Suits for Benefits Under ERISA

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ARTICLES

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I. INTRODUCTION

The central policy of the Employee Retirement Income Security Act (ERISA)\(^1\) is that employees should receive the pensions and other benefits they were led to believe they would get.\(^2\) Much of the statute consists of preventative rules and standards, designed to ensure that benefit expectations are well grounded and to lessen the risk of disappointment.\(^3\) Other provisions are remedial. They supply cures for misdeeds that threaten the ultimate payment of benefits.\(^4\)

Section 502(a)(1)(B) is ERISA's benefit recovery provision. It specifies that a participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of his plan."\(^5\) The provision is obviously remedial. But it provides a remedy of a special kind and differs from ERISA's other remedial provisions in an important respect. The other provisions safeguard expectations by permitting removal of threats to the plan's ability to pay benefits. For example, one provision allows courts to remove such risks by ordering transgressing fiduciaries to restore funds they caused the plan to lose.\(^6\) By contrast, section 502(a)(1)(B) does not deal with risks. Rather, it supplies participants and beneficiaries with a direct means for their benefit expecta-

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3. See, e.g., 29 U.S.C. §§ 1081-1086; I.R.C. § 412 (funding standards ensuring that plans have sufficient assets to pay promised benefits); 29 U.S.C. § 1053; IRC § 411 (minimum vesting standards ensuring that promised benefits become non-forfeitable within a reasonably short period).

4. See, e.g., 29 U.S.C. § 1140(a) (protection from interference with benefit rights in workplace).


tions to be fulfilled. One might say that the provision is ERISA's bottom line.

This bottom-line provision is drafted simply. It allows suit to be brought for "benefits due under the terms of [the] plan." It appears to describe an action with only one substantial issue: whether the terms of the plan entitle the claimant to the benefits sought. Yet courts have not treated suits for benefits in this straightforward way. Instead, they have imported concepts and rules from labor law, fiduciary law, pre-ERISA benefit plan law and elsewhere, to create a scheme in which entitlement to benefits may be only a secondary issue. Under the current framework, the primary questions in a suit for benefits may include: (1) whether the claimant has exhausted all administrative procedures available under the plan;[7] (2) whether the plan document limits judicial review of decisions about benefit entitlement;[8] (3) whether any potential conflicts of interest suggest impropriety in the benefit-determination process;[9] and (4) whether the plan decisionmaker's interpretation of the plan was "tainted by self-interest."[10] A court might determine the "legally correct interpretation" of the plan only to help it assess the legitimacy of the reasons offered by the plan decisionmaker for a contrary interpretation.[11] If the reasons are acceptable, a court may even uphold a denial of benefits that it believes to be wrong.[12]

Congress unquestionably intended courts to develop some set of rules to govern actions for benefits under section 502(a)(1)(B). But the rules developed must be consistent with the purposes of ERISA. The current law pays little attention to ERISA's central purpose of safeguarding benefit expectations. Indeed, it often seems perversely designed to thwart benefit expectations, for no better reason than judicial force of habit.

This article examines what is wrong with current law and shows why the action for benefits needs to be reformulated as the simple, entitlement-fulfilling action Congress intended it to be. Part I sets the stage

10. Id. at 1566-67 & n.12.
by analyzing what the structure and legislative history of ERISA show about the action for benefits. It demonstrates that actions for benefits enforce a non-fiduciary duty to participants and beneficiaries and that Congress intended courts to develop an appropriate law to govern such actions. Congress gave courts little direction regarding this development. One can conclude, however, that Congress rejected state law as a guide and, contrary to the views of some, did not Congress mandate labor law as one. Regarding labor law, one can also conclude that labor law should not be a guide because labor law policies favoring group rights and arbitration are incompatible with ERISA’s policy of facilitating judicial protection for benefit rights. These conclusions provide standards for the subsequent critique of current law.

Part II examines one of the two prevailing models for benefit suits: the suit for benefits as appellate review of a claim that has been denied in a prior arbitration-type or administrative-type proceeding. This model underlies the requirement that litigants exhaust plan claims procedures before bringing suit. Part II concludes that this model, along with the exhaustion requirement, has no support either in the statute or the legislative history and represents an unwarranted importation of labor law policy into ERISA. The exhaustion requirement has little purpose other than to reduce the number of suits for benefits. Such purpose, however, is contrary to ERISA’s policy of making courts accessible to participants who seek to vindicate their rights.

Part III examines the other prevailing model for benefit suits, that of a proceeding to review fiduciary decisionmaking. This model purports to legitimate judicial deference to a fiduciary’s denial of a claim. The model emerged as a result of the uncritical importation of state common law rules, which had been mildly protective of benefit rights, into new legal contexts. In those new contexts, the rules had the effect of limiting the protection of benefit rights. Courts sought to rationalize these protection-limiting features through questionable reliance on trust law, an effort that culminated in the Supreme Court’s decision in Firestone Tire & Rubber Co. v. Bruch.13 This model, along with its rule of deference, is incompatible with ERISA’s text and policies, and, again, seems to have no purpose other than to limit the number of benefit suits.

The current law of benefit suits cannot be reconciled with ERISA’s language, legislative history, or purposes. In fact, it under-

mines those purposes. If there is a genuine problem of too many benefit
suits in federal court (which is by no means clear), it is a problem to be
remedied by congressional rethinking of proper policies for the law of
plans.

II. UNDERSTANDING THE SUIT FOR BENEFITS

To understand the nature of the suit for benefits under ERISA,
one turns first to the statute and then, to the extent necessary, to legis-
lative history and other extrinsic sources of guidance. Such an exami-
nation discloses far more about what the suit is not than what it is.

A. The Interpretive Problems of Section 502(a)

ERISA's provision for benefit suits is found in section 502(a),
which deals generally with civil enforcement. Section 502(a) provides
that:

A civil action may be brought—
(1) by a participant or beneficiary—(A) for the relief provided for in sub-
section (c) of this section, or (B) to recover benefits due to him under the terms
of his plan, to enforce his rights under the terms of the plan, or to clarify his
rights to future benefits under the terms of the plan;
(2) by the Secretary [of Labor], or by a participant, beneficiary or fiduciary
for appropriate relief under section 409;
(3) by a participant, beneficiary, or fiduciary, (A) to enjoin any act or prac-
tice which violates any provision of this title or the terms of the plan, or (B) to
obtain other appropriate equitable relief (i) to redress such violations or (ii) to
enforce any provisions of this title or the terms of the plan;
(4) by the Secretary [of Labor] or by a participant, or beneficiary for ap-
propriate relief in the case of a violation of [section] 105(c);
(5) except as otherwise provided in subsection (b), by the Secretary [of La-
bor] (A) to enjoin any act or practice which violates any provision of this title, or
(B) to obtain other appropriate equitable relief (i) to redress such violation or
(ii) to enforce any provision of this title; or
(6) by the Secretary [of Labor] to collect any civil penalty under subsection
(c)(2) or (i) or (l) of this section. 14

This collection of rules has a curious structure. Each rule identifies
which of four plan-related entities—participants, beneficiaries, fiducia-
ries, or the Secretary of Labor—has standing to bring certain kinds of
actions. Some of the rules also describe the nature of the claim that the
identified persons may bring; some do not, referring instead to other
provisions of ERISA. Similarly, some of the rules describe the relief

available to the persons having standing; others do not. Structurally, section 502(a) is more than a collection of standing provisions, but less than a complete and systematic description of claims and remedies available under ERISA.

In fact, section 502(a) is quite unsystematic and it contains much duplication. For example, a participant, beneficiary, or fiduciary may bring suit to enjoin a breach of fiduciary duty under either section 502(a)(2) or 502(a)(3)(A). Which provision is relied on appears to make no material difference. Similarly, a participant or beneficiary may bring an action to enforce the terms of the plan under either section 502(a)(1)(B) or 502(a)(3)(B)(ii). Still more duplication can be found for other types of suits.16

Section 502(a) is incomplete as well as unsystematic. It is incomplete in its description of standing. For example, it fails to deal with suits brought by plans. ERISA expressly permits plans to "sue or be sued under [Title I] as an entity."18 But neither section 502(a) nor any other provision of ERISA states what plans may sue or be sued about. Thus, courts have had to develop standing and other procedural rules to govern suits by plans.17 Similarly, although ERISA permits assignment of welfare benefits, section 502(a) fails to specify when assignees and subrogees may sue. Again, courts have had to develop appropriate standing and other procedural rules.18

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15. See, e.g., Amalgamated Clothing & Textile Workers Union v. Murdock, 861 F.2d 1406, 1413 (9th Cir. 1988) (constructive trust remedy available under §§ 502(a)(2) and 502(a)(3)(B)).
Section 502(a) is also incomplete in its listing of plan-related claims on which suit can be brought. ERISA is not a comprehensive body of plan regulation. It was intended only as a first step toward benefit plan regulation, and Congress knew that many important issues remained to be addressed.\textsuperscript{19} Despite its incompleteness, ERISA preempts (with only narrow exceptions) \textit{all} state laws that relate to employee benefit plans.\textsuperscript{20} This textual incompleteness, coupled with ouster of state law, leaves huge gaps in the regulation of employee benefit plans.

Congress intended federal courts to develop a body of common law that would fill those gaps and implement ERISA’s principles and policies.\textsuperscript{21} Courts have carried out this responsibility, among other ways, by developing substantive rules for non-statutory plan-related claims.\textsuperscript{22} Yet Congress failed to provide for the enforcement of these gap-filling and other claims. Instead, Congress left it up to the courts to develop appropriate rules for jurisdiction, standing, and remedies.

Thus, section 502(a)—and more generally the entire civil remedial scheme of ERISA—is neither systematic nor complete. It is both redundant and full of holes. Yet despite these obvious characteristics, the Supreme Court flatly stated, in \textit{Massachusetts Mutual Life Insurance Co. v. Russell},\textsuperscript{23} that section 502(a) forms a comprehensive “enforcement scheme,” which was “carefully integrated” and “crafted with . . . evident care.”\textsuperscript{24} Regrettably, lower courts have treated this doubtful characterization as dogma.\textsuperscript{25} They routinely state, for example, that

\begin{itemize}
\item 20. 29 U.S.C. § 1144(a).
\item 23. 473 U.S. 134 (1985).
\item 24. 473 U.S. at 146-47.
\item 25. A rare exception is Winstead v. J.C. Penney Co., 933 F.2d 576 (7th Cir. 1991) (Posner, J.), where the court observed, albeit in dictum, that: ERISA’s jurisdictional provisions are unusually detailed and it is tempting to suppose that the more detailed a statute is, the less likely legislative mistake and omission are and so the
\end{itemize}
“civil actions under ERISA are limited only to those parties and actions Congress specifically enumerated in section [502],” as if there were no body of claims under the common law of plans.

The desultory character of section 502(a) thus creates interpretive problems. The language is terse and needs elaboration. Yet many traditional precepts of statutory interpretation will not work. For example, the principle that interpretations should be avoided that result in redundancy is inapropos. Section 502(a) unquestionably contains duplication. Nor can one necessarily reason that what is not included was intended to be omitted, because Congress instructed courts to fill in many of the gaps.

How, then, is section 502(a)(1)(B), and in particular the provision regarding suits “to recover benefits due . . . under the terms of [a] plan,” to be interpreted?

B. What the Statutory Structure Shows

It is tempting to conclude immediately that a suit for benefits
under section 502(a)(1)(B) cannot be a suit to enforce a fiduciary obligation, because to do so would make section 502(a)(2) redundant. Unfortunately, for the reason just given, this line of argument is unpersuasive; yet, the conclusion is correct. This will emerge from careful examination of section 502(a)(2) and the duties it enforces.

1. The Character of Fiduciary Obligation

Section 502(a)(2) is a pure standing provision. It merely authorizes a participant, beneficiary, fiduciary or the Secretary of Labor to seek relief under section 409. Section 409(a), in turn, creates a statutory claim for breach of fiduciary duty and describes the remedies available for such a breach. It provides that:

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by [Title I] shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.28

Section 409(a) is designed to provide a civil remedy for those and only those wrongs that are breaches of the fiduciary rules. It expressly governs "any" breach of fiduciary responsibility and is thus comprehensive. Furthermore, it governs only breaches of fiduciary responsibility and is therefore exclusive as well. The fact that section 409(a) is coextensive with the duties whose breach it remedies is critical for this allows one to clarify important aspects of fiduciary responsibility that ERISA does not fully explain.

Fiduciary obligation under ERISA differs from conventional trustee obligation. Unlike a conventional trustee, an ERISA fiduciary is generally allocated only a part of the total responsibility for managing and administering the plan and its assets, and is a fiduciary only with respect to the areas of his managerial or administrative responsibility.29 ERISA makes its fiduciary duties second-order duties that regulate the manner in which a fiduciary is to carry out his primary or first-order duties relating, for example, to plan management or administration.30

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30. 29 U.S.C. § 1104(a). For other important differences between ERISA fiduciary law and trust law, see infra part IV(B)(2).
A recurring problem in this fiduciary structure is determining what conduct and responsibilities are part of plan management, plan administration, and plan asset management, and thus subject to ERISA's fiduciary rules. ERISA gives little express guidance. Some cases have taken a functional approach to the problem. They reason that because plan management, administration and asset management are substantially coextensive with the potential scope of fiduciary responsibility, one may determine whether conduct or responsibility is part of plan management or administration, or plan asset management, by determining whether it is the kind of activity that ought to be governed by the fiduciary rules.\textsuperscript{31} The structure of the statute, its policies and its legislative history help with this determination. For example, ERISA's structure and purpose make clear that the processing and payment of benefits is an activity that should be considered part of plan administration and subject to the fiduciary rules.\textsuperscript{32}

Another recurring problem is that of identifying the persons to whom fiduciary duties are owed. The statute is silent. It does not help to look at the underlying duties, for there is no necessary connection between the person to whom fiduciary duties are owed and the person to whom primary duties are owed. It is perfectly intelligible to say, for example, that the plan trustee has responsibility, under the terms of the plan, to provide periodic reports on her activities to the sponsor's board of directors—a first-order duty owed to the board—as well as the fiduciary duty to make sure that the report is accurate and complete—a second-order duty owed to someone else. A functional approach, however, is again possible. Because of the coextensiveness of section 409(a) and the underlying fiduciary duties, one may say, in general, that there is a fiduciary duty in a given situation to the extent, and only to the extent, that section 409(a) provides a remedy for its breach.\textsuperscript{33} In par-

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\textsuperscript{31} E.g., Hoozler v. Midwest Fasteners, Inc., 908 F.2d 1155 (3d Cir. 1990). For an extended discussion of this approach, see Conison, Foundations, supra note 2, at 649-53.


\textsuperscript{33} The functional definition in the text is consistent with the general understanding of legal duty as a relation between two persons wherein certain conduct by one engenders his liability to the other. See, e.g., Restatement of Property § 1 cmt. a (1936) (duty exists where one person has "a legally enforceable obligation to do or not do an act."); Restatement (Second) of Torts § 4 (1965) (duty exists where an "actor is required to conduct himself in a particular manner at the risk that if he does not do so he becomes subject to liability to another to whom the duty is owed"); W. Page Keeton, Dan B. Dobbs, Robert E. Keeton & David G. Owen, Prosser & Keeton on the Law of Torts § 53 (5th ed. 1984). A formal definition of "duty of x to y with
ticular, because section 409(a) remedies only losses to the plan and provides relief only to the plan, ERISA's fiduciary duties may be said to be owed only to the plan. The Supreme Court essentially recognized this in *Massachusetts Mutual Life Insurance Co. v. Russell*.

2. Fiduciary Obligations and Benefit Obligations

The recognition that ERISA's fiduciary duties are owed to the plan, rather than to individual participants and beneficiaries, helps clarify some important features of the statute. It helps one to understand both the interrelationships and differences between suits for benefits and suits for breach of fiduciary duty. Section 502(a)(1)(B) provides for enforcement of a first-order duty owed to participants and beneficiaries. The remedy for a breach is an award of benefits due. Breach of this first-order duty is not itself a breach of fiduciary duty owed to the plan.

Breach of the duty to pay benefits, however, may be accompanied


Hohfeld's conceptual scheme, which makes use of this notion of legal duty, can be used to clarify the relations between §§ 404, 409(a), and 502(a)(2), and the functional equivalence described in the text. One may say that § 409(a) defines the remedial duty of plan fiduciaries that arises whenever a plan fiduciary violates a fiduciary duty set forth in § 404(a); and that § 502(a)(2) confers on participants, beneficiaries, fiduciaries, and the Secretary of Labor the power to enforce the remedial duties owed to the plan. See generally Wesley N. Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 26 Yale L.J. 710 (1917); Arthur L. Corbin, *Legal Analysis and Terminology*, 29 Yale L.J. 163 (1919).

34. See Conison, *Federal Common Law*, supra note 19, at 1075-77, for a further argument that, because a plan is a single-focus activity, rather than an individual (like a person or a corporation), the loyalty of an ERISA fiduciary to the plan is better understood on the analogy of a player's loyalty to "the game" than on the analogy of a trustee's loyalty to trust beneficiaries. This formal difference between the loyalty of a plan fiduciary and the loyalty of a trustee further supports the conclusion later reached, that there are fundamental differences between trust law and ERISA fiduciary law, which demand that care be used in drawing on the former to develop rules for the latter. See *infra* part IV(B)(2). The characterization of the ERISA fiduciary's loyalty as loyalty to an activity is not very important for purposes of this article, and will not be pursued further.


    does not impose a fiduciary duty to provide individualized notice of the effect a particular event may have on a participant or beneficiary's eligibility to receive benefits... [F]iduciaries should be able to rely upon the detailed and uniform guidance ERISA provides with regard to disclosure requirements rather than bearing the practically impossible burden of anticipating, and comprehensively addressing, the individualized concerns of thousands of employees, especially without notice of those concerns.
by a breach of fiduciary duty. If so, the appropriate remedy for the latter would be something very different from an individual award of benefits. For example, an administrator surely has a fiduciary obligation to the plan not to deny benefits that ought to be paid. Proper remedies for breach of this duty might include, in an appropriate case, compensation to the plan for litigation expenses incurred because of an improper denial. But there may be breaches of the fiduciary duties involved in benefit payment activity without there being a breach of the non-fiduciary duty to pay benefits. For example, a plan administrator surely is under a fiduciary obligation to the plan not to pay benefits that are not owed. Proper remedies for this breach may include reimbursement of the amount wrongfully paid and even, in extreme cases, removal of the fiduciary.

3. **Fiduciary Obligations and Common Law Obligations**

Under ERISA, a participant’s or beneficiary’s protectible interest is his interest in receiving benefits from a plan. The statute does not impose obligations on fiduciaries, or anyone else, not to invade those personal interests. Protection of other interests is left to other bodies of law.

Indeed, the protectible interest of participants and beneficiaries under ERISA is even narrower than the interest in benefits, for the statute protects only benefit expectations systematically created by plans. The statute is not concerned with protection of individual benefit expectations created adventitiously; that protection is left, for example, to the federal common law of estoppel. The provisions of ERISA are designed to eliminate or reduce only structural and generalized threats to the realization of benefit expectations. The vesting, funding and termination insurance provisions serve just this purpose.

So, too, do the fiduciary rules. They protect employee plan-based expectations of benefits by prohibiting fiduciaries from carrying out their responsibilities in a way that increases risks that the expectations

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36. *See, e.g.*, LeFebre v. Westinghouse Elec. Corp. Management Disability Benefits Plan, 747 F.2d 197, 207 (4th Cir. 1984) ("A trustee has the obligation to guard the assets of the trust from improper claims, as well as the obligation to pay legitimate claims.").

37. *See, e.g.*, Black v. TIC Inv. Corp., 900 F.2d 112 (7th Cir. 1990).

of the participants as a group will be disappointed. For this reason, the remedy for a breach of fiduciary duty is the group-oriented remedy of removal of the risk to generalized benefit expectations.

It does not follow, however, that plan fiduciaries have no fiduciary-like duties to individual participants and beneficiaries. A sense prevails that fiduciaries (and, perhaps, other persons involved in the operation of plans) should have enforceable obligations, including fiduciary-like obligations, to individual participants and beneficiaries. Acting on this belief, courts and commentators have often strained to read ERISA's fiduciary rules as creating obligations to individual participants and beneficiaries. Some have also strained to read into section 502(a)(3), which provides only for equitable relief, a damage remedy for individuals when one of these fiduciary-like duties has been breached. The problem with these strained constructions is that the language of ERISA will not support them. In any event, they are unnecessary, because ERISA leaves ample room for additional obligations and remedies of the kind thought to be needed. ERISA preempts the state laws that might supply such duties and remedies without itself filling in the

39. See Amalgamated Clothing & Textile Workers Union v. Murdock, 861 F.2d 1406 (9th Cir. 1988); Leigh v. Engle, 727 F.2d 113 (7th Cir. 1984).

40. Where the plan has ceased to exist, or otherwise become incapable of carrying out its purpose of providing benefits to participants and beneficiaries, relief under § 409(a) may be given directly to the participants and beneficiaries as a class. For example, in Gruber v. Hubbard Bert Karle Weber, Inc., 675 F. Supp. 281 (W.D. Pa. 1987), suit was brought claiming that the administrator and other fiduciaries had caused the bankruptcy of an association of employers created to provide health benefit plans for employers to offer to their employees. The class of participants sued the fiduciaries for damages in the amount of unpaid benefits. The court held that the claim was proper, notwithstanding the individualized character of the relief sought:

In the absence of a functioning plan, it is the class of beneficiaries and their rights under this plan which represent the interests of the plan for the purposes of Section 409. The plan's foremost interest as a non-profit trust is to satisfy the obligation to its beneficiaries. Because the present case presents not merely the claim of an individual to the exclusion of others, but the collective claim of the trust's beneficiaries, the relief sought would inure to the benefit of the plan as a whole, even though no plan technically exists.

675 F. Supp. at 284.

In another case, the court imposed a constructive trust for the benefit of the plan participants and beneficiaries on the profits of a fiduciary made through the risky and self-serving use of plan assets. The remedy was constructive trust, rather than an order compelling the fiduciary to pay the profits to the plan, because the plan contained a reversion provision that would have permitted the fiduciary to terminate it and recover the wrongfully obtained profits. Amalgamated, 861 F.2d 1406.

gap, thereby leaving the area to common-law development. 42 For example, it is arguable that courts, consistent with ERISA, may impose on fiduciaries and others a common-law duty of care, owed to participants and beneficiaries in the processing of benefit claims. 43

Thus, in the context of benefit administration, three varieties of duty, and three concomitant types of remedy, potentially are involved in any given case: (1) the duty owed to individual participants and beneficiaries to pay benefits, which is enforced through section 502(a)(1)(B); (2) the statutory fiduciary duties owed to the plan, which are enforced through sections 409(a) and 502(a)(2); and (3) other, non-statutory duties owed by fiduciaries (and others44) to individual participants and beneficiaries, which are enforced under federal common law. These duties are distinct, and the principles governing them are not necessarily the same.

C. What Legislative History Shows

Although a suit under section 502(a)(1)(B) is not a federal common law claim in the sense of a judicially recognized claim that fills a statutory gap, it is still a federal common law suit in the sense that courts must implement congressional intent and give substance to a mere statutory outline.46 A review of the legislative history reveals that Congress intended courts to develop a law of benefit obligations and claims. Congress, however, provided only negative guidance as to what the content of the law should be.

1. The Legislative History

ERISA emerged from the reconciliation and refinement of four bills, two each in the House of Representatives and Senate. In each house, one of the two bills was proposed initially as labor legislation,

42. There are important constraints on such development. Any such duties must be subordinate to the statutory fiduciary duties: otherwise conflicts of interest could arise. ERISA's fiduciary rules prevent a fiduciary from favoring the interests of some participants or beneficiaries, or acting to advance the interests of some to the detriment of others. Morse v. Stanley, 732 F.2d 1139, 1145 (2d Cir. 1984); Winpisinger v. Aurora Corp. of Ill., 456 F. Supp. 559, 566 (N.D. Ohio 1978). If fiduciaries had equally weighted loyalties to individual participants, they might be forced to choose between promoting plan interests and participant interests.


45. For an analysis of these two different kinds of federal common law, see id. at 1099-1119.
and the other as tax legislation. The two labor bills were the ones concerned with benefit obligations and claims.

The House labor bill initially provided that:

Civil actions under this title may be brought—
(1) by a participant or beneficiary—

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(B) to recover benefits due him under the terms of his plan or to clarify his rights to future benefits under the terms of the plan . . . 46

This provision remained in the bill throughout its progress in the House, and ultimately was incorporated verbatim into ERISA as section 502(a)(1)(B). The meaning of the provision, however, changed radically between introduction and enactment.

The provision initially was intended only to confer standing and federal jurisdiction, leaving state law to apply in suits brought under it. 47 The preemption provision of the same bill makes this clear, stating in relevant part:

It is hereby declared to be the express intent of Congress that, except for actions authorized by [the provision for suits to recover benefits] . . . the provisions of this Act shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the fiduciary, reporting and disclosure responsibilities of persons acting on behalf of employee benefit plans . . . . 48

In the Senate, a labor bill with similar provisions was introduced. 49


47. It is doubtful whether Article III allows Congress to confer jurisdiction on federal district courts to hear non-diversity suits governed entirely by state law. See Mesa v. California, 489 U.S. 121 (1989); Textile Workers Union v. Lincoln Mills, 353 U.S. 448 (1957) (Frankfurter, J., dissenting).

48. H.R. 2, supra note 46, at § 114, reprinted in 1 Legislative History, supra note 46, at 50-51.

49. The bill provided that:

Suits by a participant or beneficiary entitled, or who may become entitled, to benefits from an employee benefit plan or fund, subject to the Welfare and Pension Plans Disclosure Act, as amended by this Act may be brought in any court of competent jurisdiction . . . against any such plan or fund to recover benefits due him required to be paid from such plan or fund pursuant to the document or documents governing the establishment or operation of the plan or fund, or to clarify his rights to future benefits under the terms of the plan.

S. 4, 93d Cong., 1st Sess. § 604 (1973), reprinted in 1 Legislative History, supra note 46, at 184. The preemption provision stated, in relevant part, that:

It is hereby declared to be the express intent of Congress that, except for actions
Both houses ultimately passed bills with enforcement and preemption provisions that authorized suits for benefits governed by state law. Notwithstanding this agreement, the Conference Committee made a critical change that became part of ERISA. It broadened preemption so that ERISA would expressly oust "all State laws insofar as they . . . relate to any employee benefit plan." There no longer was an exception for benefit suits. The reason for rejecting the state law of benefit claims was not given in the Conference Report, but is suggested elsewhere. House and Senate reports for predecessor bills had criticized existing state law on the ground that "courts strictly interpret the plan inden- ture and are reluctant to apply concepts of equitable relief or to disre-gard technical document wording." 60

Because the bill contained no rules to replace the preempted state laws governing benefit obligations and claims, federal common law would have to be developed. To emphasize this important new result, the Conference Report explained that:

All such actions [under ERISA § 502(a)(1)(B)] in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947.61

The Committee used this analogy because the Supreme Court had previously construed section 301 of the Labor-Management Relations Act of 1947 (LMRA) as legislative authorization for courts to develop a federal common law governing suits to enforce collective bargaining agreements,62 even though LMRA section 301 (like ERISA section 502(a)(1)(B)) on its face does nothing more than confer standing and jurisdiction.63

authorized by section 604 of this title, the provisions of this Act or the Welfare and Pension Plan Disclosure Act shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act or the Welfare and Pension Plan Disclosure Act. . . .

Id. at § 609(a), reprinted in 1 LEGISLATIVE HISTORY at 186.
53. LMRA § 301(a) provides that:

Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce . . . , or between any such labor organizations, may be brought in any district court of the United States having jurisdiction
The legislative history contains no discussion of what the character and content of that law should be, perhaps because the decision to have federal common law govern benefit suits came so late. The main significance of the legislative history, then, lies in its rejection of the state law of benefit claims.

2. The Spurious Appeal to Labor Law

The Committee's reference to section 301 of the LMRA was meant only to clarify the federal common law character of the applicable law. Clarification was needed because the Conference Committee had suddenly, and probably unexpectedly, discarded provisions of earlier bills that would have let state law govern benefit claims. Contrary to what many commentators and courts have stated, the reference to section 301 of the LMRA does not mean that courts should import into ERISA the specific rules that have been developed under section 301. Neither the Conference Report nor any other document suggests that Congress intended such a result or that such a reading of the passage is even remotely plausible.

of the parties, without respect to the amount in controversy or without regard to the citizenship of the parties.


55. E.g., Barrowlough v. Kidder, Peabody & Co., 752 F.2d 923, 939 (3d Cir. 1985); Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980).

56. Those who have read the passage as calling for incorporation of substantive rules of labor law have failed to notice the intimate connection between the provisions concerning benefit suits and preemption of state law. Most of those courts and commentators assume that their reading of the passage is self-evident, and that further explanation is not necessary. A few, e.g., Schneider, supra note 54, at 279-80; Shell, supra note 54, at 547, have sought to bolster their reading of the passage by reference to a supposedly pertinent arbitration requirement, contained in the final Senate bill but dropped in Conference, which provided that:

(a) Each employee benefit plan subject to this part shall provide—

(1) a procedure for the fair and just review under the plan of any dispute between the administrator of the plan and any participant or beneficiary of the plan, and

(2) an opportunity, after such review and a decision by the administrator (or a failure to make a decision within a reasonable period of time be the administrator), for the arbitration of such disputes.

(b) A participant or beneficiary of such a plan may bring a civil action in accordance with the provisions of section 693 of this Act in lieu of submitting the dispute to arbitration
There are, in fact, compelling reasons why Congress would not have wanted courts uncritically to extend rules for the enforcement of collective bargaining agreements to suits for benefits under ERISA. First, the LMRA expressly declares a preference for resolution of disputes involving collective bargaining agreements through non-judicial means—\textsuperscript{59}—in particular, through the grievance and arbitration process. By contrast, ERISA declares that one of its purposes is to provide "ready access to the Federal courts."\textsuperscript{58} The law governing suits under section 301 has been developed so as to implement the LMRA's policy in favor of non-judicial resolution of disputes; indeed, it greatly restricts access to and relief available from federal courts.\textsuperscript{69} Its rules cannot be

\textsuperscript{59} (d) The arbitration of disputes in accordance with the requirements of this section, and judicial proceedings relating thereto, shall be governed by the laws, decisions, and rules applicable to the arbitration of disputes under section 301 of the Labor Management Relations Act, 1947.

S. 4, supra note 49, at § 691, reprinted in 1 LEGISLATIVE HISTORY, supra note 46, at 1488-89. For several reasons, however, this "arbitration provision" has no tendency to show that Congress intended rules developed under LMRA § 301 to govern suits for benefits.

First, the bill containing this arbitration provision also contained the usual provisions allowing suits for benefits governed by state law. Sections 694 and 699 of the bill are respectively identical with §§ 604 and 609 of S. 4 as introduced. See S. 4, supra note 49, 1 LEGISLATIVE HISTORY, supra note 46, at 1491, 1493-94. Thus, the bill relied upon to infer a congressional intent to apply labor law rules to benefit suits expressly provides that suits for benefits should be governed by state law.

Second, the provision governs "any dispute" between plan participants and plan administrators; not just disputes over benefit entitlements. That it really means any dispute is clear from subsection (b), which permits suit under § 693 as an alternative to arbitration. Yet § 693 was the provision governing "[c]ivil actions . . . to redress or restrain a breach of any responsibility, obligation, or duty of a fiduciary." 1 LEGISLATIVE HISTORY, supra note 46, at 1490-91. Thus, if this arbitration provision is evidence of congressional intent that the rules of LMRA § 301 be applied to benefit claims, it must also be evidence of congressional intent to apply those same rules to fiduciary claims. Yet no one argues that the rules developed under § 301 should apply to all claims for breach of fiduciary duty.

In fact, the only benefit-related suits that this provision required to be governed by the rules of § 301 were appeals of arbitration decisions. But Congress eliminated such actions in the bill it ultimately enacted.

57. "Final adjustment by a method agreed upon by the parties is declared to be the desirable method for settlement of grievance disputes arising over the application or interpretation of an existing collective-bargaining agreement. . . ." 29 U.S.C. § 173(d).

58. 29 U.S.C. § 1001(b). The civil enforcement provisions, 29 U.S.C. § 1132, are among the few provisions applicable to all plans subject to ERISA.

applied wholesale to suits for benefits, where ERISA’s express policy of making available judicial resolution of disputes must control.60

The difference between the two bodies of law regarding the preferred means for resolution of disputes itself results from deeper differences between statutory goals. Consider first the LMRA. As the Supreme Court has explained, a collective bargaining agreement is not simply a contract between the employer and the union. Rather, it “is an effort to erect a system of industrial self-government.”61 Accordingly, labor arbitration functions as more than a substitute for litigation. It functions as a “substitute for industrial strife”—in particular, a substitute for the strike—and is itself an essential part of the system of industrial self-government. It is a means for the employer and the union to continue the process, institutionalized by the collective bargaining agreement, of peaceably managing the workplace.64

As the basis for a system of self-government, the collective bargaining agreement and its grievance-and-arbitration procedure “of necessity subordinate[] the interests of an individual employee to the collective interests of all employees in a bargaining unit.”65 The employee rights protected by the federal labor laws are collective, rather than individual, rights. As the Supreme Court explained:

[T]hey are protected not for their own sake but as an instrument of the national labor policy of minimizing industrial strife “by encouraging the practice and procedure of collective bargaining.”

Central to the policy of fostering collective bargaining, where the employees elect that course, is the principle of majority rule. . . . In establishing a regime of majority rule, Congress sought to secure to all members of the unit the benefits of their collective strength and bargaining power, in full awareness that the superior strength of some individuals or groups might be subordinated to the interest of the majority. As a result, “[t]he complete satisfaction of all who are represented is hardly to be expected.”68

62. Id. at 578.
63. See Textile Workers Union v. Lincoln Mills, 353 U.S. 448, 455 (1957) (“[T]he agreement to arbitrate grievance disputes is the quid pro quo for an agreement not to strike.”).
The common law that governs actions under section 301 of the LMRA drastically limits individual access to courts and to judicial relief, and instead maximizes the domain of arbitration. This protects the interests of the employer and the union, both of whom desire an expansive scope for arbitration, but at the expense of the individual worker, who may well prefer that courts be available to vindicate his rights. By permitting the parties to a collective bargaining agreement to limit the role of courts, the LMRA demonstrates a willingness to sacrifice the protection of individual rights for the protection of an asserted common good.

This attitude of labor law toward individual employee rights is inconsistent with the attitude taken by ERISA. ERISA is not concerned with the protection of process; it is concerned with achieving results. Under ERISA, the paramount goal is the protection of employee rights and the fulfillment of employee benefit expectations. There is no overriding collective interest, such as an interest in peaceful industrial relations, to trump the statutory goal of protecting employees. Those who manage and administer the plan must do so “solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries,” and are subject to severe sanctions for acting to promote any other interest.

* * *

Thus one reaches the following conclusions. Suits for benefits are one of three distinct kinds of suits that may be brought in connection with the administration of benefit payments. They are not fiduciary claims and do not enforce fiduciary obligations. They are common law suits, not in the sense that they are gap-filling claims, but in the sense that they are statutorily based claims for which substantive standards must be developed almost entirely by the courts. In developing those standards, courts must be wary of relying on state law and labor law. The first was rejected by Congress as a body of law to govern benefit claims. The latter was not adopted by Congress for benefit suits, and its basic policies are inconsistent with those of ERISA.

68. See id. at 659-70 (Black, J., dissenting).
70. 29 U.S.C. § 1104(a)(1).
III. The Myth of Review

Although the language of section 502(a)(1)(B) seems to describe an enforcement action, courts invariably treat the law of benefit suits under ERISA as an appellate-type law. Section 503(2) of ERISA requires every plan to establish an internal claim-review procedure that complies with regulations issued by the Secretary of Labor and “afford[s] a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.” Most courts treat sections 502(a)(1)(B) and 503(2) as implementing a consolidated, two-level procedure to govern claims for benefits, with a suit for benefits as the second phase. In particular, they require participants and beneficiaries to exhaust available plan procedures before bringing suit under section 502(a)(1)(B), and treat those suits as proceedings for appellate review of the decision made under the plan’s internal procedures. This approach to benefit proceedings has no tenable basis. It is unsupported by the text of the statute, the legislative history or any policy that is consistent with ERISA.

A. Statutory Text

An immediate objection to the appellate interpretation of section 502(a)(1)(B) is the language of ERISA. Sections 502(a)(1)(B) and 503(2) appear to be independent, rather than interdependent, provisions. Section 502(a)(1)(B) makes no reference to section 503(2) or internal plan procedures, and in no way suggests that actions for benefits are actions for review of a claim denial. To the contrary, it characterizes the action as one “to recover benefits due.” Correspondingly, section 503(2) makes no reference to section 502(a)(1)(B) and suggests no connection with actions for benefits. Rather, the provision appears to be self-contained.

There is a further text-based difficulty. The appellate interpretation reads section 503(2) as imposing mandatory, rather than optional, claim-review procedures. Yet there is nothing in the text to suggest such a reading. Section 503(2) only requires that a plan “afford a reasonable opportunity to any participant” to have his initial denial of benefits reviewed by a plan fiduciary. The key word is “opportunity.”

72. Interestingly, § 503(2) requires the plan to afford a reasonable opportunity for review only to participants, and not to beneficiaries, even though both may bring suit for benefits under §
Nothing in section 503(2) adds a requirement that participants and beneficiaries make use of it.

A straightforward reading of section 503(2) would suggest that it was included for the benefit of participants and beneficiaries alone. It requires a plan to offer a claims procedure for those who wish to vindicate their benefit rights without litigation, but it does not make the procedure obligatory.

B. Legislative History

The legislative history provides no support for the appellate model of benefit suits, either. Rather, it strongly suggests that plan claims procedures and suits for benefits were intended to be independent vehicles for the recovery of benefits.

Although the House labor bill contained the provision governing benefit suits that ultimately was enacted as section 502(a)(1)(B), it did not contain a provision requiring plans to have an internal procedure for review of benefit claims. Section 502(a)(1)(B), thus, could not originally have been intended by the House to create an appellate-type proceeding. 73

The Senate labor bill, however, did contain a provision requiring plans to have a claims procedure. In fact, the provision, with only minor differences, is identical to section 503 of ERISA. 74 But its sole stated purpose was to "rectify [the] inequity" to participants of plans not providing a means for challenging the denial of a claim. There was

502(a)(1)(B). If the limitation of § 503(2) to participants were read literally, then §§ 503(2) and 502(a)(1)(B) would have to be treated as independent; for one could not read the simple language of § 502(a)(1)(B) as authorizing two very different kinds of suits: review proceedings in the case of suits by participants, and original actions in the case of suits by beneficiaries.

It is doubtful, however, that the limitation should be read literally. Although all prior versions of § 503(2) contained the same limitation to participants, both the Senate and Conference Committee reports construed it as requiring that beneficiaries, too, be given the opportunity for full and fair review. Thus, the omission of beneficiaries was probably inadvertent. S. Rep. No. 127, supra note 50, at 34-35, reprinted in 1974 U.S.C.C.A.N. at 4870; H.R. Conf. Rep. No. 1280, supra note 51, at 328, reprinted in 1974 U.S.C.C.A.N. at 5108.

73. In fact, the House intended that persons claiming benefits from a plan should have unimpeded access to courts. It is telling that a provision in the bill conferred special status on suits for benefits: "Except as to actions brought pursuant to [the provision for suits relating to benefits] . . ., no action shall be brought except upon leave of the court obtained upon verified application and for good cause shown . . ." H.R. 2, supra note 46, at § 106(f)(2), reprinted in 1 Legislative History, supra note 46, at 35.

74. S. 4, supra note 49, at § 510, reprinted in 1 Legislative History, supra note 46, at 181.
no expression of intent that the provision should benefit sponsors, fiduciaries, or anyone else.\footnote{75}

The bill also contained a provision for suits to recover benefits.\footnote{76} Nothing in the bill or in the committee report accompanying it, however, suggests any intent to link the provision for benefit suits with the requirement that a plan have a claims procedure. Nor is it plausible that the Senate intended there to be such linkage. While participants and beneficiaries of any plan subject to the act could bring suit for benefits under the civil-enforcement provision,\footnote{77} only plans with twenty-five or more participants were required to have procedures for internal claims review.\footnote{78} Furthermore, as noted earlier, until the bill emerged from Conference, state law was to govern benefit claims. Hence, the Senate bill must have intended that states continue to develop rules for benefit claims, which might or might not include exhaustion requirements and related appellate-type rules. Significantly, there was no general state law exhaustion requirement at the time of ERISA's enactment.

The Senate Finance Committee proposed deleting both the requirement that plans have an internal claims procedure and the provision for suits to recover benefits, and substituting a voluntary system

\footnote{75. The Senate Report explained that:}
\footnote{\[T\]he Committee has found that a substantial number of plans fail to provide adequate and fair procedures to participants and beneficiaries when their benefit claims or applications are denied. [The provision] is intended to rectify this inequity by requiring plans to provide adequate notice in writing to participants or beneficiaries whose benefits have been denied, setting forth the specific reasons in terms that can be readily grasped by the participant, and to afford a reasonable opportunity for a full and fair review by the plan administrator of any decision denying benefits.}
\footnote{76.}
\footnote{Suits by a participant or beneficiary entitled, or who may become entitled, to benefits from an employee benefit plan or fund, subject to the [WPPDA], as amended by this Act may be brought in any court of competent jurisdiction . . . against any such plan or fund to recover benefits due him required to be paid from such plan or fund pursuant to the document or documents governing the establishment or operation of the plan or fund, or to clarify his rights to future benefits under the terms of the plan.}
\footnote{S. 4, supra note 49, at § 604, reprinted in 1 LEGISLATIVE HISTORY, supra note 46, at 184.}
\footnote{77. S. 4, supra note 49, at § 503(c), reprinted in 1 LEGISLATIVE HISTORY, supra note 46, at 152-53.}
\footnote{78. S. 4, supra note 49, at § 510, reprinted in 1 LEGISLATIVE HISTORY, supra note 46, at 169, 181 (requirement of claim procedure as amendment to Welfare and Pension Plan Disclosure Act); Welfare and Pension Plan Disclosure Act, Pub. L. No. 85-836, § 4(b)(4), 72 Stat. 998 (1958) (repealed by ERISA) (coverage limited to plans with 25 or more participants).}
for arbitration of benefit disputes by the Secretary of Labor.79 Again, the express intent was to benefit participants and beneficiaries. The accompanying committee report explained that:

The committee believes that all workers and plan beneficiaries should have the opportunity to resolve any controversy over their retirement benefits . . . in an inexpensive and expeditious manner. Hardships have been encountered in the past by workers who are unable to plan for their retirement because of the uncertainty of their benefits and by beneficiaries who have lost benefits to which they were entitled. Accordingly, the committee has decided to provide that controversies as to retirement benefits are to be heard by the Department of Labor.80

The Senate bill as approved did not contain the provision for voluntary arbitration. It contained instead a new requirement that plans have an arbitration procedure for resolution of all disputes (including disputes concerning fiduciary and other statutory obligations),81 and a provision for suits to recover benefits, governed by state law, substantially the same as the one in the original labor bill.82 These methods of recovering benefits were clearly intended to be alternatives available to the participants and beneficiaries.

The Conference Committee eliminated the Senate’s comprehensive arbitration provision. The final bill contained only: (a) the provision

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79. The Committee’s proposal stated:

(a) IN GENERAL—The Secretary of Labor is authorized to hear and decide disputes arising under qualified plans . . . between participants or their beneficiaries in such plans and administrators of such plans with respect to the present or future benefits of such participants or their beneficiaries, upon application made by any such participant or beneficiary.

* * * * *

(d) APPEAL—Any decision made by the Secretary under this section may be appealed to any district court of the United States within the jurisdiction of which the proceeding was held. The provisions of chapter 7 of title 5, United States Code, shall apply to any such appeal, and on appeal the facts upon which the award is based are subject to trial de novo by the reviewing court.

S. 1179, 93d Cong., 1st Sess. § 602 (1973), reprinted in 1 LEGISLATIVE HISTORY, supra note 46, at 988-90.

80. S. Rep. No. 383, 93d Cong., 1st Sess. 117 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 5000. The bill, though, contemplated that other avenues for benefit recovery might be available, even if not required to be provided: “The procedures provided by this section of the bill are provided as alternatives to existing procedures that may be available to plan participants and beneficiaries. . . .” Id. Presumably, these alternatives included state law causes of action and voluntarily established plan claim procedures.

81. See S. 4, supra note 49, at § 691, reprinted in 1 LEGISLATIVE HISTORY, supra note 46, at 1488-89.

82. H.R. 2, supra, §§ 691, 694, reprinted in 3 LEGISLATIVE HISTORY, supra note 46, at 3813-17.
requiring a plan claims procedure, which had been contained in the original Senate labor bill; and (b) the provision for suits for benefits, which had been contained in the House bill. No necessary connection was seen between the requirement of a plan claims procedure and the provision governing benefit suits. The claims procedure was understood as something for the benefit of a participant or beneficiary, of which he might avail himself before, or in lieu of, bringing suit. For example, as Senator Williams explained:

It should be noted that prior to bringing an action to recover benefits from the plan, the participant or beneficiary would have the right to receive written notice from the plan of the special reasons his claim for benefits was denied; and, in addition, would be entitled to a full and fair review by the plan administrator of the decision to deny such benefits.83

Thus, the legislative history provides no support for the view that a suit for benefits was intended to be the second, appellate stage of a process beginning with the plan claims procedures.

C. Judicial Rationales

Congress granted courts broad discretion to develop the law of benefit claims. Courts, however, have offered no tenable reasons, consistent with ERISA, for requiring participants and beneficiaries to exhaust their plan remedies before bringing suit, and for treating benefit suits as a form of review.

1. Explicit Rationales

Amato v. Bernard84 is one of the cases that originated the exhaustion requirement for benefit suits under ERISA.85 Examination of that opinion discloses the unsoundness of the judicial rationales for linking claim procedures and benefit suits.

83. 120 Cong. Rec. 29,933 (1974), reprinted in 3 LEGISLATIVE HISTORY, supra note 46, at 4745. See also id. at 29,935, reprinted in 3 LEGISLATIVE HISTORY at 4753, Senator Javits stating: Every employee is entitled to notice in writing if his claim for benefits has been denied, with the specific reasons for the denial set forth in understandable language. In addition, every employee is entitled to a full and fair review by the plan administrator of any benefit denied and has the right to bring an action in a Federal court, regardless of the amount in controversy, to recover benefits wrongfully denied.
84. 618 F.2d 559 (9th Cir. 1980).
In *Amato*, the court began with a presumption:

The usual rule in the field of labor law is that where administrative procedures have been instituted for the resolution of disputes between parties to a collectively bargained or other agreement, the courts will generally require the exhaustion of those procedures before exercising the jurisdiction they might otherwise have over disputes subject to resolution through said procedures.86

The court offered no justification for extending this presumption to benefit claims under ERISA. In fact, none is available.

First, there is no "usual rule" as sweeping as the court suggests. Labor law itself recognizes that the presumption in favor of arbitration is not universal and that its scope must be determined by the role of labor arbitration as a substitute for industrial strife.87 Labor law's preference for arbitration does not extend to disputes involving statutory and other rights defined outside the collective bargaining agreement because these rights are not matters of industrial self-governance.88

Moreover, as explained earlier, ERISA and the LMRA differ radically in their attitudes toward judicial resolution of disputes. The LMRA promotes, as fundamental policy, non-judicial resolution of disputes through grievance and arbitration. ERISA promotes, as fundamental purpose, the availability of a judicial forum to resolve plan-related claims. Congress intended "to remove jurisdictional and procedural obstacles which in the past appear to have hampered . . . recover[y] of benefits due to participants."89 The "usual rule," whatever its scope, is inconsistent with ERISA and cannot legitimate any judicially created "strong federal policy . . . encouraging private resolution of ERISA-related disputes."90

Courts have lately begun to appreciate that the presumption in favor of exhaustion is not applicable to claims under ERISA. Recognition began with *Schneider Moving & Storage Co. v. Robbins*.91 The Supreme Court unanimously held in that case that trustees of a multi-employer plan could bring suit against participating employers to enforce plan provisions relating to contributions, without first exhausting arbitration procedures established by the collective bargaining agree-

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86. 618 F.2d at 566.
ment. The issue was whether the bargaining agreement should be construed under a presumption in favor of arbitration of the trustee-employer dispute. The Court held that it should not, explaining that:

Such a presumption [in favor of arbitrability] furthers the national labor policy of peaceful resolution of labor disputes and thus best accords with the parties' presumed objectives in pursuing collective bargaining. There is, however, less to commend the presumption in construing the applicability of arbitration clauses to disputes between the employer and the trustees of employee-benefit funds.

Arbitration promotes labor peace because it requires the parties to forgo the economic weapons of strikes and lockouts. Because the trustees of employee-benefit funds have no recourse to either of those weapons, requiring them to arbitrate disputes with the employer would promote labor peace only indirectly, if at all. We conclude, therefore, that the presumption of arbitrability is not a proper rule of construction in determining whether arbitration agreements between the union and the employer apply to disputes between trustees and employers . . . .92

In a subsequent case, the Court of Appeals for the Seventh Circuit recognized a further reason for not extending the presumption in favor of arbitrability to disputes between multi-employer plan trustees and participating employers: "Congress has affirmatively opened the federal courts to trust funds so that they might enforce an employer's obligations."93

The reasoning of Schneider Moving was extended to benefit disputes in Anderson v. Alpha Portland Industries, Inc.94 In Anderson, retirees whose health insurance benefits had been terminated brought suit against the employer challenging the termination. The employer argued that the retirees first had to exhaust the claims procedures in the plan (which were, in fact, the grievance and arbitration procedures of the collective bargaining agreement). The court disagreed, holding that the presumption in favor of arbitration was inapplicable. The court emphasized that unions do not serve as exclusive bargaining representatives for retirees and that retiree health benefits are not mandatory subjects for collective bargaining.

[This fact] [e]liminates concerns with inhibition of negotiations and with economic warfare. Retirees have no recourse to economic weapons other than a hope that active employees will strike in their behalf, a hope that was also available to

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92. Id. at 371-72 (citations and footnotes omitted). The trustees had brought suit under both ERISA § 502 and LMRA § 301. The Court's reasoning did not distinguish the statutory bases for suit.
94. 752 F.2d 1293 (8th Cir.) (en banc), cert. denied, 471 U.S. 1102 (1985).
the trustees in *Schneider*. . . . We must conclude that retirees are more similarly situated with trustees than with active employees and are equally “outside the collective bargaining relationship.” A presumption in favor of arbitrability again would further the “national labor policy of peaceful resolution of labor disputes * only indirectly, if at all.”

In a footnote, the court suggested that the rationale of *Schneider Moving* might cast doubt on the holding of *Amato*.\(^9\)

The court in *Amato* also suggested that an exhaustion requirement had been implicitly included in ERISA. The court noted the Conference Committee’s reference to section 301 of the LMRA, reasoning that Congress wished courts to apply the labor law exhaustion requirement to suits for benefits under ERISA.\(^9\) This reasoning is incorrect; courts have had little difficulty seeing through it when presented with arguments for importing into ERISA other rules developed under section 301. For example, they have rejected the argument that the reference to section 301 means there should be a right to jury trial (which is available in many actions under section 301) in actions under ERISA section 502(a)(1)(B) of ERISA.\(^9\) As one court stated:

> The quoted statement merely indicates Congress’ intent that federal courts should create federal common law in civil actions under § 502(a)(1)(B) of ERISA, just as the Supreme Court in *Textile Workers Union v. Lincoln Mills* ruled that the courts could establish federal common law for claims “arising under” § 301 of the Labor-Management Relations Act. The Committee states that § 502(a)(1)(B) claims are to be regarded “in similar fashion” to § 301 actions, not that the identical rules of federal common law are necessarily to apply in both statutory claims.\(^9\)

The court in *Amato* also drew conclusions from the text of the statute. It noted that Congress had required every plan to have a claims procedure, and concluded that:

\(^9\) *Id.* at 1298 (quoting *Schneider Moving*, 466 U.S. at 371-72) (footnote omitted).
\(^9\) *Id.* at 1298 n.9.

\(^9\) The court in *Amato* never explained why Congress should have been so cryptic if what it truly wanted was application of an exhaustion requirement to benefit claims.


\(^9\) *Wardle*, 627 F.2d at 829 (citations omitted).
[T]he institution of such administrative claim-resolution procedures was apparently intended by Congress to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned. It would certainly be anomalous if the same good reasons that presumably led Congress and the Secretary to require covered plans to provide administrative remedies for aggrieved claimants did not lead the courts to see that those remedies are regularly used.100

The key term in this paragraph is the weasel word “apparently”: it betrays the description of congressional intent to be sheer speculation. Nothing in the legislative history shows that section 503 was intended to help reduce “frivolous lawsuits.”101 Nothing in the legislative history shows that section 503 was intended to promote “consistent treatment” of claims for benefits. Nothing in the legislative history shows that section 503 was intended to minimize the costs to anyone but participants and beneficiaries. Nothing in the legislative history shows that the requirement of a plan claims procedure was meant to serve any purpose other than to afford participants and beneficiaries an alternative to litigation for vindication of their claims. The court in Amato was asserting, without a shred of evidence, that the requirements imposed by ERISA section 503(2) protecting participants and beneficiaries were also intended to benefit employers. The court’s hypothetical reasons, most of which deal with the advantages of claims procedures to employers, may be good reasons in the abstract, but they are not Congress’ reasons and are based on an erroneous view of this participant-protective requirement.

The court also offered practical arguments, but they fail as well. It argued that “implementation of the exhaustion requirement will enhance [fiduciaries’] ability to expertly and efficiently manage their

100. Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980). In Taylor v. Bakery & Confectionery Union & Indus. Int'l Welfare Fund, 455 F. Supp. 816 (E.D.N.C. 1978), on whose analysis Amato relies, the court concluded, ipse dixit, that, “[m]uch like the labor grievance system, this claim/appeals mechanism is designed to reduce frivolous claims, promote the consistent treatment of claims, and create a non-adversarial method of claims settlement.” Taylor, 455 F. Supp. at 820.

101. To the contrary, Congress was concerned that plan claim procedures might promote frivolous claims. In the final debate on the bill, Senator Javits explained that:

The Senate bill provided that each plan was to incorporate a procedure for arbitration of benefit claim disputes between the plan and participants and beneficiaries. The House bill contained no comparable provision on grounds that it might be too costly to plans and a stimulant to frivolous benefit disputes, and at their insistence if was dropped in conference. 120 Cong. Rec. 29,941 (Aug. 22, 1974), reprinted in 3 LEGISLATIVE HISTORY, supra note 46, at 4769.
funds by preventing premature judicial intervention in their decision-making process.” The argument is fallacious and demonstrates a lack of understanding of ERISA. The argument presumes that the ability of fiduciaries to make decisions “expertly and efficiently” is something to be promoted independently of the impact of the decisions on participants and beneficiaries. Implicit here is a view that fiduciary decision-making has such an important institutional role that fiduciaries must be allowed to practice it free of judicial intervention. The result of non-intervention may be wrongful denial of benefits in some cases, but that is the necessary price to be paid for protecting the ability of fiduciaries to make decisions.

While an argument of this kind makes sense in the collective bargaining context, where arbitration unquestionably serves purposes other than the vindication of individual rights, it makes no sense as applied to benefit plans. The central purpose of ERISA is to protect the interest of participants and beneficiaries in receiving their benefits. The reason ERISA demands a claims procedure is the same as the reason it facilitates access to the courts: to increase the likelihood that participants and beneficiaries receive the benefits due them. The plan claims procedure functions to help vindicate participant benefit rights. There is no value to fiduciary proficiency except as a means to facilitate the vindication of those rights.

Finally, the court reasoned that “fully considered actions by pension fund trustees interpreting their plans and perhaps also refining and defining the problem in given cases, may well assist the courts when they are called upon to resolve the controversies.” While this is true, the argument proves too much, because it is true with respect to any kind of controversy. A court may better be able to resolve any controversy if a procedure is available to help resolve it before suit. But that fact has not led courts to impose a general requirement that every negligence plaintiff, for instance, pursue an informal dispute resolution procedure before filing suit. Courts have not done so because there are additional factors to consider, such as whether the procedure is worth the added cost and whether requiring a plaintiff to use it would interfere with some important right or interest. The court’s argument in Amato ignored those additional, and often countervailing, considera-

102. See supra part II(C)(2). See also, e.g., United Steelworkers of America v. American Mfg. Co., 363 U.S. 564, 568 (1960) (“[t]he processing of even frivolous claims may have therapeutic values of which those who are not part of the plan environment may be quite unaware”).

103. Amato, 618 F.2d at 568.
tions. Perhaps an argument for exhaustion could be made as to some kinds of plans or some kinds of claims; but the argument would have to be spelled out and the plans and claims in question identified.

Thus, the reasons advanced in the Amato opinion fail to justify an appellate approach to benefit suits. No court has articulated any other reason for it. Most have been content to rely on the analysis contained in Amato and in cases that offer similar arguments. The exhaustion requirement and the treatment of benefits suits as appeals from plan benefit decisions are both unwarranted.

2. Implicit Rationales

Before leaving the topic of the appellate interpretation of section 502(a)(1)(B), it is worth examining some additional, unexpressed reasons, why courts may have adopted it. The inquiry will show further what is wrong with the interpretation, why it is not consistent with the purposes of ERISA, and what a proper approach to benefit suits must take into account.

Courts reflexively think of claims for benefits as contract claims. Because contract disputes are primarily state-law disputes, courts also tend to think of benefit claims as lacking in any true federal interest; claims that happen to be in federal court merely because jurisdiction is granted by section 502. Courts, thus, tend to treat benefit suits in the very way that Congress determined they should not: as state law claims in federal court.

This way of viewing benefit claims generates two significant errors. One is the courts' refusal to acknowledge their own essential role in developing the law. A plan does not confer rights to benefits on employees of its own force. It does so only to the extent that its terms are enforceable under some system of law. ERISA's preemption clause sweeps away state laws, leaving federal law as the only basis for benefit

104. E.g., Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 138 (1985) (referring to recovery by participants of "extracontractual damages" in addition to benefits); Delaney v. Union Carbide Corp., 749 F.2d 17, 19 (8th Cir. 1984) ("[T]he right that plaintiff seeks to enforce are wholly created by contract, the very contract that also contains the arbitration clause plaintiff seeks to avoid.").

105. See, e.g., Brundage-Peterson v. Compass Health Servs. Ins. Corp., 877 F.2d 509, 512 (7th Cir. 1989) (involving suit for benefits by participant in health plan against insurer where the court found "it difficult to understand why such cases should be litigated in federal court . . . .").

106. See, e.g., McLendon v. Continental Group, Inc., 602 F. Supp. 1492, 1503 (D.N.J. 1985) (referring to benefit suits as "the enforcement of contractual rights, for which ERISA merely provides a federal forum").
rights with respect to a benefit plan. Thus, it is nonsense for courts to say that:

When an employee brings a suit under ERISA with respect to § 1132(a)(1)(B), he is seeking to remedy alleged violations of rights accorded him under the terms of a benefit plan. Congress did not accord him any right to receive retirement of disability benefits, but simply allowed him to bring a civil action to enforce already existing contractual rights . . . .

Benefit rights do not exist independently of federal law.

Even more important, because of the silence of ERISA, the substance of the right to benefits is a matter of federal common law. Courts that believe benefit rights are "preexisting," and believe they have nothing to contribute to the substantive law of benefit obligations and claims, miss the true meaning of the Conference Report's reference to LMRA section 301. Federal courts have everything to contribute to the definition and enforcement of benefit rights because the law of benefit obligations and claims is what these courts say it is. To treat benefit suits as if they were merely an occasion for review of decisions made by some other primary decisionmaker is to abdicate the congressionally allocated responsibility to develop this area of law.

A second, related, error is for courts to think of benefit claims as much less important than fiduciary and other statutory claims. There is no evidence that Congress ever took such an attitude, and, in any event, it is profoundly wrong. The courts err in failing to appreciate that a suit for benefits is the bottom-line suit under ERISA. The prophylactic standards for vesting, accrual and funding are imposed for the sole purpose of helping to ensure that benefits are available to be paid when expected and due. The remedial provisions, allowing suits to rectify


108. This is especially so when the appellate interpretation of § 502(a)(1)(B) is coupled with a rule giving deference to the plan decisionmaker's denial of the claim.

A telling exception to this widespread abdication of judicial responsibility is the matter of severance benefits in cases of sale of the assets of a corporation or one of its divisions. The affected employees generally continue to work without interruption, but for a new employer. Until recently, few severance plans contemplated this kind of termination of employment. Because severance plans are often quite informal, and lack both claims procedures and provisions for judicial deference to fiduciary decisionmaking, courts have been forced to develop substantive rules to help decide the cases. See, e.g., Reichelt v. Emhart Corp., 921 F.2d 425 (2d Cir. 1990), cert. denied, 111 S. Ct. 2854 (1991); Frank v. Colt Indus., Inc., 910 F.2d 90 (3d Cir. 1990); Wildbur v. Atlantic Richfield Retirement Plan, 765 F. Supp. 891 (W.D. La. 1991); Maryonovich v. Market Data Retrieval Inc., 716 F. Supp. 343 (N.D. Ill. 1989); Bennett v. Gill & Duffus Chems., Inc., 699 F. Supp. 454 (S.D.N.Y. 1988).
breaches of fiduciary duty and other violations of ERISA, are also included for the purpose of helping to ensure that benefits are available to be paid when expected to be paid. Suits to remedy fiduciary and statutory violations of ERISA could be deemed more important than suits for benefits only if they protected something other than the participants' and beneficiaries' interest in benefits. But they do not. Under ERISA, there is nothing else to protect.

If any hierarchy of suits under ERISA is to be made, the proper one arguably would place benefit claims first. To develop the law of benefit suits properly, courts must take them seriously and appreciate that they are the suits by which ERISA's purpose is most directly realized.

IV. THE MYTH OF DEFERENCE

Another judicial interpretation of section 502(a)(1)(B) also involves treating a suit for benefits as a kind of review proceeding, but disregards the possible interaction with section 503. The focus of this interpretation is not on plan procedures but on the fiduciary status of the plan decisionmaker. Its significance lies not in what it demands the claimant to do (i.e. exhaust plan remedies) but in what it demands courts to do: limit the scope of proceedings and defer to the decisionmaker's denial of the claim. The prevailing rule under this interpretation is that an employer may draft a plan document so as to immunize the fiduciary's benefit decisions from reversal by courts, except where a decision constitutes an abuse of discretion.109

On its face, this rule seems inconsistent with ERISA's purpose. The obvious objection is that it allows an employer to structure a plan so as to facilitate the defeat of benefit expectations.110 Even more ob-

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110. Cf. Northeast Dep't ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund, 764 F.2d 147 (3d Cir. 1985) (relying on just this objection to invalidate a provision in a health plan that denied benefits where the participant's spouse was covered by a comparable plan). The court explained that:

[T]he incorporation of escape clauses in benefit plans reflects . . . impermissible conduct. A major impetus for Congress' enactment of ERISA was the alarming frequency with which employers who had been promised welfare or retirement benefits by employers were deprived of anticipated benefits because of the inequitable character or financial instability of their benefit plan. . . .

Thus, one very important policy underlying ERISA is that employees enrolled in a benefit plan should not be deprived of compensation that they reasonably anticipate under the plan's purported coverage. Escape clauses, however, risk just such a result.

764 F.2d at 163 (footnote omitted).
jectionable is the fact that the employer, or a person with an economic incentive to deny claims, may be the very person who has the immunized discretion.\textsuperscript{111}

The inconsistency of this sweeping judicial deference with the basic purpose of ERISA has been criticized before.\textsuperscript{112} Yet despite the criticism, courts seem institutionally incapable of making any profound change. It is true that the rule of immunized decisionmaking may be in the process of being slowly whittled down. For example, until the Supreme Court held otherwise in Firestone Tire & Rubber Co. v. Bruch,\textsuperscript{113} courts had presumed that they should defer to fiduciary decisionmaking about benefit entitlements in nearly all cases, without reference to the language of the plan document.\textsuperscript{114} Since the decision in Bruch, courts have increasingly found that a conflict of interest on the part of the decisionmaker should reduce the extent of deference in a given case.\textsuperscript{115} Throughout these developments, however, courts still presume that deference to fiduciary decisionmaking is appropriate and often desirable. That presumption has no tenable foundation.

\textbf{A. The History of the Deferential Standard of Review}

Any standard of review has two aspects. It may be viewed "as an enabler and legitimator of review or as a limit on the reviewer."\textsuperscript{116} Most courts and commentators suppose that the aspect of deferential review requiring justification is its limitation on judicial oversight of plan administrative affairs. Although this is true today, it was not always, because deferential review did not originate as a \textit{limitation} on the judicial role. To the contrary, it emerged as a means for courts to


\textsuperscript{113} 489 U.S. 101 (1989).

\textsuperscript{114} For extended analyses of pre-\textit{Bruch} approaches to suits for benefits, see Bruce, supra note 112, at ch. 7; Flint, supra note 112, at 139-57.


\textsuperscript{116} 1 \textsc{Steven A. Childress} & \textsc{Martha S. Davis}, \textit{Standards of Review} § 1.1, at 4 (1986).
protect participants within a legal framework that otherwise provided virtually no protection. Only when deferential review was uncritically imported into new, more participant-protective, legal frameworks, did it take on an expectation-defeating character that had to be defended.

It is well-known that ERISA’s deferential approach to review can be traced back to the approach developed for review of benefit decisions by Taft-Hartley plan trustees.117 The approach actually can be traced back much further, to the very first pension claim cases. These early cases arose within a radically different legal framework and were concerned, not with trusts and trustee discretion, but with pensions viewed as gratuities and plans viewed as employer property.

1. Legal And Conceptual Background

To understand how deferential review originally was employee-protective, one must understand the legal framework in which it arose. That framework has been described at length elsewhere.118 For present purposes, an overview will suffice.

Before ERISA, pension plan law existed mainly as state common law. What made pension plan law from the outset a distinct body of law is the dual character of pension plans. From the employer’s perspective, plans are programs established to serve business needs. For example, the prospect of a pension from the plan could be used to attract employees, reduce turnover, prevent unionization, and induce other desirable features in the workforce. From the employee’s perspective, however, the plan is a source of representations and a systematic


A student Note concluded, on the basis of an inaccurate reading of the labor cases, that the deferential standard for Taft-Hartley plans arose as a means by which federal courts could assert jurisdiction over suits challenging benefit denials. McCreary, supra at 1037-40. The Taft-Hartley cases that originated the approach for such plans, see infra part IV(A)(3), however, did not concern themselves with jurisdictional issues, and predated by many years the case, Insley v. Joyce, 330 F. Supp. 1228 (N.D. Ill. 1971), the case that first sought to link federal court jurisdiction over claims with a deferential review approach to them. Regrettably, the erroneous analysis of that Note has been relied on by others. See Bruch, 489 U.S. at 109-110; Bradley R. Duncis, Note, Judicial Review of Fiduciary Claim Denials: An Alternative to the Arbitrary and Capricious Standard, 71 cornell L. Rev. 986, 992-94 (1986).

118. For an extended examination of the matters treated in this section, see Conison, Foundations, supra note 2, at 575-618. Citations to primary sources may be found there.
creator of expectations. In particular, it is a source of expectations about benefits that induce reliance over a long term.

This dual character of plans supports competing interests: the employer's interest in using a plan for its own business ends and the employees' interest in having that expectation of benefits fulfilled. These competing interests will not necessarily be reconciled satisfactorily in the course of the parties' unconstrained dealings, for while the employer has the incentive to create the expectation of a pension, it does not necessarily have the incentive to fulfill it. Moreover, there is little, if anything, that individual employees can do to cause employers to confer the expected pensions. Plans, thus, tend to present a substantial danger of defeating the expectations they systematically create. The central problem of pension plan law was to develop a satisfactory accommodation of the employer's interest in using the plan as an industrial relations tool and the employees' interest in receiving the benefits they had come to expect.

Pre-ERISA pension plan law never succeeded in accomplishing this goal. It invariably gave employer interests substantial weight and employee interests very little. Many courts went so far as to treat a plan as employer property with which the employer could do as it pleased. Some courts that adopted this proprietary framework purported to treat pensions as gifts from the employer. Other courts characterized pensions as the subject matter of "peculiar" contracts, the terms of which were determined unilaterally by the employer. Either way, employee interests were given almost no recognition or protection.

Most courts did not adopt the extreme position of treating plans as employer property. Instead, they recognized that employees had expectations of receiving benefits from a plan, and agreed that the expectations were entitled to some protection and enforcement. These courts, however, generally assumed that classical contract law sufficed as the legal framework for enforcement of the employees' expectations.

Exclusive reliance on classical contract law, though, undermined the courts' ability to enforce employee expectations. In applying that law, courts would unhesitatingly enforce the terms of the written plan, as if they were terms of a negotiated deal. But the plan documents were not even remotely similar to bilateral contracts that consensually adjusted parties' rights. The documents were drafted unilaterally by the employer, without any involvement of the employees, and were replete with provisions limiting the employees' rights. What the courts were enforcing, then, was substantially limited to whatever the em-
ployer was willing to let be enforced. While this approach recognized that employees had protectible rights, in practice it did not protect them.

2. Benefit Suits Under State Common Law

From the beginning of their use of formal pension plans, employers routinely inserted a clause purporting to make benefit determinations of the plan’s administrators final and, sometimes, unreviewable by courts. Provisions making benefit determinations unreviewable usually were found invalid.119 Provisions making determinations final, however, were upheld. Yet they were construed in a way different from what the employers had intended. In McNevin v. Solvay Process Co.,120 the first reported pension claim case, the plan document specified that the plan trustees had the final authority to decide all questions concerning the rights of employees. The court did not question the provision because it viewed the plan as property of the employer:

It must be conceded at the outset that a person or corporation proposing to give a sum for the benefit of any person or any set of persons has the right to fix the terms of his bounty, and provide under what circumstances the gift shall become vested and absolute.121

The court thus refused to overturn the decision denying a claimed benefit. In significant dictum, however, it suggested that the trustees’ actions might be reviewed under the court’s equitable power to remedy bad faith and restrain mismanagement.

Through this dictum, the court created a narrow exception to its overwhelmingly employer-solicitous approach to plans. Some judicial review would be available to protect participants. Its scope, however, was not defined and no rationale was given for it. This may be because no rationale was possible within the court’s conceptual framework. A sense of fairness was the unstated justification for the exception and the sole determinant of its scope. Limited review, thus, was adopted initially as no more than an ad hoc, employee-protective exception to the proprietary view of plans.

119. "Where . . . contractual rights are involved one party may not arbitrarily deny the rights of the other and thereafter be subject to no judicial sanctions." Siegel v. First Pa. Banking & Trust Co., 201 F. Supp. 664, 669 (E.D. Pa., 1961).
121. McNevin, 53 N.Y.S. at 99.
Although \textit{McNevin} dealt with the conduct of “trustees,”\textsuperscript{122} the rule that courts could engage in limited review of claim denials was not treated as a trust-law rule. Subsequent cases were indifferent as to whether there was a trust.\textsuperscript{128} The applicability of the rule was contingent only on a plan provision making benefit determinations final, where even limited review could mitigate the finality provision’s potentially harsh effects. By contrast, in the rare cases where the plan document contained no such finality provision,\textsuperscript{124} or where it could be disregarded,\textsuperscript{125} there was no need for this limited protection. Courts in such cases determined benefit entitlements without any deference to the plan administrator’s decision.\textsuperscript{128}

In theory, courts that treated plans as sources of enforceable employee expectations should have rejected the limited-review approach to benefit claims. The recognition of employee interests ought to have induced development of a principled approach to protection of employee expectations in which the meager,\textsuperscript{127} \textit{ad hoc} protection afforded by lim-

\textsuperscript{122} It does not appear that there was a genuine trust involved, because the plan document repeatedly stated that the funds accumulated belonged to the employer. \textit{See McNevin}, 53 N.Y.S. at 99.

\textsuperscript{123} One of the next important cases after \textit{McNevin} was Clark v. New England Tel. & Tel. Co., 118 N.E. 348 (Mass. 1918). There, on the basis of the fact that “this was a fund supplied and kept up entirely by the defendant and administered at its own expense,” the court held that the employer could structure the plan as it wished, and limit its obligations as it pleased. \textit{Clark}, 118 N.E. at 350. “So far as that plan is executed in good faith, no sound reason appears why its terms should not govern the rights of the parties.” \textit{Id.} There was no trust involved, and the court, in fact, labelled the plan a contract “of a peculiar nature.” \textit{Id.}


\textsuperscript{125} \textit{See} McLemore v. W. Union Tel. Co., 171 P. 390 (Or. 1918); Schofield v. Zion’s Co-op. Mercantile Inst., 39 P.2d 342 (Utah 1934). In some later cases, where the plan administrator had decided that the plaintiff forfeited his right to benefits, the court disregarded or substantially narrowed the scope of the provision that made the determination final. \textit{See}, e.g., Levitt v. Billy Penn Corp., 283 A.2d 873 (Pa. Super. Ct. 1971).

\textsuperscript{126} Later cases even accepted the principle that the terms of a contract should be construed against the employer who had drafted it; and even that they should be construed liberally in favor of the employee. \textit{See}, e.g., Frieztsche v. First W. Bank & Trust Co., 336 P.2d 589, 590 (Cal. Dist. Ct. App. 1959); Conner v. Phoenix Steel Corp., 249 A.2d 866, 868 (Del. 1969); Anger v. Bender, 335 N.E.2d 122, 125 (Ill. App. Ct. 1975); Brulotte v. Cormier Hosiery Mills, Inc., 387 A.2d 1162, 1163 (N.H. 1978); Russell v. Princeton Lab., Inc., 231 A.2d 800, 803 (N.J. 1967).

\textsuperscript{127} Although the limited-review approach to benefit suits was adopted to mitigate some of the consequences of the employer-property perspective, in practice it gave no real protection to employees. In almost every case in which the courts engaged in such review, the decision went against the employee. \textit{See} Menke v. Thompson, 140 F.2d 786 (8th Cir. 1944); \textit{In re} Missouri Pac. R.R. Co., 49 F. Supp. 405 (E.D. Mo. 1943); Western Union Tel. Co. v. Butler, 225 S.W.2d 649
ited review would be superfluous. This did not happen. Mesmerized by contract law, courts “protected” employee interests by mechanically enforcing the plan’s provisions, including provisions granting final and authoritative decisionmaking authority to the plan administrators. Because enforcement of these, and other, plan terms often worked to defeat employee expectations, there remained a need for the protection, however paltry, that the limited-review approach could provide.

Courts rarely were concerned with the justification for this widely-accepted approach. They did not have to be. Because the law overwhelmingly favored the employer, the very existence of employee rights was commonly the dispositive issue in a case.128 When the less fundamental issue of scope of review was reached, employees assumed that they could obtain no protection from the courts beyond what the limited-review approach provided. No reported pre-LMRA case reveals an argument by an employee for a more expansive scope to the action. Employers, while perhaps preferring no review at all, could not complain about the results, which were almost always in their favor. Hence, the parties never demanded that courts justify their assumption that the appropriate relief for employees, who had enforceable rights under the plan and whose claims for benefits had been denied, was review to see whether there had been abuse or bad faith.129 Employers almost

128. See Comment, Consideration for the Employer’s Promise of a Voluntary Pension Plan, 23 U. CHI. L. REV. 96, 96-97 (1955) (“The courts have had some analytical difficulty with voluntary plans. The central issue is whether or not consideration can be found for the employer’s promise of a pension plan, and if it can, whether the consideration is in the continuity of employment or in the employee’s daily work.”).


None of the books or law review articles that dealt with plans treated the scope of the action for benefits as an issue of substantial concern. See, e.g., EDWIN W. PATTERSON, LEGAL PROTEC-
never found it necessary to urge that standard as a way to prevent courts from providing more protection to employee benefit expectations.\textsuperscript{130}

This was the pre-ERISA state law that Congress decided to replace with federal common law. It is clear why importing it into ERISA would have made no sense. Because of ERISA’s extraordinary level of protection for employee expectations, the rule of limited review, in its function as an employee-protective device, would be superfluous. Yet if the rule were to be treated instead as a limitation on otherwise available protection, it would undermine ERISA’s main purpose. Either way, the rule would be inappropriate.

3. Benefit Suits and the LMRA Cases

The Labor-Management Relations Act of 1947 authorized so-called Taft-Hartley plans: collectively-bargained plans covering employees of one or more employer, which are administered jointly by union and employer representatives.\textsuperscript{131} Thereafter, suits challenging denials of benefits from the United Mineworkers of America Welfare and Retirement Fund (“the Fund”) gave the District of Columbia federal courts opportunities to consider how suits for benefits from such plans

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\textsuperscript{131} The controlling statute for such plans is § 302(c)(5) of the Labor-Management Relations Act, 29 U.S.C. § 186(c)(5), which authorizes employer contributions to:

A trust fund established by a representative [of its employees], for the sole and exclusive benefit of the employees of such employer, and their families and dependents . . . : Provided, That (A) such payments are held in trust for the purpose of paying, either from principal or income or both, for the benefit of employees, their families and dependents, for medical or hospital care, pensions on retirement or death of employees, compensation for injuries or illness resulting from occupational activity or insurance to provide any of the foregoing, or unemployment benefits or life insurance, disability and sickness insurance, or accident insurance; (B) the detailed basis on which such payments are to be made is specified in a written agreement with the employer, and employees and employers are equally represented in the administration of such fund, together with such neutral persons as the representatives of the employers and the representatives of the employees may agree upon . . . ; and (C) such payments as are intended to be used for the purpose of providing pensions or annuities for employees are made to a separate trust which provides that the funds held therein cannot be used for any purpose other than paying such pensions or annuities.

\end{quote}
should be treated. These courts initially adopted the common law approach described above, but modified it in subtle and important ways.

In the first such case, Hobbs v. Lewis, the plaintiff brought suit after the Fund trustees had decided he was not eligible for retirement benefits. After an evidentiary hearing, the court concluded that the plaintiff had "established by a preponderance of the evidence his eligibility for a pension." Accordingly, the court awarded the plaintiff his benefits.

Because the action proceeded as an original determination of entitlement to benefits, the plaintiff did not have to rely on the meager protection afforded by the common-law, limited-review approach. The court, nonetheless, was called on to address its propriety because the trustees, in their closing argument, had argued that the common-law rule largely immunized their benefit decisions from judicial examination. What is significant here is that it was the trustees who were arguing for the limited-review approach. In effect, they sought to transform the common-law rule from one that protected employees into one that limited judicial protection.

One of the trustees' arguments was that the limited-review approach was compelled by the plan document: that the plan's terms deprived the participants of any right of judicial review, save in cases of "arbitrary or unreasonable acts." The court rejected the argument, but only on the facts of the case. In dictum, it accepted the principle urged by the trustees, that otherwise unfettered judicial power to resolve disputes over benefit entitlement could be limited by a plan document. But it found the plan document in question to impose no such limitation. As the court concluded:

I do not believe [the plan] comprehends the deprivation of applicant's right of recourse to the Courts when he disagrees with the determination of the Trustees

133. Id. at 285-86.
134. "Whether [plaintiff] has met the eligibility requirements of the trust . . . depends upon the totality of the evidence." Id. at 284.
135. The argument seems to have been an afterthought. The court noted that the trustees had not contended for such a limitation on review in their answer and the trial was a plenary proceeding. Id. at 286.
136. The trustees also urged the court to view pensions as gratuities, on the basis of a proprietary perspective on plans. They argued that "the Fund is a charitable trust and that the court cannot interfere in its decisions unless the Trustees acts arbitrarily or unreasonably." Id. The court rejected the argument. In its view, pensions were "deferred, contingent compensation" to which employees had a judicially enforceable "contractual right." Id.
137. Id.
on this point, regardless of whether they acted arbitrarily or unreasonably. Neither the Resolution, nor the Wage Agreement which is the source of the authority, contemplates such deprivation, because in them there is no provision that the determination of the Trustees as to whether an applicant comes within their regulations shall be final and conclusive, as is found in those instances where recourse to the Courts has been denied.138

_Hobbs_ thus marks an important development for the law of benefit claims. The court uncritically accepted the common-law rule that, where a plan contains a finality provision, there is limited judicial review of benefit denials. Unaware that it was changing the character of the rule, however, the court treated it as a limitation on judicial power to protect employees.

The next case marked further change. In _Ruth v. Lewis_,139 a different judge of the same court dealt with the same plan document. The judge read the plan document as purporting to confer unreviewable discretion on the trustees to determine eligibility for benefits. The court rejected this effort. It held, relying on common-law precedents and a view of participants as trust beneficiaries, that judicial review of benefit denials “does lie where applicants can show a breach of fiduciary trust, fraud or arbitrary action.”140 The court thus understood the rule as a trust-law rule for protecting employees.141 Yet it also understood the rule as a limitation on otherwise available judicial power. The reasons for the limitation were largely practical:

It is not the Court’s function to run the trust, but rather to see that it is run within the terms of the agreement in such a way that the benefits are properly distributed in order to protect beneficiaries from arbitrary or capricious action.

138. _Id._ (citing _Hurd v. Illinois Bell Telephone Co._, 136 F. Supp. 125, 154 (N.D. Ill. 1955); and _Menke v. Thompson_, 140 F.2d 786, 791 (8th Cir. 1944)). The court stated that the trustees’ decision was “arbitrary and unreasonable,” and would have been overturned had a deferential approach to review been applied. See _id._ at 287.


140. _Id._ at 349.

141. The trust-law rule of limited review, like the common law rule tracing back to _McNevin_, is primarily a rule for the _protection_ of beneficiaries; it is not a rule for limiting protection. Under trust law, courts presume that they should not make decisions regarding the administration of a trust. See, e.g., _Haines v. Schultz_, 14 A. 488, 494 (N.J. Sup. Cl. 1888); GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, _LAW OF TRUSTS AND TRUSTEES_ § 560 (rev. 2d ed. 1980); Edward C. Halbach, Jr., _Problems of Discretion in Discretionary Trusts_, 61 _COLUM. L. REV._ 1425, 1428-29 (1961). Accordingly, they presume that they should not control exercises of discretionary power in the course of trust administration. Against this background, the rule allowing review for abuse of discretion is an exception for protection of the beneficiaries, and it is justified under trust law as a protective mechanism.
There is also a practical reason for this holding. The trust here involved is quite large, consisting of over 65,000 members. . . . [T]he Court believes it is administratively simpler and more practical to limit the Court's review to the application, evidence of its support, and in the light of this, whether the Trustees acted in accordance with their fiduciary obligation and properly exercised their discretion."\(^{142}\)

The court thus continued the trend toward understanding limited review primarily as a limitation on the courts' power to protect employee rights.

There was another, even more significant, development in the case. Unlike the courts in the common-law cases, the court in \textit{Ruth} purported to base its rule, in part, on trust-law principles. In the court's opinion, the "plaintiff is in the position of a beneficiary of a noncharitable trust, not the possessor of a contractual right."\(^{143}\) For this reason, the court did not base review-with-deference on a finality provision in the plan document. Under the rule of \textit{Ruth}, there was a single approach to benefit suits that applied to any Taft-Hartley plan. \textit{Ruth} thus marked the beginning of limited review as a general approach to benefit suits, and the end of its role as a way to overcome plan document limitations.

The last of the early cases analyzing the scope of review was \textit{Kennett v. United Mineworkers of America},\(^{144}\) another case arising from a denial of benefits under the United Mineworkers plan. The trustees in \textit{Kennett} argued that their decisions denying benefits were "not subject to judicial review except for fraud or on the ground that their action is arbitrary and capricious."\(^{145}\) The court rejected the argument. While it agreed that its role was to review benefit determinations, it saw the purpose of such review as the protection of employee rights and believed that such protection called for more searching review than the trustees had suggested.

The court's analysis of the proper approach to benefit suits had two parts. First, to justify the role of courts as protectors of employee

\(^{142}\) \textit{Ruth}, 166 F. Supp. at 349.

\(^{143}\) \textit{Id.} At this time, there was increasing attention given to the possibility of applying trust law to benefit plans, but for purposes of protecting the assets against mismanagement and abuse. \textit{See}, e.g., David Ziskind, \textit{The Law of Employee Benefit Plans}, 1955 \textit{WASH. U.L.Q.} 112, 122-25 (1955); Note, \textit{Regulation of Employee Benefit Plans: Activate the Law of Trusts}, 8 \textit{STAN. L. REV.} 555 (1956).


\(^{145}\) \textit{Id.} at 317.
rights, it appealed to both trust law and contract law. In drawing on trust law, the court, echoing *Ruth*, explained that:

In effect, we are confronted with a trust fund . . . . One of the principal branches of equity jurisprudence has traditionally been the protection of the rights of beneficiaries of trust funds. A beneficiary of a trust fund is entitled and has always been entitled to have recourse to a court of equity to secure the proper performance of the duties of the trustees and his rights in the fund. Consequently, on this ground alone the Court would have the power to determine the plaintiff's legal rights in the fund and the correctness of the action of the trustees in denying him a pension.146

And in drawing on contract principles, the court explained that:

There is another approach to this problem. Contrary to the argument of defendant's counsel, the payments made from the fund are not gifts or gratuities. . . . This fund was established pursuant to a contract between the union and the employers governing the terms of employment. Payments into the fund are part of the compensation received by the employee over and above his weekly wages. . . . The employee who meets the test of eligibility has earned his pension as part of the compensation for his work over the required period and . . . may be regarded as a third-party beneficiary to a contract . . . .147

It followed that "recourse to judicial action may be had to enforce rights under this fund."148

The court then turned to the proper scope of that judicial action. At this point, a gap in the analysis occurs. Consistent with its protective outlook, the court adopted a broadened, but still deferential, scope for its review of benefit denials:

[T]he Court will review the legal rights of the plaintiff and determine whether any erroneous decision has been reached by the trustees on questions of law. It will also review, to a limited extent, decisions of the trustees on questions of fact . . . . [I]t will determine whether there is substantial evidence in the record as a whole sustaining the finding. Finally, and it is not denied that this may be done, the Court will review the question whether the action of the trustees is in any way arbitrary or capricious.149

But the court did not attempt to justify the choice of this standard. Under *Kennet*, deferential review continued to be an approach without a rationale.

146. *Id.*
147. *Id.* at 317-18.
148. *Id.* at 318.
149. *Id.*
The next important case, *Danti v. Lewis*,\(^{150}\) was the first to reach the court of appeals. In *Danti*, the court simply adopted three axioms with no explanation. First, the court presumed that the action, despite its characterization by plaintiff as a direct action for benefits, “was really [one] attacking the trustees’ denial of his claim.”\(^{151}\) Second, because the plan trustees conceded that their decisions were: “[s]ubject to judicial review to determine ‘whether the Trustees have acted arbitrarily, capriciously or in bad faith; that is, . . . is the decision of the Trustees supported by substantial evidence’ ”\(^{152}\) and because the plaintiff did not argue for any other standard, the *Kennet* approach was accepted as a given. Finally, the court presumed that the main function of the limited-review approach to benefit suits was to confine the scope of judicial inquiry, rather than to protect employees.\(^{153}\) These axioms provided the basis for all subsequent LMRA decisions.\(^{154}\)

Although the *Hobbs-Danti* line of cases is generally regarded as the source of the limited-review approach to benefit suits, it represents no such thing. It does little more than import the long-established common-law approach into a new, more employee-protective context\(^{155}\) and begin its transformation into a limitation on employee protections. Furthermore, although later courts read *Hobbs-Danti* as relying on trust law to rationalize the limitations on judicial control of benefit determinations, such a reading is incorrect. In *Ruth* and *Kennet*, trust law was relied on for a very different purpose: to reject trustee arguments that courts could not re-examine benefit determinations, and to justify a *protectionist* role for courts. The only justification offered in the cases for a *limitation* on judicial control of benefit determinations was the docket-control rationale advanced in *Ruth*.

Even after *Danti* fixed the canonical approach for benefit claims,

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150. 312 F.2d 345 (D.C. Cir. 1962).
151. Id. at 348.
152. Id.
153. See id. at 351 (Bazelon, C.J., dissenting).
154. Occasionally a participant has argued for a more searching judicial inquiry. Beam v. International Org. of Masters, Mates & Pilots, 511 F.2d 975, 980 (2d Cir. 1975). Occasionally the plan trustees argued for no review at all. Hayes v. Morse, 347 F. Supp. 1081, 1086 (E.D. Mo. 1972), aff’d, 474 F.2d 1265 (8th Cir. 1973). All such arguments have been rejected.
155. Because Tart-Hartley plans are collectively bargained for on behalf of the participating employees, and are statutorily required to be established “for the sole and exclusive benefit of the employees . . . and their families and dependents,” 29 U.S.C. § 186(c)(5); there can be no doubt that employees have enforceable rights under them. This is a very significant difference from state common law, where the very existence of employee rights in a plan was the fundamental problem.
courts remained concerned that the scope of inquiry was more limited than might be thought appropriate. They were concerned that the limitation have a sound basis; yet the reasons they offered were all after-the-fact rationalizations that treated limited review as received wisdom. They were not arguments for such a limitation as an original matter. No court in a subsequent LMRA case ever suggested that the limited-review approach be modified or discarded. Nor did any court attempt to assess the appropriateness of this approach in light of the policies of the LMRA. Instead, the courts merely sought a comforting justification, usually in the trust-like character of Taft-Hartley plans. But how the law of trusts supposedly justified the limitations was never itself explained.

4. The Importation Into ERISA

The earliest ERISA cases to address the issue of the proper approach to benefit claims involved Taft-Hartley plans and the courts simply applied the Danti approach without any doubt as to its propriety. In Bueneman v. Central States, Southeast & Southwest Areas Pension Fund, the first such case, the court, in a footnote, peremptorily rejected the participant’s argument that ERISA “has replaced the common law standard and federal courts should fashion federal com-

156. Although a few courts treated deferential review as a means of protecting employees against trustee claims that the court had no power of review at all, Miniard v. Lewis, 387 F.2d 864, 865 (D.C. Cir. 1968) (per curiam); Kosty v. Lewis, 319 F.2d 744, 747 (D.C. Cir. 1963); Hayes v. Morse, 347 F. Supp. 1081, 1086 (E.D. Mo. 1972); Collins v. United Mine Workers of America Welfare & Retirement Fund of 1950, 298 F. Supp. 964, 968 (D.D.C. 1969) (per Holtzoff, J., author of the Kennett opinion), the overwhelming majority treated it as a limitation on judicial intervention, and on the protection that otherwise could be afforded employees. E.g., Rehmar v. Smith, 555 F.2d 1362, 1371 (9th Cir. 1977); Beam v. International Org. of Masters, Mates & Pilots, 511 F.2d 975, 979-80 (2d Cir. 1975); Giler v. Board of Trustees of Sheet Metal Workers Pension Plan of S. Cal., 509 F.2d 848, 849 (9th Cir. 1975); Lowenstein v. International Ass’n of Machinists and Aerospace Workers, 479 F.2d 1211, 1213 (D.C. Cir. 1973); Brune v. Morse, 475 F.2d 858, 860 n.2 (8th Cir. 1973); Gomez v. Lewis, 414 F.2d 1312, 1314 (3d Cir. 1969); Inslay v. Joyce, 330 F. Supp. 1228, 1233 (N.D. Ill. 1971); Bolgar v. Lewis, 238 F. Supp. 595, 597 (W.D. Pa. 1960).


159. 572 F.2d 1208 (8th Cir. 1978).
mon law in this area."\textsuperscript{160} The sole ground for the conclusion was that "this Circuit, in cases arising subsequent to the enactment of ERISA, has uniformly applied the arbitrary and capricious standard in reviewing actions of trustees."\textsuperscript{161} In the next case, \textit{Bayles v. Central States, Southeast & Southwest Areas Pension Fund},\textsuperscript{162} a different court adhered to the principle that "the actions of trustees in the administration of the pension plan must be sustained as a matter of law unless plaintiff can prove such activities have been arbitrary or capricious."\textsuperscript{163} The court relied on \textit{Bueneman} as having "expressly held that the 'arbitrary and capricious' standard of review is applicable to cases arising under ERISA."\textsuperscript{164}

The shallowness of the early ERISA cases is strikingly demonstrated in \textit{Riley v. MEBA Pension Trust}.\textsuperscript{165} The court of appeals there rejected an invitation to develop a new approach to benefit suits, writing that:

\begin{quote}
It has been suggested that after January 1, 1975, new federal standards of fairness must apply . . . . We have no difficulty with the first branch of the argument, but we know of no federal standard that would here be applicable other than the arbitrary and capricious one.\textsuperscript{166}
\end{quote}

Given the state of pension plan jurisprudence, it was a matter of reflex for courts to extend the limited-review approach to plans unilaterally established by employers.\textsuperscript{167} In \textit{Paris v. Wolf, Inc., Profit Sharing Plan},\textsuperscript{168} the first such case to reach a court of appeals, the court felt compelled to accept a very limited role for courts in benefit suits. Citing \textit{Bayles} and \textit{Bueneman}, it weakly explained that:

\begin{quote}
Although the determination of eligibility for pension benefits seems to be a matter of contract law, "the clear weight of federal authority" mandates that the trustees' determinations of eligibility are to be upheld unless arbitrary or capricious.\textsuperscript{169}
\end{quote}

\begin{thebibliography}{9}
\bibitem{160} \textit{Id.} at 1209 n.3.
\bibitem{161} \textit{Id.}
\bibitem{162} 602 F.2d 97 (5th Cir. 1979).
\bibitem{163} \textit{Id.} at 99.
\bibitem{164} \textit{Id.} at 100 n.3.
\bibitem{165} 570 F.2d 406 (2d Cir. 1977).
\bibitem{166} \textit{Id.} at 413 (citations omitted).
\bibitem{168} 637 F.2d 357 (5th Cir. 1981).
\bibitem{169} \textit{Id.} at 362.
\end{thebibliography}
Yet as these words show, courts in ERISA cases appreciated the irony of applying an approach whose main effect was to facilitate defeat of benefit expectations. Because the approach was perceived as well established, however, courts were reluctant to make any substantial changes.

To relieve some of the tensions with ERISA's policies, a few courts began to allow a more thorough review in limited cases. This line of development eventuated in Bruch v. Firestone Tire & Rubber Co. 170 In that case, the Court of Appeals for the Third Circuit created a wholesale exception for unfunded welfare plans administered by the employer: in such cases there would be "de novo" review, where no deference would be given to the plan fiduciary's decision. Yet these cases—even Bruch—involved no more than tinkering. They continued to accept the principle that the default approach to benefit suits should be limited review, and concerned themselves only with eliminating the most egregious consequences.

Courts were not willing to resolve the inconsistency between deferential review and ERISA's purpose by discarding, or even substantially modifying the approach. Hence, the pressure increased to justify its limitation on judicial power. Yet the courts could find no new justifications: they merely recited the old trust-law and docket-control rationalizations that had been invoked in the LMRA cases. 171

One isolated case did appreciate the rationalizing character of the prevailing justifications for deference. In Van Boxel v. Journal Co. Employees' Pension Trust, 172 the Court of Appeals for the Seventh Circuit acknowledged that the prevailing approach to review had no principled justification. The court concluded that the approach was not based on the policies of ERISA; had emerged in a legal environment very different from ERISA; 173 and that, "[t]ransposed to the ERISA setting, the arbitrary and capricious standard may be inapt, a historical mistake, or a mechanical extrapolation from different settings . . . " 174 The court saw its task to be that of finding a justifiable new standard to replace the prevailing one.

171. E.g., Dennard v. Richards Group, Inc., 681 F.2d 306, 313 (5th Cir. 1982).
172. 836 F.2d 1048 (7th Cir. 1987) (Posner, J.).
173. The court, though, believed that it had first appeared in the LMRA cases.
174. Van Boxel, 836 F.2d at 1052.
As solution, the court proposed to make the degree of deference turn on the facts:

[Flexibility in the scope of judicial review need not require a proliferation of different standards of review; the arbitrary and capricious standard may be a range, not a point. There may be in effect a sliding scale of judicial review of trustees’ decisions—more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is.176

The court argued that, so modified, the limited review approach could be given a justification: that it works in practice, by calling only for the amount of deference appropriate to a case. As the court explained:

Flexibly interpreted, the arbitrary and capricious standard, though infelicitously—perhaps even misleadingly—worded, allows the reviewing court to make the necessary adjustments for possible bias in the trustees’ decision. So there is no urgent need to throw it overboard and cast about for an alternative verbalization. Where...the claimant does not argue or is unable to show that the trustees had a significant conflict of interest, we reverse the denial of benefits only if the denial is completely unreasonable. The greater the conflict of interest of a majority of the trustees, the less we defer to a denial of benefits that appears to be wrong.178

Even this modified approach is unsatisfactory, and ultimately unjustified, because it ignores the underlying hard question. One can agree with the court that, if deference to a plan fiduciary’s decision is ever appropriate, the extent of such deference ought to depend on various factors. But still, if ERISA’s purpose is to protect benefit entitlements, why should a court ever defer to “a denial of benefits that appears to be wrong”?

B. The Arbitrary Assumptions of Bruch

In Firestone Tire & Rubber Co. v. Bruch,177 the Supreme Court set out to determine “the appropriate standard of review in [section 502(a)(1)(B)] actions challenging denials of benefits based on plan interpretations.”178 The Court rejected the LMRA cases as irrelevant179

175. Id. at 1052-53.
176. Id. at 1053.
178. Id. at 108. The Court observed that the question arose 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.
179. The conclusion, that the LMRA cases were irrelevant, was right but the reasoning was wrong. The Court accepted the erroneous view, originating in a student article, see McCrea,
but, just as those cases had done, sought the answer in trust law. The Court assumed that an action under section 502(a)(1)(B) is a proceeding for review and that what is reviewed is a plan fiduciary's exercise of a power (within the meaning of trust law). The Court then observed that "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers" conferred by the trust instrument. On this basis the Court concluded that deference to benefit decisions of an ERISA fiduciary is not appropriate where the plan document fails to give the fiduciary any discretion to construe it or to make eligibility determinations. In the case at hand, the plan document did not give the administrator such discretion. Thus, a deferential standard of review was not appropriate.

The Bruch decision is important because it holds that deference in a given case must be justified, rather than presumed. The opinion can be read narrowly, as leaving for another day the question of what justifications for deference, if any, would suffice. So read, it is a cautious first step toward a restructuring of the law.

Yet the opinion can be read much more expansively, as actually deciding when deference is justified. In dictum, the Court suggested that a term purporting to confer discretion to interpret the plan or determine benefit entitlements would be valid under ERISA and would justify deferential review. The Court also suggested—again relying on trust law—that whenever the plan document grants discretion, a conflict of interest may affect the review. These dicta can be understood as establishing a general framework for deference in benefit suits and lower courts predictably have read the opinion this way.

supra note 117, and repeated in Van Boxel, 836 F.2d 1048, that deferential review served primarily as justification for the exercise of federal court jurisdiction over suits for benefits from Taft-Hartley plans. The Court rejected the authority of the LMRA cases, but only because ERISA supplies an express basis for jurisdiction over suits for benefits. Thus, in the Court's view, there was no need for the LMRA's supposedly jurisdictional rule. Bruch, 489 U.S. at 109-10.

180. Bruch, 489 U.S. at 111.
181. After concluding that "there is no evidence that under Firestone's termination pay plan the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference," id., the Court considered and rejected Firestone's argument that "the interpretation of the terms of the plan is an inherently discretionary function," and that it was entitled to deference as a matter of law. Id. at 112-14.
182. Actually, the Court never stated this expressly. It said only that "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a [deferential] standard of review." Id. at 115. In the concluding paragraph of the part of the opinion addressing the standard of review, however, the Court clearly proceeded on the assumption that discretion could be conferred through appropriate terms in the plan document. Id. at 115.
To the extent the Court was seriously trying to develop a principled approach to judicial deference, it did not succeed. Its attempt, though, is instructive, and a potentially useful guide for the proper development of the law, because it constitutes a methodological failure. The Court in Bruch relied on the very same assumptions about benefit suits and fiduciaries that have been the foundation for lower court justifications of deferential review. By its efforts, the Court has demonstrated—although unintentionally—that these assumptions cannot legitimate the deferential-review approach to benefit suits. The assumptions in question are: (1) that a benefit determination is the exercise of a trust power; (2) that the law of benefit suits must be guided by trust-law principles; and (3) that benefit suits are a kind of judicial review. By examining them, and by diagnosing how the Court’s reasoning goes wrong, it becomes clear that any effort to rationalize deferential review under ERISA is almost surely doomed to fail.

I. Benefit Determinations and the Exercise of Trust Powers

The Court in Bruch began with a supposed analogy between a plan fiduciary’s decisionmaking about benefits and a conventional trustee’s exercise of a power. Although the validity of the analogy is not self-evident, the Court accepted it without discussion. In fact, the analogy is implausible and its adoption begs the question.

a. Begging the Question

Even if (as the Court presumes) trust law must be the source for principles governing benefit suits, trust law provides other plausible analogies and rules. For instance, a rule of trust law provides that: “If the trustee is under a duty to pay money immediately and unconditionally to the beneficiary, the beneficiary can maintain an action at law against the trustee to enforce payment.” Before ERISA, the rule was

184. The analogy can be found, with varying degrees of explicitness, in both LMRA cases, see Hayes v. Morse, 347 F. Supp. 1081, 1086 (E.D. Mo. 1972), aff’d, 474 F.2d 1265 (8th Cir. 1978); Ruth v. Lewis, 166 F. Supp. 346 (D.D.C. 1958), and ERISA cases, see Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134 (3d Cir. 1987), aff’d in part and rev’d in part, 489 U.S. 101 (1989).

applied to suits for benefits from plans.\textsuperscript{186} Courts continue to rely on it to justify the use of legal (as opposed to equitable) procedures in suits for benefits under ERISA section 502(a)(1)(B).\textsuperscript{187} Hence, trust law supplies a competing analogy that, on its face, seems equally plausible. The Court gave no reason for choosing one over the other.

The Court adopted the trustee-power analogy only because it thought the analogy could rationalize a role for deferential review, which it presumed to be legitimate. The Court’s explanation for the analogy consisted, in entirety, of its noting that “[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers,” and then accepting the analogy without more.\textsuperscript{188} This reasoning is circular and contributes nothing to a principled development of the law.

It is difficult to fathom why the Court proceeded in this way.\textsuperscript{189} It was certainly illogical for it to presume uncritically that deferential review is appropriate in principle. The Court had already rejected the LMRA cases as authority for a deferential review approach. Since those cases were the proximate source for deferential review under ERISA, the Court had removed the approach’s precedential foundation. The logical course would have been to jettison any presumption of deferential review’s appropriateness and turn to the question precipitated by the rejection of the LMRA cases: What is the appropriate form of an action for benefits? To answer this question, the Court should have examined the structure of ERISA, its policies, and its legislative history. Instead, inexplicably continuing to presume the appropriateness of deferential review, the Court turned to the different, narrower question: How can the presumption be rationalized? Yet that

\begin{footnotesize}
\textsuperscript{186} Cf. Delaware Trust Co. v. Delaware Trust Co., 222 A.2d 320, 325 (Del. Ch. 1966) (treating benefit claims as contractual claims, although pension plan was funded through a trust); McNevin v. Solvay Process Co., 53 N.Y.S. 98, 100 (1898), aff'd mem., 60 N.E. 1115 (N.Y. 1901) (“Whether the disposition and management of this fund may or may not be the subject of control in an equity action . . . is a question not before the court, this being a simple legal action to recover the sum standing to the plaintiff's credit. . . .”).


\textsuperscript{189} Professor Langbein argues that the weakness of the Court’s reasoning in \textit{Bruch} and other ERISA cases may betray lack of interest in the subject matter. See John H. Langbein, \textit{The Supreme Court Flunks Trusts}, 1990 Sup. Cr. Rev. 207, 228-29 (1991).
\end{footnotesize}
question is ultimately beside the point, because other approaches to benefit suits might be equally, if not more, justifiable.

The Court also failed to grasp how difficult it would be to justify deferential review (were the task at hand merely that of justifying a given). The Court recognized that a deferential-review approach to benefit suits contravenes ERISA's purpose of protecting the interest of participants and beneficiaries in their expected benefits.190 This observation should have warned the Court that much more would be required by way of justification than a casual analogy to trust law. Yet the Court entirely missed the signal, and did not even try to gauge the legitimacy of any proposed justifications. The Court's reasoning strikingly illustrates how powerful is the judicial addiction to deferential review.

b. The Untenability of the Analogy

The Court appeared to think that the trustee-power analogy was so obvious it needed no justification. The Court may have been influenced by a semantic similarity. ERISA fiduciaries generally are fiduciaries because they have some discretionary authority or discretionary responsibility in plan affairs.191 "Discretionary authority" looks like "discretionary power," which, in trust law, is the touchstone for abuse-of-discretion review. If one takes the further step of identifying "authority" with "power," the analogy and the trust-law rule of review would seem to apply of their own force. The Supreme Court probably took this step.192

The identification of "authority" with "power" is erroneous. Consider the particular area of payment of benefits. An ERISA fiduciary may have discretionary authority with respect to benefit payments but will never have the kind of "discretionary power" over it that serves as predicate for abuse-of-discretion review under trust law. Under trust

191. 29 U.S.C. § 1002(21)(A) provides that:
[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan...

law, whether a power is mandatory or discretionary depends on whether the fiduciary has a duty to exercise it. As the Restatement of Trusts explains:

The powers of a trustee are at least as extensive as his duties. If the trustee is under a duty to the beneficiary to do an act, he can properly do the act; and if the trustee is under a duty to the beneficiary not to do an act, he can properly refrain from doing the act. In these cases the trustee's power is mandatory.

The trustee, however, may have a privilege to do an act, although he is not under a duty to do it, or refrain from doing an act, although he is not under a duty to refrain. In these cases the trustee's power is discretionary.193

But ERISA imposes on fiduciaries a strict duty to follow the plan document.194 If benefits are "due under the terms of [the] plan," then the fiduciary has a duty to cause them to be paid. He has no privilege to pay or not to pay them in his discretion. If one wishes to find a trust law category that is analogous to the authority to pay "benefits due under the terms of [the] plan," it must be that of a mandatory power, rather than a discretionary one.195 If one takes the trust power analogy seriously, the power to pay benefits must be subject to strict judicial control.196

193. Restatement (Second) of Trusts § 186 cmt. e (1957). See also Nichols v. Eaton, 91 U.S. 716, 723-24 (1875) (trustee not obligated to exercise discretionary power) (case relied on by Supreme Court in Bruch); Bogert & Bogert, supra note 141, at § 552 ("If the power is discretionary, the trustee . . . has no duty to exercise [it].").
195. Under trust law, when a trustee has discretionary power over payments to beneficiaries, he is under no corresponding duty and may pay or not pay in his discretion. Lineback v. Stout, 339 S.E.2d 103, 106-08 (N.C. App. 1986); Restatement (Second) of Trusts § 187 cmt. e (1957).
196. Even under trust law, the power to construe the trust document is not discretionary. Trustees are obligated to comply with the terms of the trust instrument. They may request guidance from courts when in doubt over how to comply with the trust instrument and, at times, may be required to seek such guidance from the courts. Hence, the trustee's power to construe the trust instrument cannot be deemed "discretionary" in the respect of concern to the Court. Bogert & Bogert, supra note 141, at § 559.

Oddly, the Court was aware of this. It cited authority for the inapplicability of abuse-of-discussion review in the context of trustee interpretations of the trust document. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989). In explaining why the determination of benefit entitlements is not intrinsically discretionary, the Court explained that:

As they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation. "The extent of the duties and powers of a trustee is determined by the rules of law that are applicable to the situation, and not the rules that the trustee or his attorney believes to be applicable, and by the terms of the trust as the court may interpret them, and not as they may be interpreted by the trustee himself or his attorney." 3 W. Fratcher, Scott on Trusts § 201, at 221 (emphasis added). A trustee who is in doubt as to the interpretation of the instrument can protect himself by obtaining
2. *The Reliance on Trust Law*

The error of conflating fiduciary "authority" and trustee "power" with respect to benefit payments illuminates a more general point: ERISA is not concerned with fiduciary powers but rather with fiduciary duties. This difference between the two bodies of law is profound, and it necessitates caution in applying trust-law principles to ERISA. In particular, it precludes importation of the law of "powers" into ERISA.

A conventional trustee is primarily a bearer of powers: a person who implements the settlor's intent through exercise of powers delegated for that purpose.\(^{197}\) A basic function of trust law is to regulate the exercise of such delegated powers and control their misuse.\(^{198}\) The traditional rules of fiduciary responsibility govern trustee powers precisely to this end. ERISA, however, is not concerned with implementing the plan sponsor's intent. Rather, it is concerned with protecting the participants' and beneficiaries' expectations of benefits. Because sponsor intent is unimportant, so, too, are the powers through which the intent might be fulfilled. For this reason ERISA, in contradistinction to trust law, views fiduciaries primarily as bearers of duties and imposes fiduciary rules primarily to govern the "discharge of . . . duties with respect to a plan." What ERISA calls "discretionary authority" is not discretionary power, but simply authority of the kind which ought to subject one to ERISA's fiduciary rules.

It is striking that, in seeking justifications for deferential review, the Court looked only to trust law for guidance. Why the narrow focus? The most likely reason is force of habit: courts, for long, have been looking there and only there. The reason the Supreme Court offered, however, is that ERISA required it to look only at trust law. This stated reason is unpersuasive.

The Court explained its supposedly mandated reliance on trust law as follows. It observed that federal courts must develop a common law for benefit claims. It then noted that "ERISA abounds with the language and terminology of trust law," and that "ERISA's legislative history confirms that the Act's fiduciary responsibility provisions . . . "codify[ ] and mak[e] applicable to [ERISA] fiduciaries certain princi-

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\(^{197}\) *Bruch*, 489 U.S. at 112.


\(^{198}\) See Frankel, *supra* note 197, at 809.
ples developed in the evolution of the law of trusts.’ ”199 From these premises, it concluded that, “[i]n determining the appropriate standard of review for actions under [ERISA section 502(a)(1)(B)], we are guided by principles of trust law.”200

The premises may be true but the conclusion is false. It is true that Congress intended courts to develop a common law of plans. It is also true that Congress intended courts to develop a fiduciary law specially suited to plans. But it is not true that Congress intended the whole of the common law of plans to be a fiduciary law. The common law of plans deals with many subjects that are neither part of fiduciary law nor informed by fiduciary principles. Among these subjects are preemption of state law,201 enforcement of oral representations about benefits202 and plan interpretation.203 Most telling, the common law regarding exhaustion of plan remedies is based (albeit erroneously) on labor law principles.204 The common law of plans is not identical with the fiduciary law of plans.

Remarkably, the Court itself recognized that sources other than trust law could have been used to guide the development of rules for benefit suits. It observed that contract law might be available, pointing out that “[a]ctions challenging an employer’s denial of benefits before the enactment of ERISA were governed by principles of contract law.”205 Yet so strong was the predisposition toward trust-law rationalizations that the observation was used only to corroborate the trust-based standard already accepted.

The Court could easily have resisted the pull of trust law, for blind reliance on it was inconsistent with the insight of Massachusetts Mutual Life Insurance Co. v. Russell, that a suit for benefits does not necessarily implicate ERISA’s fiduciary concerns.206 The duty to pay benefits, which is owed to individual participants and beneficiaries and enforced through section 502(a)(1)(B), is distinct from ERISA’s fiduciary obligations, which are owed to the plan and which are enforced

199. Bruch, 489 U.S. at 110.
200. Id. at 111.
202. E.g., Black v. TIC Inv. Corp., 900 F.2d 112 (7th Cir. 1990).
204. See supra part III(C)(1).
through sections 502(a)(2) and 409(a). ERISA's fiduciary rules govern the way in which the duty to pay benefits is carried out. The content of those fiduciary rules may well be inspired by traditional trust-law principles, but the trust-law influence does not necessarily trickle down to the underlying duty to pay benefits. So far as concerns individual participants and beneficiaries, the payment of benefits to them is not a fiduciary matter. It is simply a matter of paying what is owed, and the principal obligor with respect to that duty is surely the plan, not the fiduciaries. To invoke trust principles reflexively in order to shape the duty to pay benefits is to confuse duties that ERISA demands be kept distinct.

3. The Presumption of Review

The third, and most fundamental, of the Supreme Court's assumptions in Bruch was the assumption that a suit for benefits must be treated as a proceeding for review. This assumption, by itself, is enough to limit the scope of the proceeding and to induce deference to the decision reviewed. A post-Bruch case laid bare the logic:

In virtually all decisional review, some deference is given to the fact finder, whether it is a district court giving deference to an administrative body, or an appellate court giving deference to the district court. We see no reason why the plan administrator, i.e., the trier of fact, should be placed in a different status.\textsuperscript{207}

The assumption thus creates the need for a "standard" and for additional assumptions about how that standard should be divined.

The Supreme Court did not try to justify this fundamental assumption. Indeed, the Court seemed unaware that it was making any controvertible assumption at all. But it surely was. Not all benefits are provided through plans and not all suits for benefits are brought against plans. When a person seeks benefits that are not provided through a plan, he likely will have a claim based on an insurance policy, an employment contract, or promissory estoppel. An action to enforce any such claim will be a direct action for benefits, in which the court (or a jury) determines the claimant's rights on the basis of the evidence presented.\textsuperscript{208} It is not intuitively obvious that an action for benefits

\textsuperscript{207} Pierre v. Connecticut Gen. Life Ins. Co., 932 F.2d 1552, 1559 (5th Cir. 1991) (citations omitted). In that case, the court, primarily because of the presumed character of an action for benefits, distinguished Bruch and held that factual determinations that underlie determinations of benefit entitlements are always to be reviewed under an abuse of discretion standard.

\textsuperscript{208} See, e.g., 20 John A. Appleman, Insurance Law & Practice ch. 372 (1980).
under a plan should be treated any differently. As shown earlier, the current justifications for review-type treatment are unavailing and inconsistent with ERISA.

The Court's assumption that benefit suits are review proceedings appears to be yet another case of blind adherence to received tradition. This is most unfortunate. A review proceeding is one for the correction of errors. It is not a proceeding for the original determination of facts or rights and necessarily is more limited than the proceedings to be reviewed. Its scope will depend, possibly in large part, on considerations other than ascertaining truth or settling a dispute. In particular, it will depend on institutional considerations, such as the respective roles and competencies of the initial and reviewing decisionmakers, and the need for efficiency and fairness in the system. By requiring suits for benefits to be treated as review proceedings, the Supreme Court required their form and scope to be guided by considerations other than the correct determination of benefit entitlement. Yet by failing to identify the policies and considerations that might properly determine the character of review, the Court invited indiscriminate reliance on non-ERISA considerations.

This has led to questionable rules that purport to elaborate on the framework sketched in Bruch. A rule adopted by some lower courts, for example, is that, while "de novo review" is review without deference to the fiduciary's decision, it is still limited to the record that was before the fiduciary. Thus, a suit for benefits is never an evidentiary proceeding. As the leading case adopting this view has explained:

In the ERISA context, the role of the reviewing court is to determine whether the administrator or fiduciary made a correct decision, applying a de novo standard. Nothing in the legislative history suggests that Congress intended that federal district courts would function as substitute plan administrators, a role they would inevitably assume if they received and considered evidence not presented to administrators concerning an employee's entitlement to benefits.

Such a procedure would frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme.\footnote{213}

This rule is unacceptable. Nothing in ERISA or its regulations compels a plan to provide an evidentiary hearing remotely comparable to a federal court trial. Thus, benefit suits, in contrast with other federal district court proceedings, are to proceed on the basis of skimpy factual records, without the benefit of evidence-generating provisions of the Federal Rules of Civil Procedure and Federal Rules of Evidence. What is the rationale? That an evidentiary hearing in district court would “frustrate the goal of prompt resolution of claims by the fiduciary.” This is pure speculation, untainted by fact.

Yet even if there were some basis for believing that the treatment of a benefit suit as an evidentiary proceeding would interfere with “prompt resolution of claims by the fiduciary,” the rationale would still fail. For it to be plausible, one would have to add two premises: that “prompt resolution of claims” is something Congress intended for the protection of sponsors and fiduciaries; and that such protection of sponsors and fiduciaries is more important than protection of the participants’ right to receive benefits due. Merely to state these premises is to reveal their untenability. By demanding, without reason, that benefit suits be treated as review proceedings, the Supreme Court invited lower courts to invent rules and rationales of precisely this ilk.

An even stranger and more questionable rule has emerged to implement Bruch’s dictum that a conflict of interest on the part of the decisionmaking fiduciary should affect the review of a benefit denial. The Court never explained why a conflict of interest should matter, let alone how it should. Again, the Court casually borrowed a trust-law principle (indeed, a trust-power principle) that looked right\footnote{214} without examining its appropriateness under ERISA. Lower courts were charged with giving ERISA-content to the trust-law rule, but they were given no guidance. Some lower courts have produced the rule that, where a conflict of interest is found to exist, the court must proceed in two stages.\footnote{215} First, it must determine whether the fiduciary’s decision to deny benefits was wrong. Otherwise, it is irrelevant what

\footnote{213. \textit{Perry}, 900 F.2d 963, 966 (6th Cir. 1990).}
\footnote{214. \textit{Cf.} Van Boxel v. Journal Co. Employees’ Pension Trust, 836 F.2d 1048 (7th Cir. 1987) (sliding scale of deference based on extent of conflict of interest).}
standard of review is used. Then, if the decision was wrong, the court must determine whether that decision and its supporting rationale constitute an abuse of discretion, and uphold the decision if it does not. As a consequence, a decision denying benefits will be upheld even if the court has found it to be wrong.

Courts that have created this rule have not bothered to explain how upholding a denial of benefits known to be wrong could possibly be thought consistent with the purposes of ERISA. Nor have they seen any need for such explanation, because the Supreme Court, having accepted the review interpretation of benefit suits, has practically invited such an approach. The lower court rule in its disregard for ERISA's fundamental purpose amounts to a reductio ad absurdum of the interpretation of benefit suits as review proceedings. The emergence of such a rule powerfully demonstrates that ERISA requires a different underlying theory.

C. The Suit for Benefits as Suit for Benefits

The rule of deferential review is an anachronism. It is an artifact of a different legal framework and it serves no apparent function other than to impede protection of employee benefit rights. Courts persist in adhering to it, not for good and thoughtful reasons, but simply because courts in prior cases adhered to it—still without good and thoughtful reasons.

It is the idea that benefit suits must be review proceedings that covers deferential review with a veneer of plausibility. But once that notion is itself seen to be unfounded, deference to fiduciary decision-making stands exposed as an arbitrary practice. The real issue that underlies all discussion of deference and standards is an issue of reconciling non-statutory policies with ERISA. Those who espouse limited judicial involvement in benefit claims must answer the straightforward, but very hard, question: May a court, consistently with ERISA, ever decline to order payment of benefits when it believes the plan's denial of them to be wrong?

Under the current statutory framework, the answer probably is no. One might suppose, as a counterexample, that welfare benefit determinations under Taft-Hartley plans present a case for limitations on judicial oversight. After all, the deprivation of a welfare benefit is arguably not so serious as the deprivation of a pension. One might also argue that (at least sometimes) representatives of the employee are involved in making the benefit decision, and to that extent provide much of the
protection (especially from employer abuse) that might be provided by a court. But those arguments are really excuses. One must still ask what legitimate purpose, if any, is advanced by deferring to the trustees' decisions or limiting the scope of the action.

Throughout the history of benefit plan law, the main policy argument advanced for deference has been that it reduces the judicial caseload. Even if that contention were true, it would be unavailing, since caseload reduction is not a value easily reconciled with ERISA. Federal courts have special responsibilities to ensure that benefits are paid. Courts understandably seem to dislike suits for benefits. These cases rarely have importance beyond their facts and often involve small dollar stakes. But Congress arguably has debarred courts from translating lack of enthusiasm into rules of limitation. Contrary to the mechanically repeated excuse for judicial non-involvement in benefit suits, Congress did intend courts to be the vindicators of benefit rights when plan fiduciaries fail to pay benefits due.

In any event, the docket control argument is speculative. No one has offered any evidence to show that permitting benefit suits to go forward as evidentiary proceedings would, as dreaded, increase the number of such suits. One can equally well argue a priori that judicial deference would increase the judicial caseload, by promoting slapdash decisionmaking and generating far more wrong decisions for participants and beneficiaries to challenge.216

If treating suits for benefits as suits for benefits really were to cause bloated federal dockets, there would be many solutions possible. Specialized tribunals, amount-in-controversy limitations, mandatory mediation, and an increase in the number of judges are a few of the more obvious ones. But any solution would have to emerge from Congress, for it is Congress that would have created the problem by giving federal courts their responsibility for benefit suits. The conferral of that responsibility, and the decision that federal courts should be easily accessible for the vindication of benefit rights, may be wise or may be foolish. The question can be fairly debated. But at present it is a fact, a datum for the interpretation and implementation of ERISA; and courts may not avoid it by transforming benefit suits into something they were never intended to be.

216. See Bruce, supra note 112, at 322 n.108.
V. Conclusion

The current law of benefit claims and suits under ERISA is an unprincipled potpourri. The rules have never been the object of serious attempts at justification. In any event, it is unlikely that they could be justified. The extent to which the law has developed without any consideration of ERISA’s purposes, principles, language and legislative history is remarkable, and stands as paradigm of how federal courts should not develop common law.

There really is no choice but to start over. The rules for benefit claims and suits must be redeveloped, so as to implement ERISA’s language, its principles, and its policies, and to accommodate them with other considerations so far as ERISA permits. Some considerations examined here—labor law policies, fiduciary principles, docket control concerns—have, at most, limited applicability. Other considerations may be examined on a case-by-case basis.

The law that results from this rethinking should be much simpler, treating an action for benefits as an action for benefits. It should permit section 502(a)(1)(B) to serve its intended purpose of facilitating the vindication of individual benefit rights.