immediately before the onset of disability . . . [I]t is unreasonable for Reliance to define "regular occupation" differently from its plain meaning or even the somewhat more relaxed understanding of [citations omitted] without explicitly including that different definition in the Policy.[70]

Having concluded that Dr. Lasser's "regular occupation" for purposes of disability coverage was that of an "orthopedic surgeon in a four-person practice group in New Jersey," the court turned its attention to what Dr. Lasser actually was required to do in connection with his regular occupation (for example, he saw patients during office hours, performed scheduled surgeries, took night call, and performed emergency surgeries).[71] Without reference to Dr. Lasser's particular duties, however, RSL had commissioned a labor market survey and determined that performing emergency surgery and being on-call were not material duties for an orthopedic surgeon.[72] Additionally, the company relied heavily on the Department of Labor's "Dictionary of Occupation Titles" to uphold its initial denial.[73] Upon consideration of the entire administrative record, the Third Circuit found that:

> Dr. Lasser's "regular occupation" was that in which he was actually engaged immediately before becoming disabled: an orthopedic surgeon in a four-person practice group in New Jersey. We also hold that on-call and emergency surgery duties are material to Dr. Lasser's practice and that he is disabled from performing those duties. We agree with the District Court that Reliance's conclusion to

[70] *Id*. at 385-87.
[71] *Id*. at 387.
[72] *Id*. at 387-88.
[73] *See Lasser* at 387, n 5. The Dictionary of Occupational Titles [hereinafter DOT] was created by the Employment and Training Administration, and was last updated in 1991. It is included on the Office of Administrative Law Judges (OALJ) web site because it is a standard reference in several types of cases adjudicated by the OALJ, especially in older labor-related immigration cases. The DOT, however, has been replaced by the O*NET. Office of Administrative Law Judges, *Dictionary of Occupational Titles Fourth Edition*, UNITED STATES DEPT. OF LABOR (July 1, 2010), http://www.oalj.dol.gov/libdot.htm (last visited July 1, 2010).

> the contrary was unsupported by substantial evidence and therefore was arbitrary and capricious. We accordingly affirm the District Court's judgment in favor of Dr. Lasser.[74]

B. Attempts by Reliance Standard to Have Lasser Overturned

Because the Third Circuit's holding in *Lasser* would preclude RSL's continued use of itself-serving and unlawful definition for the term "regular occupation" as the basis for denial of otherwise legitimate disability claims the company has attempted repeatedly to have the decision overturned. It is worth mentioning that because RSL is headquartered within the Third Circuit (i.e., Philadelphia); the *Lasser* decision would be applicable to the review of *all* claim denials, even in cases where the plan participant is a resident of another jurisdiction. This is so, of course, because a Third Circuit decision not overruled by the Supreme Court is "binding on all inferior courts and litigants in the Third Judicial Circuit . . ."[75]

The District Court of New Jersey first entered judgment against RSL in *Lasser* on June 13, 2001.[76] The Third Circuit Court of Appeals affirmed that decision more than two years later, on September 18, 2003.[77] RSL next filed a petition for rehearing *en banc*, which was denied on October 22, 2003. Finally, in a last-ditch effort to save its procedure for denying claims, the company hired attorney Kenneth Starr to present the matter before the United States Supreme Court on Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit, on February 19, 2004.[78] Mr. Starr's petition was denied on May 24, 2004; more than three years after Dr. Lasser had first obtained a judgment in his own favor.[79]

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[74] *Id.* at 392.

[75] *See* United States v. Mitlo, 714 F.2d 294, 298 (3d. Cir.1983) (quoting Allegheny General Hospital v. NLRB, 608 F.2d 965, 970 (3d Cir.1979)).

[76] Lasser v. Reliance Standard Life Ins. Co., 146 F.Supp.2d 619 (D.N.J. Jun 13, 2001).

[77] Lasser v. Reliance Standard Life Ins. Co., 344 F.3d 381 (3d Cir. 2003).

[78] Petition for Writ of Certiorari, Reliance Standard Life Ins. Co. v. Lasser. 541 U.S. 1063 (2004), No. 03-1203, 2004 WL 349612.

[79] Reliance Standard Life Ins. Co. v. Lasser. 541 U.S. 1063 (2004).

C. Reliance Standard's Refusal to Abide by the Lasser Decision

Viewing these court decisions from an ethical perspective, one would reasonably expect RSL to amend its boilerplate denial language and desist from applying the proscribed meaning for the undefined term "regular occupation." Alternatively, it would be reasonable to expect the company to expressly define the term in its policies. After all, the matter had been fully exhausted in the courts, and the mandate was clear that "regular occupation" is to henceforth be accorded its plain meaning, unless the term is defined differently in RSL's disability policy. To the contrary, thirteen years after its unlawful denial of Dr. Lasser's claim for disability benefits RSL continues to apply the same prohibited language in its denial of other legitimate claims. For example, in *Creasy v. Reliance Standard Life Insurance Company*, RSL denied another application for disability benefits, applying the *exact same* definition for regular occupation that it had used in *Lasser*, despite the fact that doing so was a knowing violation of ERISA.[80] Ruling against the insurer, the district judge wrote: "[i]n its 2005 denial of Plaintiff's application, Reliance apparently ignored the *Lasser* Court's 2003 holding [regarding the term 'regular occupation']; in seeking summary judgment, Reliance effectively asks me to do the same. Obviously, I will not. Reliance improperly determined Plaintiff's 'regular occupation.'"[81] In 2004, another district court rejected the same interpretation of "regular occupation" under a substantially similar employee benefit plan:

> Reliance [Standard] explained that it was interpreting "regular occupation" to mean the insured's vocation or profession as it typically exists in the general economy, and thus reference to the DOT was reasonable to assist in the determination of [the plaintiff's] duties. A plain reading of the unambiguous terms of the Policy, however, does not suggest such a broad interpretation. Within the applicable provision of the Policy, the term "regular occupation" is modified by the qualifier "his/her." Thus the Policy's plain language supports some particular connection between the insured and the occupation, rather than a "national" standard. This construction is also supported by a plain and fair reading of the subsequent provision defining eligibility for benefits after twenty-four months of payments, when the insured is considered disabled only if he or she "cannot perform material duties of *any*

[80] No. 07-3789, 2008 WL 834380 at *2 (E.D. Pa. Mar. 26, 2008).
[81] *Id.* at *3.

> occupation." Thus, within the Policy itself, the term occupation is broadened, but only after the insured has already received twenty-four months of payments. The Court therefore disagrees with the interpretation offered by Reliance [Standard], as it would broaden the term "regular occupation" to mean "any" occupation during the elimination period. Such an interpretation is inconsistent with the eligibility requirements after twenty-four months and therefore is incorrect.[82]

RSL's unlawful post-*Lasser* conduct continues in cases like *Wirries v. Reliance Standard Insurance Co.*,[83] in which the plaintiff, a corporate vice-president, sought long-term disability benefits under an RSL plan that defined "total disability" as an inability to perform "the *material duties* of his/her *regular occupation*" just as it did in *Lasser*.[84] RSL concluded that the plaintiff was not totally disabled, relying on its medical consultant's assessment that the duties of a "vice-president" listed in the DOT description for that position were sedentary and that the plaintiff could perform sedentary work.[85] The plaintiff argued that RSL's review of her claim was unreasonable because it failed to take into account certain material duties associated with her position, including non-sedentary duties such as travel.[86] Completely ignoring the court's holding in *Lasser*, RSL argued that its analysis was proper because the plaintiff was "not entitled to benefits just because she is unable to perform the material duties of her job *at* [her employer], but only if she is unable to perform the material duties of *her occupation as a vice president*."[87]

The court in *Wirries* flatly rejected RSL's previously-litigated and unlawful interpretation of "regular occupation," holding:

> [T]he Court finds that Reliance Standard] did not properly interpret the plan language which discussed "regular occupation" when it defined [the plaintiff's] duties solely under the DOT definition because "regular occupation" should have been defined as a

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[82] Freling v. Reliance Standard Life Ins. Co., 315 F.Supp.2d 1277, 1287-88 (S.D. Fla. 2004) (internal citations omitted).

[83] No. CV 01-565-E-MHW, 2005 WL 2138682 (D. Idaho, Sept. 1, 2005).

[84] *Id*. at *2 (emphasis in original).

[85] *Id*. at *9.

[86] *Id*. at *6.

[87] *Id*. at *3 (emphasis in original). RSL stated that "[t]he difference between an occupation and a job being that an occupation is a vocation or profession as it typically exists in the general economy whereas a job is a set of specific tasks performed for a specific employer." *Id.* at *2.

> position of the same general character as the insured's previous job, requiring similar skills and training, and involving comparable duties. This is not limited to [the plaintiff's] particular job, but to a position of the same general character as the insured's previous job. Without belaboring the point, there can be a tremendous amount of difference between being a vice president for a small family-owned corporation engaged in the heating and cooling business, for example, compared to being a vice president for a national corporation such as Microsoft.[88]

The *Wirries* court further concluded that under a proper interpretation of the term "regular occupation," the plaintiff's material duties included duties which are non-sedentary in nature, such as travel, and that RSL's denial of her claim was therefore arbitrary and capricious.[89]

As other circuits have adopted the reasoning of *Lasser*, RSL has become more desperate to salvage the manner in which it has been denying claims. For example, in cases where aggrieved plan participants have invoked the *Lasser* decision, RSL has occasionally argued that, in light of its decision in *Gallagher v. Reliance Standard Life Insurance Company*,[90] the Fourth Circuit actually supports RSL's actions, despite the applicable law of the Third Circuit.[91] However, that argument fails to tell the whole story, and has therefore generally been rejected by various district courts. For example, in *Shahpazian v. Reliance Standard Life Ins. Co*., the court held that RSL's interpretation of the plan was "*de-novo* wrong," and even if that interpretation were based on reasonable grounds, RSL failed to carry its burden to prove that its interpretation was not "tainted by self-interest."[92] In its analysis of *Gallagher*, the *Shahpazian* court stated:

> The *Gallagher* decision does not apply here, where Reliance Standard does not argue that the Plan requires Plaintiff to show he is unable to perform "each and every" material duty [of his regular occupation]. Further, in comparing the actual duties of the plaintiff's job and the DOT description used by [RSL], the *Gallagher* court's opinion impliedly recognizes that the description of duties used by

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[88] *Id*. 2005 WL 2138682 at *5.

[89] *Wirries*, 2005 U.S. Dist. LEXIS 22152, at *6.

[90] Gallagher v. Reliance Standard Life Ins. Co., 305 F.3d 264 (4th Cir. 2002).

[91] *See*, *e.g.*, Transcript of Oral Argument, Mar. 8, 2010, at 34, Kelly v. Reliance Standard Life Ins. Co., 2011 WL 6756932, No. 09-2478 (D.N.J. Dec. 22, 2011) (attorney for RSL arguing that the court's decision in *Gallagher* supports RSL's argument).

[92] 388 F. Supp. 2d 1368 (N.D.Ga. 2005)).

> the administrator should reflect the actual duties of the claimant's specific job. To the extent that *Gallagher* is relevant, it undermines, rather than supports, [RSL's] interpretation of the Plan here.[93]

Also consider *Ranson v. Unum Life Insurance Company of America*, which cited *Gallagher* for the proposition that "the review of [the administrator's] benefits denial decision appropriately begins with a precise and detailed listing of the essential duties of [the claimant's] position at [his employer]" and that "[t]his is so because the Plan definition for disability is stated in terms of the claimant's occupation".[94]

Indeed, *Lasser*, *Creasy*, *Shahpazian*, *Ranson*, *Freling*, and *Wirries* are just a few of the numerous decisions rejecting the unlawful interpretation of "regular occupation" that RSL knowingly continues to use today in its evaluation of disability benefit applications from injured plan participants. Indeed, the overwhelming majority of these cases hold that the term "regular occupation" is not susceptible to the broad interpretation consistently applied by RSL despite the company's full knowledge that such repeated action violates ERISA.

By way of further example, the court in *Smith v. Reliance Standard Life Insurance Company* held that Reliance Standard's broad definition of the plaintiff's "regular occupation" was unreasonable because "it ignores the qualifier 'his/her' in the Policy's language . . . .and the fact that Reliance's own claim form includes a section entitled 'Occupation Analysis' within which a claimant's employer is asked various questions about the 'employee's occupation.'"[95]

Similarly, the Court in *Ebert v. Reliance Standard Life Insurance Company* held that the administrator's use of the DOT to define the claimant's "regular occupation" was improper because a description of the claimant's actual job duties was available to the administrator and "[t]here is no reason to assume that a national standard set forth in the DOT defines the duties of [the claimant's] regular occupation."[96]

The court in *Conrad v. Reliance Standard Life Insurance Company* held that the administrator's decision to deny benefits based on the plaintiff's ability to perform "the material duties of his/her regular occupation" was unreasonable because its vocational experts failed to "examine [the plaintiff's] ability to do any of the specific tasks required

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[93] *Id.* at 1378 (citation omitted).
[94] 250 F. Supp. 2d 649, 656-57 (E.D.Va. 2003).
[95] 350 F. Supp. 2d 993, 999 (S.D.Fla. 2004).
[96] Ebert v. Reliance Standard Life Ins. Co., 171 F. Supp. 2d 726, 735 (S.D.Ohio 2001).

by the job [he] held."[97]

In *Greene v. Reliance Standard Life Ins. Co.*, the court held that the administrator's use of the generic definition of his position in the DOT was unreasonable because the generic definition did not include certain activities that were material to the plaintiff's job with his employer, namely climbing stairs, ladders and catwalks and crawling in and around industrial equipment. The *Greene* court held:

When making an eligibility determination under an ERISA-covered policy, a plan fiduciary must use an 'objectively reasonable' description of the insured's occupation which includes duties comparable to those actually performed by the insured.[98]

D. Ethical Considerations Regarding ERISA Violations

It might surprise readers to learn several of the above cases were litigated on behalf of RSL by the same defense attorneys. For example, the same attorneys lost *Weinberger,*[99] *Lasser,*[100] *Freling,*[101] *Shahpazian,*[102] and *Creasy*[103] on substantially similar grounds.

After the first defeat, these holdings should have come as no surprise to the defense lawyers, who continued to lose nearly identical arguments, on identical issues, about nearly identical insurance policies, for nearly identical conduct, by the same client.[104] Nevertheless, the plan administrator forced these disabled and out-of-work plan participants to court with full knowledge that doing so was unlawful and in violation of ERISA.

Despite myriad rulings that RSL's conduct violates ERISA, the company continues to apply the very same unlawful definition for the term "regular occupation" that it has been applying for more than thirteen years.[105] Although there can be no question that RSL knows

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[97] Conrad v. Reliance Standard Life Ins. Co., 292 F. Supp. 2d 233, 240-241 (D. Mass. 2003).

[98] Greene v. Reliance Standard Life Ins. Co., No. 7:03-cv-00025, 2004 U.S. Dist. LEXIS 23401, at *1-2 (W.D.Va. Oct. 26, 2004).

[99] Weinberger v. Reliance Standard Life Ins. Co., 54 F. App'x. 553 (3d Cir. 2002).

[100] 344 F.3d at 386.

[101] 315 F. Supp. 2d at 1288.

[102] 388 F. Supp. 2d at 1368.

[103] 2008 U.S. Dist. LEXIS 24257.

[104] *Id*.

[105] *See e.g.* Amended Complaint at ¶96 Kelly v. Reliance Standard Life Ins. Co., No. 09–2478, 2011 WL 6756932 (D.N.J. Dec. 22, 2011).

application of the proscribed definition to be unlawful the denials continue to the detriment of disabled employees and their families.

There is no doubt that the company's continued violations of ERISA are willful and knowing. For example, one of the same lawyers for RSL who lost the numerous above-referenced cases on *Lasser* grounds appeared before the United States District Court for the District of New Jersey on December 14, 2010, at which time he was questioned by the Court regarding his client's continued use of the same prohibited language; specifically, at oral argument on the plaintiff's motion for summary judgment in *Kelly v. Reliance Standard Life Ins. Co.*, defense counsel acknowledged and admitted the company's violations, stating:

> I understand your Honor's concerns. Trust me when I say [sic] I saw the letter I said, well, why did you do that . . . . Without waiving any privileges I called the client and said, for God's sake make sure this isn't a template, you can't do this.[106]

Noting that "Reliance should want to look as clean as a whistle, given the number of judges that are jumping all over their heads," the court issued an order remanding the matter for further consideration, as the "price that the company pays for looking as if they are literally thumbing their nose at the Third Circuit."[107]

III. ERISA Lacks Any Real Deterrent Against Unlawful Claim Denial

During periods of disability, plan participants must predictably turn to other sources of income, such as: liquidation of savings and retirement accounts (with penalties for early withdrawal); sale of real property (perhaps at a loss in the current market); lines of credit (with applicable interest); home equity loans; and the cash surrender of insurance policies that were originally intended to provide for loved ones at death. RSL would likely classify these losses, penalties, and interest payments as "consequential damages" that are beyond the scope of ERISA recovery and therefore unrecoverable; however, they are indeed very real losses suffered at the company's own hands and are the proximate result of its intentional wrongdoing.

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[106] Transcript of Oral Argument at 10:21-11:2 (Dec. 14, 2010), Kelly v. Reliance Standard Life Ins. Co., 2011 WL 6756932, No. 09-2478 (D.N.J. Dec. 22, 2011).

[107] *Id.* at 13:3-5, 12:21-23.

Consider Dr. Lasser's case, in which his lawsuit against RSL was filed in 1999.[108] Presumably, the good doctor had gone without work-related income for some time before that date, because the plan first required him to satisfy the Elimination Period and to then exhaust his available administrative remedies after the claim was denied. The matter was not finally concluded until the Supreme Court of the United States denied *certiorari* five years later, on May 24, 2004.[109] Therefore, even though Dr. Lasser ultimately "won" his case, he may have gone without promised income for more than four years, something that many disabled employees cannot afford to do, especially during a period of disability with its associated medical costs.

Meanwhile, RSL had use and enjoyment of Dr. Lasser's money during the entire time with knowledge that Dr. Lasser could not recover lost interest or consequential damages under ERISA. Reflect for a moment on the fact that RSL, with full knowledge that its unreasonable interpretation of "regular occupation" constitutes a *per se* violation of ERISA, continues to apply that same interpretation. Consider also that, despite knowledge of the unlawfulness of its conduct, the company appears willing to force each claim to the courts. At some point, it becomes appropriate to ask "why does a corporate defendant willingly refuse to comply with federal law even where it is certain to lose in the end?" In the opinion of this author, the reason is that (putting morals and ethics aside for the moment) it makes good business sense for companies like RSL to intentionally and knowingly violate ERISA because there is no penalty for doing do beyond a possible award of attorney fees.

A. Remanding Cases to the Plan Administrator Seems Illogical

After determining that a plan administrator acted arbitrarily and capriciously in violation of ERISA, courts often remand the matter right back to the offending administrator for a third bite at the apple.[110] For example, in *Pakovich v. Broadspire Services, Inc.*, the Seventh Circuit held in pertinent part that "when the plan administrator has not issued a

[108] Brief of Appellant at 5, Lasser v. Reliance Standard Life Ins. Co., 344 F.3d. 381 (3d Cir. 2001), No. 02-4123. 2003 WL 24045981 (stating that Lasser's case was removed from state to federal court in 1999).

[109] Reliance Standard v. Lasser, 541 U.S. 1063 (2004).

[110] Administrative review is the first "bite at the apple," administrative appeal is the second, and remand is the third.

decision on a claim for benefits that is now before the courts, the matter must be sent back to the plan administrator to address the issue in the first instance."[111] However, a more appropriate result from the same Circuit may be found in *White v. Airline Pilots Association*, where the court found that "it would be unreasonable for [the administrator] to deny the application for benefits on any ground" and that "[the administrator's] conduct was patently unreasonable in failing to provide a full and fair review."[112] The court thus had no confidence that the plan administrator would give the applicant a full and fair review if the case was remanded.[113]

Some courts have recognized that the remedy of remand actually penalizes aggrieved plan participants and benefits the offending plan administrator. For example, consider *Zervos v.Verizon New York, Inc.*, in which the court held that "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."[114]Also consider *Grosz-Salomon v. Paul Revere Life Insurance Company* holding that "a plan administrator will not get a second bite at the apple when its first decision was simply contrary to the facts."[115] Finally, take into account *Watson v. UNUMProvident Corporation*, refusing to order remand following a finding that the insurer had acted arbitrary and capriciously in order that the insurer face the "consequences of its unreasonable and unprincipled deliberative process."[116]Also persuasive is a recent symposium article on the subject:

> Philosophically, the notion of a remand is antagonistic to our system of civil jurisprudence; moreover it defeats the congressional purpose of the ERISA Statute. A law designed for the protection of plan participants and their beneficiaries fails to meet that goal where plan administrators are given multiple opportunities to shore up a defective record and benefits are either delayed or denied.[117]

In light of the cases and authorities discussed herein, it would

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[111] *Pakovich* 535 F.3d 601 at 605 (7th Cir. 2008).
[112] 364 F.Supp.2d 747, 765-66 (N.D. Ill. April 8, 2005)
[113] *Id.*at 766.
[114] 277 F.3d 635, 648 (2d Cir. 2002).
[115] 237 F.3d 1154, 1163 (9th Cir. 2001).
[116] 185 F. Supp. 2d 579, 587 (D. Mich. 2002).
[117] Mark D. DeBofsky, *The Paradox of the Misuse Of Administrative Law in Erisa Benefit Claims*, 37 J. MARSHALL L. REV. 727 AT 749 (2004).

appear that ERISA, however well-intended by Congress at its inception, has actually resulted in a bizarre system of judicial review for denials of employee benefits where the unscrupulous plan administrators are financially rewarded for intentionally violating federal law.

B. Result - ERISA's Current Framework is Insufficient to Deter Bad Faith Denials

Consider the following scenario for the proposition that ERISA is insufficiently drafted so as to deter knowing violations by unscrupulous plan administrators. Further, consider the argument that ERISA perversely *incentivizes* the intentional wrongful denial of legitimate benefit disability claims. Imagine that "Employer" provides its employees with a disability plan like the one in *Lasser* by purchasing a group disability insurance policy whereby covered employees will earn 66.6% of covered earnings in the event that they become totally disabled and cannot perform the material duties of their regular occupation. The term "regular occupation" is undefined in the policy. "Employee," who earns $80,000 per year, becomes totally disabled and cannot return to work. After completing the requisite elimination period Employee applies for long-term disability benefits from the plan administrator (in this hypothetical, the employer has contractually shifted responsibility for administration and eligibility determinations to the carrier).

Plan Administrator denies the claim for the same reasons set forth by RSL in *Lasser*. Employee files an administrative appeal without the assistance of counsel. The denial is upheld by the Plan Administrator. Employee then hires an attorney who files a complaint in federal court. While he is waiting for the claim to be heard Employee is without income and must sell assets, liquidate his 401(k) account (with penalties), cash in his policies of insurance on his life, and borrow against the equity in his home (with interest).

Under ERISA Employee is only permitted to ask for the actual benefits denied. This means that if he is disabled for an entire year, he would only be eligible to receive $52,800 (i.e. 66.6% of $80,000). The defense lawyers file their summary judgment motions and attach canned briefs from their firm brief bank. The plaintiff's lawyer (hired on a contingent basis) files his own cross-motion for summary judgment citing *Lasser* and its progeny. After the matter has been fully briefed (more than a full year after Employee became eligible to receive

benefits) the Plan Administrator offers to settle the entire case for $52,800 (i.e. the full value of benefits owed).

Of course, under these facts, Employee's attorney would be hard-pressed to pass on the settlement offer, despite the strong merits of his case because he has obtained 100% of the benefits owed under the applicable plan. Employee collects the $52,800, but must first pay his lawyer 1/3 in contingent fees, or $17,424 (because the case did not go to judgment thereby permitting a petition for fees under ERISA), leaving Employee with only $35,376, minus the penalties, interest, and losses incurred to replace the lost income during the first year of disability (the so-called "consequential damages"). The Plan Administrator, on the other hand, merely had to pay its own defense attorneys and was permitted to enjoy the "time value" of the entire $52,800 for an entire year.

Put simply, ERISA offers no sufficient disincentive for even the most egregious violations of its provisions. Plan Administrators are financially encouraged to "play the numbers", denying cases and then offering to settle for some amount less than what is owed. This is true because even if the Plan Administrator loses, it might get another bite at the apple by virtue of remand, and there is no penalty for even the most egregious misconduct. Also, when cases are remanded to the carrier the disabled employee continues without much needed income during that time. Because there are no punitive damages available under ERISA, even for bad faith denials, the plan administrator's potential losses are limited to reasonable counsel fees.

From a tax policy perspective, the incentive to wrongfully deny claims works against the public interest. In the above scenario, Employer enjoyed a tax deduction for the amount of the premium paid on the plan's disability policy.[118] But this deduction was unwarranted if the terms of that policy are not complied with by the insurer. Additionally, the income that Employee *should* have received would ordinarily be taxable, but because that income was not timely paid as it should have been, no tax revenue was generated for public benefit during the period of disability.[119] Therefore, when a plan administrator unlawfully denies a benefit claim in violation of ERISA it injures the public *in addition to* the disabled plan participant and his family.

[118] 26 U.S.C. § 162 (2012).
[119] 26 U.S.C. § 106(a) (2012).

IV. Proposed Amendments to ERISA's Recovery Framework

It is the conclusion and recommendation of this author that for the reasons stated herein ERISA lacks the requisite deterrent to fulfill its Congressional intent. Plan administrators are encouraged to refuse, or at least delay, payment of welfare benefits owed to disabled employees. Without the availability for recovery of punitive and consequential damages, aggrieved plaintiffs are compelled to settle their cases after the longest possible delay, for less than the amount owed. As a proposed solution to this legislative shortfall, the following amendments are encouraged:

1. Recovery of treble and/or punitive damages should be available to plaintiffs where a knowing and/or bad faith violation of ERISA is alleged.
2. Employers should be made vicariously liable for the conduct of their insurance carrier as a co-fiduciary even where responsibility for determination of eligibility has been delegated by the plan administrator.
3. Consequential damages should be made available to plaintiffs who can demonstrate through evidentiary proofs that an administrator's conduct has proximately resulted in losses that beyond the contractual benefits owed.
4. The Employer should forfeit any otherwise available tax deduction for payment of policy premiums where a knowing and/or bad faith violation of ERISA can be shown.
5. Where bad faith conduct can be proved, a court *shall* (i.e. not *may*) award reasonable attorney fees and costs of suit and *may* apply a multiplier to said fee where such relief is appropriate.

CONCLUSION

For the reasons set forth herein, ERISA is presently inadequate to deter bad faith denials of legitimate disability claims by plan administrators. Indeed, the Act is so weak that it financially incentivizes the bad faith denial of legitimate claims, forcing disabled participants to re-litigate well-settled issues in the courts. Through their intentional and knowing misconduct, offending plan administrators and their insurance carriers are rewarded while they continue to injure plan participants and their families. Additionally, these offending companies contribute toward a shortfall in tax revenue and overburden the judicial system with relative impunity. Accordingly, ERISA should be overhauled and amended to deter companies like RSL from continuing

to run roughshod over disabled employees while "thumbing its nose at the Third Circuit" with impunity, especially where the violations of federal law are shown to be intentional and in bad faith.