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Joshua Foster

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NOTES

ERISA, TRUST LAW, AND THE APPROPRIATE STANDARD OF REVIEW: A DE NOVO REVIEW OF WHY THE ELIMINATION OF DISCRETIONARY CLAUSES WOULD BE AN ABUSE OF DISCRETION

JOSHUA FOSTER[†]

INTRODUCTION

A recent advertisement for the American Family Life Assurance Company (“AFLAC”) shows the iconic Yogi Berra deadpanning that you need AFLAC so that “when you get hurt, and miss work, it won’t hurt to miss work.”¹ But what happens when your insurance company does not disperse your benefits because, according to *their* definition, you are not “disabled” or “unable to work”?² And what happens if your plan administrator

[†] J.D. Candidate, June 2008, St. John’s University School of Law; M.A., Theology, 2004, Boston College; B.A., 2002, Boston College. The author would like to thank all the professors and mentors who influenced his academic experience at all levels, and most importantly, Kelly James, who is simply the best person he has ever met.

¹ In addition, “they give you cash, which is just as good as money.”

² A good recent example of the interests involved in these cases is *Hillery v. Metropolitan Life Insurance Co.*, 453 F.3d 1087 (8th Cir. 2006). In *Hillery*, an employee suffering from systemic lupus erythematosus had her benefits under a long term disability plan terminated after eleven years. *Id.* at 1088–89. The plaintiff had several medical experts document that she could not return to work after her lupus became inactive, while Metropolitan Life Insurance Company (“MetLife”) introduced medical experts who determined that she could return to work. *Id.* at 1089. In reviewing the decision, the district court used an “abuse of discretion” standard of review to determine that MetLife was within its authority to terminate her benefits. *Id.* at 1090. The court of appeals affirmed despite the conflicting medical testimony. *Id.* at 1091–92.

is the only authority making this determination, to the exclusion of other figures like your boss, employer, or a medical expert?³

In 1974 Congress enacted the Employee Retirement Income Security Act ("ERISA")⁴ to protect policyholders against the potential abuses that arise out of the private pension administration of the insurance plans.⁵ ERISA provides an extremely complicated scheme that preempts state insurance law on many points.⁶ One major aspect of ERISA is that it affords statutory protections to policy holders when they have been denied benefits from their plans.⁷

Although ERISA is a "comprehensive and reticulated statute,"⁸ it is conspicuously silent regarding the standard of review for courts to employ when reviewing claims brought by policyholders.⁹ The Supreme Court ruled in *Firestone Tire &*

³ Many insurance policies accomplish this through the use of discretionary clauses. See, e.g., *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 943 (9th Cir. 1999) (holding that policy language clearly indicating administrator's authority to determine issues of interpretation adequately confers discretion); *Lundquist v. Cont'l Cas. Co.*, 394 F. Supp. 2d 1230, 1245 (C.D. Cal. 2005) (holding that a plan which states that when "making a benefit determination . . . [w]e have discretionary authority to determine [y]our eligibility for benefits" confers discretionary authority (emphasis omitted)). But see *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98, 108-09 (2d Cir. 2005) (holding that the plain language of the policy did not confer discretion to the plan administrator).

⁴ 29 U.S.C. §§ 1001-1461 (2000).

⁵ See generally JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 3-7 (2004) (discussing the genesis of ERISA and the protection it seeks to afford). Although ERISA's name and beginning suggest that it deals with pensions, ERISA actually regulates a wide variety of services including medical benefits, severance pay, and life insurance. JAYNE E. ZANGLEIN & SUSAN J. STABILE, *ERISA LITIGATION*, at xi (2003).

⁶ See *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129-30 (1992) (holding that ERISA preempts state law referring to plans regulated by ERISA even where it is "not specifically designed to affect such plans . . . and even if the law is consistent with ERISA's substantive requirements" (internal quotation marks omitted)).

⁷ 29 U.S.C. § 1001(a)-(c). The statute reads, in pertinent part: "It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . ." *Id.* § 1001(b). See also ROBERT H. JERRY II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 86 (4th ed. 2007) ("ERISA is a comprehensive federal regulatory scheme for employee benefit (i.e., pension and welfare) plans . . . 'for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,' certain fringe benefits . . ." (citing 29 U.S.C. § 1002(1))).

⁸ *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980).

⁹ Because ERISA is silent with regard to the standard of review, the federal courts have developed their own standards derived from common law principles in various areas. See Peter A. Meyers, Comment, *Discretionary Language, Conflicts of*

*Rubber Co. v. Bruch*¹⁰ that a denial of benefits under ERISA “is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”¹¹ In setting this standard, the Court explicitly recognized the importance of determining such a standard as most litigable issues arising under ERISA will “turn on the interpretation of terms in the plan.”¹² The *Firestone* decision created uniformity in terms of standards of review in ERISA litigation and, until recently, has been consistently followed without serious question.

In the United States Court of Appeals for the Second Circuit, so-called “discretionary clauses” that allocate complete discretion over an insurance policy to the plan administrator¹³ have been consistently honored.¹⁴ Under Second Circuit case law, insurance plans that grant full discretion to the plan administrator have been reviewed under the more deferential “arbitrary and capricious” standard.¹⁵ Other circuits have utilized a similar, if not the same approach.¹⁶

Interest, and Standard of Review for ERISA Disability Plans, 28 SEATTLE U. L. REV. 925, 929 (2005) (discussing the wide interpretations that have been given to the subject of standards of review due to the lack of direction from the statute itself).

¹⁰ 489 U.S. 101 (1989).

¹¹ *Id.* at 115.

¹² *Id.*

¹³ Generally, an “administrator” is “[a] person who manages or heads a business, public office, or agency.” BLACK’S LAW DICTIONARY 49 (8th ed. 2004). In the context of an insurance plan, an “administrator” is the person or company who manages the distribution of benefits. See 29 U.S.C. § 1002(16)(A)(i) (2000) (“The term ‘administrator’ means—the person specifically so designated by the terms of the instrument under which the plan is operated.”).

¹⁴ See, e.g., *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 109 (2d Cir. 2003) (holding that a discretionary clause in the policy warrants a deferential standard of review in reviewing the denial of benefits); *Kinstler v. First Reliance Standard Ins. Co.*, 181 F.3d 243, 249–51 (2d Cir. 1999) (applying the *Firestone* decision to the Second Circuit in holding that denials of benefits are to be reviewed de novo unless the policy reserves discretion to the plan administrator or fiduciary).

¹⁵ See, e.g., *Burke*, 336 F.3d at 109; *Polizzano v. Nynex Sickness & Accident Disability Benefit Plan*, 189 F.3d 461, 461 (2d Cir. 1999) (unpublished table decision) (holding that the plan clearly grants discretion and is therefore reviewable under the more deferential arbitrary and capricious standard).

¹⁶ See, e.g., *High v. E-Systems, Inc.*, 459 F.3d 573, 576 (5th Cir. 2006); *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 874–75 (9th Cir. 2004) (applying an abuse of discretion standard because the plan accorded discretion to the administrator). The Ninth Circuit formulates its deferential standard slightly differently by reviewing cases under an “abuse of discretion” standard. The difference between the abuse of discretion standard and arbitrary and capricious standard, however, seems to be semantic rather than substantive. See *Holian v.*

Recently, this approach has come under attack in New York. On March 27, 2006, the New York Insurance Department ("Department") issued a Circular Letter maintaining that the use of discretionary clauses in insurance policies violates New York State insurance laws.¹⁷ In addition, the Department advised Article 43 corporations and HMOs to remove discretionary clauses from their plans voluntarily or the Department would withdraw the approval of the plans and policies pursuant to Article 3110 of New York's Insurance Law.¹⁸ On June 29, 2006, the Department issued another Circular Letter superseding the aforementioned letter and re-examining the use of discretionary clauses in insurance plans.¹⁹ In this letter, the Department urged Article 43 corporations and HMOs to discontinue their use of discretionary clauses and noted that it would seek to enact legislation that would explicitly make the clauses illegal.²⁰

Leavitt Tube Co., Inc., No. 89-C-0354, 1989 WL 44570, at *3 (N.D. Ill. Apr. 28, 1989) ("[T]here does not appear to be a significant difference between an abuse of discretion and an arbitrary and capricious standard."). *But see* Morton v. Smith, 91 F.3d 867, 870 (7th Cir. 1996) (discussing the substantive difference between the two standards). Interestingly, the *Firestone* Court referred to the standard as "arbitrary and capricious" rather than "abuse of discretion." 489 U.S. at 109-10, 114. The arbitrary and capricious standard evidently derives from labor law cases, while the abuse of discretion standard is the language used in the Restatement (Second) of Trusts. *See* Donald T. Bogan, *ERISA: Re-thinking Firestone in Light of Great-West—Implications for Standard of Review and the Right to a Jury Trial in Welfare Benefit Claims*, 37 J. MARSHALL L. REV. 629, 631 n.11 (2004) (discussing the use of the two standards in various cases after *Firestone*).

¹⁷ Charles Rappaciulo, Asst. Deputy Superintendent, N.Y. Ins. Dep't, Circular Letter No. 8 (2006), http://www.ins.state.ny.us/cl06_08.htm [hereinafter Circular Letter No. 8]. This has also occurred in other states. *See* N.J. ADMIN. CODE § 11:4-58.1 (2007) (stating that discretionary clauses in insurance contracts function to nullify many benefits provided in the contracts themselves). In addition, there have been movements in other states to convince the state insurance departments to adopt regulations prohibiting discretionary clauses. *See* Letter from Elliott Andalman to Alfred W. Redmer, Jr., Ins. Comm'r, State of Md. (Aug. 31, 2006), <http://andalman-flynn-law.com/library/DISCRETIONARY%20CLAUSE%20-%20EA-%20INS%20COMM01.LTR.pdf> (asking for a declaratory ruling regarding the use of discretionary clauses in insurance policies in Maryland).

¹⁸ Circular Letter No. 8, *supra* note 17.

¹⁹ Charles Rappaciulo & Jeffrey Angelo, Asst. Deputy Superintendents, N.Y. Ins. Dep't, Circular Letter No. 14 (2006) (June 29, 2006), http://www.ins.state.ny.us/cl06_14.htm [hereinafter Circular Letter No. 14].

²⁰ *Id.* The tone of the second Circular Letter was markedly different from the first. In the first, the Department confidently stated that it had the authority to withdraw plans that violated its position pursuant to state insurance laws. *See* Circular Letter No. 8, *supra* note 17. In its second letter, the Department seemingly recognized that the use of discretionary clauses does not violate existing insurance law and, therefore, the exercise of its statutory authority to remove plans would be

If the Department succeeds in passing the regulation, it would have the authority to disapprove policies that utilize discretionary clauses. This would force federal courts in New York to conduct *de novo* reviews in every claim of adverse benefits administration arising under ERISA because trust law would no longer apply to the benefits determination.²¹ This consequence deprives the judicial system of its discretionary function in allocating the appropriate interpretive authority. Before the Department acts upon its threats, it is important to consider many factors that support both perspectives, and make the appropriate judgment in light of the policy issues involved. In the end, the Department's potential action has the practical effect of significantly adding to the costs on all sides associated with litigating ERISA claims, while providing only marginal improvements to the safeguarding of policy-holder's rights.

Part I of this Note will give a brief background of ERISA, New York insurance law, the assertions of the Department as set forth in the Circular Letters, and the Model Act upon which many statutory schemes draw from. Part II will examine the *Firestone* decision and its emphasis on trust law in keeping with the legislative intent underpinning ERISA. Part III will examine the policy concerns that both sides raise and will argue that the current system has benefited the parties that ERISA legislation has intended to protect while providing additional benefits to the judicial system.

I. ERISA & NEW YORK INSURANCE LAW²²

On September 2, 1974, President Ford signed the Employee Retirement Income Security Act, now commonly referred to as

useless. See Circular Letter No. 14, *supra* note 19. Ultimately, the Department chose an alternative route by attempting to change the relevant law to grant it authority over such cases.

²¹ Although ERISA is a federal statute and would normally preempt state insurance plans, Congress explicitly exempted state regulations from this through a "savings clause" in the statute. See *infra* note 37 and accompanying text.

²² For an excellent description of the political landscape leading to the passage of ERISA, see WOOTEN, *supra* note 5, at 7-11 (describing the various parties who supported and opposed the passage of ERISA). In addition, the United States Department of Labor has an excellent condensed history of ERISA on its website. See U.S. Dep't of Labor, History of EBSA and ERISA, <http://www.dol.gov/ebsa/aboutebsa/history.html> [hereinafter History of EBSA and ERISA] (last visited Oct. 25, 2007).

ERISA.²³ Congress passed this legislation in response to the growing importance of pension plans in the American workforce and the perceived abuses in the administration of private pension plans.²⁴ This legislation achieved extensive application by inducing employers to utilize plans that complied with ERISA standards through favorable tax treatment.²⁵ Although the benefits of the legislation have become evident over the years, there was significant opposition to its passage from various interest groups.²⁶ The statute was passed primarily to respond to "abuse and mismanagement in the private pension system"²⁷ that had plagued American workers.²⁸ Initially, pension administration was governed by the Internal Revenue Service under the Revenue Acts of 1921 and 1926.²⁹ At that point, pension administration was governed by tax and labor laws that generally left the terms and conditions of insurance plans to the contracting parties.³⁰ In the following years, Congress only complicated matters by enacting several statutes that suffered from a lack of criteria for fiduciary conduct.³¹ In addition, none of

²³ See WOOTEN, *supra* note 5, at 1. President Ford remarked that the legislation was a landmark moment, and sensed that "this legislation will probably give more benefits and rights and success in the area of labor-management than almost anything in the history of this country." *Id.*

²⁴ *Id.*

²⁵ See History of EBSA and ERISA, *supra* note 22.

²⁶ See WOOTEN, *supra* note 5, at 7-11 (noting that the pension reform movement "was as much a debate over competing values as it was a struggle among conflicting interests"); see also James A. Wooten, "The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA, 49 BUFF. L. REV. 683, 684 (2001) (chronicling the shutdown of the Studebaker plant in Indiana as a major catalyst for the passage of ERISA).

²⁷ BARBARA J. COLEMAN, PRIMER ON ERISA, at xi (2d ed. 1987) (giving a brief history of the regulation of pension plans before the passage of ERISA).

²⁸ *Id.* Prior to the enactment of ERISA, plan beneficiaries had few safeguards against abuses by the plan administrators. See WOOTEN, *supra* note 5, at 3 (recounting the risky state of the private pension system prior to the government's new role under ERISA).

²⁹ See History of EBSA and ERISA, *supra* note 22.

³⁰ See WOOTEN, *supra* note 5, at 3; see also COLEMAN, *supra* note 27, at xi. This ultimately meant that the riskiness of pension promises was also left to be decided by the parties. See WOOTEN, *supra* note 5, at 3.

³¹ Specifically, Congress passed the Labor Management Relations Act to govern retirement funds and the Welfare and Pension Plans Disclosure Act requiring reporting to the Secretary of Labor. See 29 U.S.C. §§ 141-87 (2000); 29 U.S.C. §§ 1140-48 (2000). For an excellent account of these difficulties, see Jennifer Claire Sprague, Note, *How Secure Are Your Lifetime Benefits?*, 30 S. ILL. U. L.J. 195, 196-97 (2005) (describing how the Labor Management Act lacked criteria for vesting of benefits and fiduciary conduct and how the Internal Revenue Code

the statutes effectively addressed the problem of procedural difficulties in the administration of benefits, ultimately resulting in an inequitable distribution of benefits.³² ERISA's passage provided a completely new regulatory scheme whereby the government plays an increasingly active role in the administration of the private pension system.³³

Because ERISA legislation was primarily passed to prevent inequities in the administration of worker's pensions, there was much less consideration given to employee welfare benefits such as health insurance.³⁴ However, as health care plans played an increasingly important role in comprehensive benefits packages for many employers, health insurance began to be regulated under ERISA as well.³⁵ Due, in large part, to the increased emphasis and importance of benefits administration as part of employer's compensation packages, ERISA has taken on enormous magnitude and importance as a regulatory scheme.

ERISA legislation is a complex statutory system that can supersede state laws that deal with employee benefit plans.³⁶ To allow states to maintain control over certain aspects of benefits administration, Congress included a savings clause that exempts

failed to protect plan participants); see also History of EBSA and ERISA, *supra* note 22.

³² See Keron A. Wright, Comment, "Stuck on You": The Inability of an Ex-Spouse to Waive Rights Under an ERISA Pension Plan, 45 WASHBURN L.J. 687, 690 (2006) (noting that a major pitfall in early pension plans centered largely around vesting requirements that were nearly impossible for employees to meet).

³³ See WOOTEN, *supra* note 5, at 3.

³⁴ See *id.*

³⁵ See History of EBSA and ERISA, *supra* note 22. This increasing emphasis on health care plan regulation is evidenced by the passage of several amendments to ERISA. In particular, two amendments continue to play a vital role. The Consolidated Omnibus Budget Reconciliation Act, popularly known as "COBRA," provides for a continuation in health benefits under certain circumstances. 29 U.S.C. §§ 1161-68 (2000 & Supp. II 2002). Additionally, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d (2000 & Supp. I 2001), popularly known as "HIPAA," is aimed at "making health care coverage more portable and secure for employees." History of EBSA and ERISA, *supra* note 22.

³⁶ See 29 U.S.C. § 1144(a) ("[T]he provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."). The scope of ERISA's preemption is intentionally broad and encompassing. The Supreme Court noted that Congress "indicated that the section's pre-emptive scope was as broad as its language." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983). "This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." *Id.* at 99 (quoting 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams)).

state insurance laws from federal preemption.³⁷ Several states have already forbidden the use of discretionary clauses in insurance contracts in their statutory schemes,³⁸ but these statutes have only recently been challenged in federal court.³⁹

New York's insurance scheme does not directly address the use of discretionary clauses, but it has several relevant provisions that are being wielded as weapons by the Department. Specifically, insurance plans issued in New York are subject to review by a Superintendent who has the power to approve or disapprove of the policy in question.⁴⁰ Decisions rendered by the Superintendent are judicially reviewable under section 326 of the New York Insurance Law,⁴¹ pursuant to Article 78 of the Civil Practice Law and Rules.⁴² Section 3201(b)(1) states that the Superintendent shall not approve of a policy unless it "conform[s] to the requirements of this chapter and [is] not inconsistent with [the] law."⁴³ Additionally, section 3201(c)(1) grants the Superintendent the ability to

disapprove any policy form for delivery or issuance for delivery in this state if he finds that the same contains any provision or has any title, heading, backing or other indication of the contents of any or all of its provisions, *which is likely to mislead the policyholder, contract holder, or certificate holder.*⁴⁴

³⁷ See 29 U.S.C. § 1144(b)(2)(A) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."). The Supreme Court has struck down challenges to the savings clause in a number of circumstances. See, e.g., *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739–40 (1985) (holding that a Massachusetts law that required certain minimum benefits in all health insurance policies is not preempted by ERISA).

³⁸ See Daniel W. Gerber & Kimberly E. Whistler, *New York Insurance Department: Discretionary Clauses Violate the Insurance Law*, N.Y. ST. B.J., Sept. 2006, at 18, 18–19 (discussing several states' forbidding the use of discretionary clauses).

³⁹ See *Burotto v. Cont'l Cas. Co.*, 163 F. App'x 565, 566 (9th Cir. 2006). While the Supreme Court has not had the opportunity to determine whether these prohibitions are excluded from preemption under ERISA, it appears likely that they would be upheld given the precedent of enforcing the savings clause.

⁴⁰ N.Y. INS. LAW §§ 3201–03 (McKinney 2007).

⁴¹ *Id.* § 326.

⁴² N.Y. C.P.L.R. 7801–06 (McKinney 2007).

⁴³ N.Y. INS. LAW § 3201(b)(1). This section also provides for an expedited process that is subject to retroactive modification to ensure that the appropriate safeguards are in place. See *id.* § 3201(b)(1)–(b)(6)(B).

⁴⁴ *Id.* § 3201(c)(1) (emphasis added).

Under these provisions, coupled with the restrictions found in Article 24,⁴⁵ the Superintendent's responsibility is to ensure that the insurance administrators are not "engag[ing] in this state in any unfair or deceptive act or trade practice."⁴⁶ In its second Circular Letter,⁴⁷ the Department contends that discretionary clauses violate sections 3201(c)⁴⁸ and 4108(a)⁴⁹ of the New York Insurance Law.⁵⁰ Specifically, the Department maintains that discretionary clauses in many insurance policies render many of the other clauses and provisions "illusory" by relegating interpretation of the policies as a whole solely to the plan administrator, which effectively precludes adequate judicial review.⁵¹ In effect, the Department expresses little faith that the judiciary, functioning according to the current structure and standard of review, can effectively protect the rights of the insured.⁵² Accordingly, the Department threatened to force a

⁴⁵ *Id.* §§ 2401–10 ("Unfair Methods of Competition and Unfair and Deceptive Acts and Practices").

⁴⁶ Circular Letter No. 14, *supra* note 19.

⁴⁷ Circular Letters from the Insurance Department are promulgated essentially as advisory opinions. See *Russo v. Cont'l Cas. Ins.*, No. 05 CIV. 5700(HB), 2006 WL 931683, at *3 (S.D.N.Y. Apr. 11, 2006) ("This change may cause courts in the future to revisit their use of the arbitrary and capricious standard of review."). This is also indicated in the text of the second Circular Letter which advises, rather than mandates, companies to discontinue their use of discretionary clauses. See Circular Letter No. 14, *supra* note 19. While the Circular Letters do not have any force of law behind them, they can cause courts to re-examine their policies. See *Russo*, 2006 WL 931683, at *3; *Downey v. Allstate Ins. Co.*, 638 F. Supp. 322, 325–26 (S.D.N.Y. 1986); Norman L. Tolle & Peter P. McNamara, *Insurance Department Seeks to Change Standard of Review*, N.Y.L.J., July 7, 2006. *But see* *Fenberg v. Cowden Auto. Long-Term Disability Plan*, No. C 03-03898 SI, 2004 U.S. Dist. LEXIS 22927, at *5 (N.D. Cal. Nov. 2, 2004) (holding that one factor in determining that a discretionary clause is invalid is the persuasiveness of the Department of Insurance's Opinion Letter).

⁴⁸ N.Y. INS. LAW § 3201(c).

⁴⁹ *Id.* § 4108(a).

⁵⁰ See Circular Letter No. 14, *supra* note 19. The Circular Letter is addressed to specific insurance entities, including Article 43 corporations, Health Maintenance Organizations ("HMOs"), and Commercial Insurers. Article 43 corporations are not-for-profit organizations that are formed pursuant to New York Insurance Law section 4301(a) and are heavily regulated by state insurance schemes. The Department regulates the filing and plan designs of HMOs in New York Insurance Law sections 12 and 13. Finally, Commercial Insurers are identified as insurers who are authorized to write policies for accident, life, health insurance, and annuities in New York. See Circular Letter No. 8, *supra* note 17; Circular Letter No. 14, *supra* note 19.

⁵¹ Circular Letter No. 14, *supra* note 19.

⁵² While the Department addresses these concerns in both of these letters, they have neglected to cite any circumstances in which they view adverse policy decisions as manifestly unjust. The closest they come is to state that recent cases have viewed

substantive change by instructing the Superintendent to decline policies that employ discretionary clauses as void against public policy.⁵³

The Department's second Circular Letter, which expressly supplanted the first, seemingly recognized its legal limitations and approached the problem from a different perspective and a markedly different tone.⁵⁴ The second letter addresses the same policy concerns with regard to discretionary clauses.⁵⁵ The Department concluded, however, that it would seek to enact legislation that would explicitly make discretionary clauses illegal rather than simply decline all policies that utilize discretionary clauses.⁵⁶ This approach ensured that the Department would avoid adverse judicial determinations brought in cases where discretionary clauses were still legal. Interestingly, it appears that the Department is much less certain of its institutional ability to prevent the use of discretionary clauses.⁵⁷

In addition to the positions stated in the aforementioned opinion letters—and those from other state insurance departments—the National Association of Insurance

discretionary clauses as “constricting the ability of the courts to exercise de novo review of policy provisions contained in the insurance policy or contract.” Circular Letter No. 8, *supra* note 17. It is unclear, however, what the Department is referring to, as they do not cite any cases or give any indication of the circumstances giving rise to this view. See Tolle & McNamara, *supra* note 47 (commenting that it is unclear to what cases the Department referred).

⁵³ See Circular Letter No. 8, *supra* note 17. Specifically, the Department urged that all insurance providers present the Commissioner with a description of discretionary clauses in their policies and a plan for their revision. If the providers did not comply, the Department threatened to withdraw approval of their policies under section 3210 of the Insurance Law. *Id.*

⁵⁴ See Circular Letter No. 14, *supra* note 19.

⁵⁵ See *id.*

⁵⁶ See *id.*

⁵⁷ Or perhaps the Department intended to coerce insurance companies into compliance with the threat of affirmative action and subsequently retreated from this strategy. In any event, the second letter seemingly indicates that the Department needs a legislative judgment that discretionary clauses in insurance policies are illegal to effectuate this substantive change. Interestingly, the California Insurance Department has also addressed this issue but opted to proceed on the strength of its own insurance provisions rather than attempting to pass legislation on the topic. See Letter from Gary M. Cohen, Gen. Counsel, Cal. Dep't of Ins., to Teresa S. Renaker, Esq., Lewis & Feinberg, P.C. (Feb. 26, 2004) (on file with California Department of Insurance) (responding to a request for determination as to whether discretionary clauses violate California insurance law).

Commissioners (“NAIC”)⁵⁸ in 2002 promulgated Model Act 42, entitled “Prohibition on the Use of Discretionary Clauses Model Act,” which, as its name implies, urges states to adopt legislation that prohibits discretionary clauses in health insurance contracts.⁵⁹ The advisory letters, opinions, and orders that have been issued from state insurance departments draw heavily on the language that appears in the Model Act in urging their legislatures to adopt the prohibition.⁶⁰ The text of the Model Act reads, in pertinent part:

No policy, contract, certificate or agreement offered or issued in this state by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

No policy, contract, certificate or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.⁶¹

The Model Act evinces a patent distrust of discretionary clauses primarily because they seem to infringe upon the protections

⁵⁸ NAIC is an organization whose mission is to “assist state insurance regulators . . . in serving the public interest” and achieve a variety of insurance regulatory goals. Nat. Ass’n of Ins. Comm’rs, About the NAIC, http://www.naic.org/index_about.htm (last visited Oct. 27, 2007).

⁵⁹ See NAT’L ASS’N OF INS. COMM’RS, PROJECT HISTORY: PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT (2002) [hereinafter PROHIBITION ON DISCRETIONARY CLAUSES]. The stated purpose of the Model Act is to “assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due.” *Id.* § 2.

⁶⁰ See, e.g., N.J. DEPT OF BANKING & INS., PROPOSED NEW RULE N.J.A.C. 11:4-58, at 3 (2006), http://www.nj.gov/dobi/proposed/prn06_268.pdf (noting that although New Jersey has not adopted the Model Act, New Jersey insurance law closely mirrors the general principles and has consistently rejected discretionary clauses in insurance contracts); Letter from Andalman to Redmer, *supra* note 17, at 2–6 (setting forth the grounds for adopting the Model Act in Maryland to declare all discretionary clauses illegal); Letter from Cohen to Renaker, *supra* note 57 (using the Model Act as support for the Insurance Department’s rejection of discretionary clauses in responding to a request for letter opinion).

⁶¹ PROHIBITION ON DISCRETIONARY CLAUSES, *supra* note 59, § 4(A)–(B).

afforded by insurance laws in every state. A few states have explicitly adopted the Model Act in an attempt to reestablish control over the regulation of benefits administration abuse that has allegedly been stripped away by this practice.⁶² While the Model Act seems to be somewhat restrictive in scope, some have suggested that it should include other insurance policies as well.⁶³

II. STANDARDS OF REVIEW FOR CLAIMS CONTESTING EMPLOYMENT BENEFITS

Although ERISA is an extensive piece of legislation, Congress did not undertake to define the appropriate standard of review for courts to employ in considering claims that challenge benefit administration. Rather, the federal court system has been left to develop its own standards to best effectuate the purposes of the Act.⁶⁴ The Supreme Court settled on the appropriate standard in its decision in *Firestone Tire & Rubber Co. v. Bruch*.⁶⁵ An examination of the *Firestone* decision and the implications of the two potential standards of review will demonstrate the important stakes at play.

In 1989, the Supreme Court decided *Firestone* and finally dictated the appropriate bounds for lower courts to determine the standard of review.⁶⁶ In *Firestone*, the District Court for the Eastern District of Pennsylvania granted summary judgment for Firestone after conducting a review of the record utilizing the

⁶² See Letter from Andalman to Redmer, *supra* note 17, at 1 (listing Maine, Oregon, and Minnesota as states that have already adopted the Model Act).

⁶³ See Letter from Cohen to Renaker, *supra* note 57, at 3 (arguing that NAIC did not intend the Model Act to be limited solely to health insurance and observing that NAIC is considering explicitly expanding its scope).

⁶⁴ See Sarah J. Weiland, *ERISA's Silence: Standards of Review in Deemed Denial Employment Benefits Claims*, 82 DENV. U. L. REV. 613, 626 (2005) (commenting that Congress intended ERISA to be silent with regard to a standard of review to allow the federal courts to develop a common law on point).

⁶⁵ 489 U.S. 101 (1989).

⁶⁶ In *Firestone*, the Firestone Tire & Rubber Co. sold one of its divisions to Occidental Petroleum Co. At issue was an unfunded severance plan that was governed by ERISA. By law, Firestone was the administrator and fiduciary of the plans, which was triggered by a "reduction in work force." *Id.* at 105-06. Two employees were rehired by Occidental and sought severance payments from Firestone under the termination pay plan. Firestone declined to extend the termination pay to the employees, maintaining that they did not suffer an appropriate reduction in workforce to trigger the plan. Firestone alone determined the meaning of "reduction in work force" under the plan. *Id.* at 106.

deferential arbitrary and capricious standard.⁶⁷ The Court of Appeals for the Third Circuit remanded, maintaining that the district court should have conducted a de novo review of the record.⁶⁸ Specifically, the court of appeals held that when a company doubles as the administrator of the policies as well, the potential conflict of interest requires the use of the more stringent de novo review.⁶⁹ Justice O'Connor delivered the opinion for a unanimous Court in holding that the appropriate standard of review in *Firestone* was de novo due to the potential conflict of interest in allowing the company full discretion over the implementation of the plan.⁷⁰ Nevertheless, Justice O'Connor explicitly left open the possibility of employing a deferential standard of review in the absence of a conflict of interest when full discretion is afforded to the plan administrator.⁷¹ As a result, the deferential standard continues to be employed by the various circuits as a means of efficiently allocating discretion to other responsible parties.

In addressing this issue, the Court reviewed the legislative history of ERISA and drew upon both contract and trust principles in the ruling.⁷² Specifically, ERISA codified "certain principles developed in the evolution of the law of trusts" and applied them to fiduciary responsibilities under the plan.⁷³ The Court found further justification for the use of deferential standards in several treatises on trust law.⁷⁴ The Supreme Court

⁶⁷ *Bruch v. Firestone Tire & Rubber Co.*, 640 F. Supp. 519, 534-35 (E.D. Pa. 1986), *rev'd in part*, 828 F.2d 134 (3d Cir. 1987).

⁶⁸ *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 149, 153 (3d Cir. 1987), *aff'd*, 489 U.S. 101 (1989).

⁶⁹ *Id.* at 144-45, 149.

⁷⁰ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

⁷¹ *Id.* at 111.

⁷² *Id.* at 110-13.

⁷³ H.R. REP. NO. 93-533 (1973), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4649. In fact, some of the central concepts and formulations of the Act rely on trust law terminology, such as the notions of a fiduciary and trustee relationship. *See Firestone*, 489 U.S. at 110.

⁷⁴ *Firestone*, 489 U.S. at 111. All of the sources that the Court cited stood for the proposition that trust law allows for a deferential standard of review when a trustee "exercises discretionary powers." *Id.*; *see* RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) ("Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion."); *see also* GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, *LAW OF TRUSTS AND TRUSTEES* § 560, at 188 (2d rev. ed. 1980) ("If the terms and extent of the power are clear, the court will not do the trustee's work . . . but will oblige him . . . the use of the judgment and discretion of

has also noted the legislative emphasis on trust law in other contexts aside from the discretionary authority in this case.⁷⁵ Ultimately, trust law dictates that if discretionary authority resides with a trust administrator, a court should only review decisions made by the administrator under a deferential standard.⁷⁶ Specifically, the Restatement (Second) of Trusts notes that the court will not interfere unless

the trustee in exercising or failing to exercise the power acts dishonestly, or with an improper even though not a dishonest motive, or fails to use his judgment, or acts beyond the bounds of a reasonable judgment. The mere fact that if the discretion had been conferred upon the court, the court would have exercised the power differently, is not a sufficient reason for interfering with the exercise of the power by the trustee.⁷⁷

The Restatement goes on to identify specific circumstances in detail and offers illustrations to guide the judiciary.⁷⁸

Thus, relying on the explicit terms of the agreement and noting that ERISA "abounds with the language and terminology of trust law,"⁷⁹ the Court determined the appropriate standard of review for the plan before the Court. Importantly, the Court noted that trust law distinguishes between mandatory and discretionary powers delegated by the trust instrument itself to interpret terms.⁸⁰ Accepted principles of trust law, however, hold

the trustee.").

⁷⁵ See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 84–85 (1995) (holding that ERISA follows trust law by binding a company to the chosen specificity of its amendment procedures for reservation clauses); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 151–52 (1985) (determining that the legislative history of ERISA indicates that Congress intended to incorporate the fiduciary standards of trust law into the statutory scheme). *But see Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999) ("Although trust law may offer a 'starting point' for analysis in some situations, it must give way if it is inconsistent with 'the language of the statute, its structure, or its purposes.'" (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996))).

⁷⁶ See RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) (delineating when the powers of the trustee are discretionary and determining when the judiciary should overturn their determinations).

⁷⁷ *Id.* § 187 cmt. e.

⁷⁸ *Id.* § 187 illus. *passim*. The illustrations provided in the Restatement cover a wide variety of circumstances and lay a basic framework for the courts to utilize.

⁷⁹ *Firestone*, 489 U.S. at 110.

⁸⁰ *Id.* at 111 (quoting AUSTIN WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, *THE LAW OF TRUSTS* § 187, at 14 (4th ed. 1987)). Interestingly, the Court injected principles of contract law into its decision at that point by implicitly rejecting the trust law doctrine that the terms of the plan may be adequate when

that the court is not bound by the instrument and can extend the duties of the trustee as “determined by the rules of law that are applicable to the situation . . . 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 by his attorney.”⁸¹ This emphasis on judicial discretion is in keeping with the Congressional intent behind the passage of ERISA: The judiciary is able to fashion a common law regarding the standard of review for adjudicating ERISA claims, rooted in principles of trust law.⁸²

In establishing these principles as guidance in future litigation, the Court determined that this scheme best “protect[ed] contractually defined benefits”⁸³ as provided under ERISA and effectively “promote[d] the interests of employees and their beneficiaries in employee benefit plans.”⁸⁴ Recognizing the degree of uncertainty that could arise when the plan administrator is unsure whether the terms of the instrument allocate full discretion, the Court emphasized that nothing prohibits the party from obtaining instructions from the court for protection.⁸⁵ The *Firestone* decision has been implemented in courts across the country and has laid the groundwork for a relatively uniform implementation in benefit claims litigation.⁸⁶

implied and construed as such by the courts. Here, the Court created a requirement that discretionary authority be vested in the clear, exact language of the plan. *Id.* at 112–13. The Court looked to actions brought for denial of benefits before the enactment of ERISA for guidance, determining that they were overwhelmingly decided on the basis of contract law. *Id.* This seemingly grafts principles of contract interpretation onto the trust-heavy doctrine already created. See Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1114 (2001) (arguing that this paradigm is consistent with ERISA’s policy of clarity for the beneficiary, but inconsistent with the policy of fairness in the claims review process).

⁸¹ SCOTT & FRATCHER, *supra* note 80, § 201.

⁸² See *supra* note 75 and accompanying text.

⁸³ *Firestone*, 489 U.S. at 113 (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)).

⁸⁴ *Id.* (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)).

⁸⁵ *Id.* at 112.

⁸⁶ Following *Firestone*, which laid down the basic principles for determining the appropriate standard of review, the most litigated issue in this regard centered around determining what language effectively conferred discretionary authority upon the plan administrator. “[M]agic words such as ‘discretion’ and ‘deference’ may not be ‘absolutely necessary’ to avoid a stricter standard of review . . .” *Jordan v. Ret. Comm. of Rensselaer Polytechnic Inst.*, 46 F.3d 1264, 1271 (2d Cir. 1995) (quoting *Schein v. News Am. Publ’g, Inc.*, No. 89-0052, 1991 WL 117638, at *4 (S.D.N.Y. June 24, 1991)). The New York Insurance Department provided two examples of clauses that have been deemed to adequately confer discretionary

In the aftermath of *Firestone*, courts across the country have participated in the invitation to apply a relaxed, deferential standard of review when discretion has been conferred on a plan administrator.⁸⁷ Some circuits employ the same arbitrary and capricious standard as the Second Circuit.⁸⁸ Other circuits employ a slightly different standard of "abuse of discretion."⁸⁹ Some circuits have suggested the difference between these two relaxed standards is a "semantic, not a substantive" one.⁹⁰

Because all of the circuits have decided to employ a deferential standard, it is important to recognize the implications. Under a deferential standard of review, only the rarest of circumstances give rise to an adverse judgment, and plan administrators are free to craft and interpret policies with minimal judicial oversight.⁹¹ On the other hand, a *de novo*

authority to the administrator. See Circular Letter No. 8, *supra* note 17 ("[T]he company has full, exclusive, and discretionary authority to determine all questions arising in connection with the policy, including its interpretation . . ."). Without such direct language, courts have held that the plan language must unambiguously demonstrate that the plan administrator has authority to construe the terms of the plan. See, e.g., *Kennedy v. Georgia-Pacific Corp.*, 31 F.3d 606, 609 (8th Cir. 1994) ("[T]he Plan Administrator . . . shall be solely responsible for the administration and interpretation of this Plan."). Nevertheless, the administrator must be careful to ensure that the language is clear. See *Sandy v. Reliance Standard Life Ins. Co.*, 222 F.3d 1202, 1207 (9th Cir. 2000) (holding that a plan requiring the beneficiary to submit "satisfactory proof of Total Disability to [the Plan Administrator]" does not confer sufficient discretion to trigger a deferential standard of review). For an argument that the holding in *Firestone* misconstrues the principles of trust law and merely functions to cause plan administrator's to insert clear language into plans to gain the deferential review, see John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 S. CT. REV. 207 (1990).

⁸⁷ For an overview of the differing approaches taken by all the circuits with regard to various issues of ERISA litigation, see ERISA SURVEY OF FEDERAL CIRCUITS (Brooks R. Magratten ed., 2d ed. 2007). This comprehensive text examines the approach taken in every circuit regarding both substantive and procedural issues.

⁸⁸ See *supra* notes 14–16 and accompanying text; see also *Sperandeo v. Lorillard Tobacco Co.*, 460 F.3d 866, 870 (7th Cir. 2006); *Tsoulas v. Liberty Life Assurance Co. of Boston*, 454 F.3d 69, 76 (1st Cir. 2006); *Smith v. Cont'l Cas. Co.*, 450 F.3d 253, 258–59 (6th Cir. 2006); *Groves v. Met. Life Ins. Co.*, 438 F.3d 872, 874 (8th Cir. 2006); *Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 281–82 (3d Cir. 2005).

⁸⁹ See *Donovan v. Eaton Corp., Long Term Disability Plan*, 462 F.3d 321, 326 (4th Cir. 2006); *Baker v. Met. Life Ins. Co.*, 364 F.3d 624, 629 (5th Cir. 2004).

⁹⁰ *Wildbur v. ARCO Chem. Co.*, 974 F.2d 631, 635 n.7 (5th Cir. 1992).

⁹¹ This does not mean that insurance administrators are free to abuse the system; they must still operate within the confines of the state insurance laws which are enacted to regulate and protect consumers. Additionally, like any other product being offered, insurance is subject to market forces and therefore insurance companies must offer acceptable coverage to remain competitive.

standard of review requires strict judicial oversight and, effectively, a second look at adverse plan determinations. Because of the polarization of these implications, it is crucial to understand and weigh the policy concerns underlying each of these positions to fully grasp what the Department intends to accomplish in New York.

III. WHY THE COURTS SHOULD CONTINUE TO USE A DEFERENTIAL STANDARD

Although federal courts have continuously upheld the principles laid down in *Firestone* that have functioned to further the policy of ERISA and provide clarity for crafting benefit plans,⁹² commentators continue to debate the wisdom of the *Firestone* decision.⁹³ While these concerns warrant discussion, ultimately the current standards prove adequate to safeguard the policies behind ERISA and the parties intended to be protected.

A. Protection for Policyholders Is Adequate

Along with the New York Insurance Department, several other commentators and organizations have raised policy concerns regarding the current scheme.⁹⁴ The Department's first

⁹² Clarity has been achieved by demonstrating the necessary language and provisions to either fall into or out of the deferential category.

⁹³ See, e.g., Julia Field Costich, Note, *Denial of Coverage for "Experimental" Medical Procedures: The Problem of De Novo Review Under ERISA*, 79 KY. L.J. 801, 825–27 (1991) (discussing the impact of employing ERISA's de novo standard of review for disbursement of medical benefits with experimental medical treatments); Kennedy, *supra* note 80, at 1167–76 (arguing for a rule that review be de novo by default); Langbein, *supra* note 86, at 211–12 (arguing that the Supreme Court has misconstrued trust law as its foundation by equating private trusts with the trusts that appear in ERISA); Peter A. Meyers, Comment, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 SEATTLE U. L. REV. 925, 951–53 (2005) (concluding that ERISA's quasi-administrative model is compromised by allowing conflicted fiduciaries to make crucial determinations without appropriate oversight). But see Tolle & McNamara, *supra* note 47 (arguing that there are many benefits to all parties in maintaining the standards set forth in *Firestone*).

⁹⁴ For example, the California Insurance Department has made similar public statements regarding the use of discretionary clauses as New York. See Cal. Dep't of Ins., Notice to Withdraw Approval and Order for Information (Feb. 27, 2004), <http://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/Notice-February-27-2004.pdf> [hereinafter California Insurance Letter]. The federal courts in California will soon be hearing arguments in a case that challenges the use of discretionary clauses in insurance policies based on

argument is that because the courts cannot conduct a de novo review, discretionary clauses can effectively “negate essential features of the policies, contracts, and certificates”⁹⁵ by rendering policies “illusory by nullifying the insurer’s, Article 43 corporations or HMO’s responsibility to pay.”⁹⁶ Boiled down, the Department is concerned that the administrator can now determine the terms of the policies differently than the allegedly agreed-upon terms. Taken to the extreme, this implies a complete perversion of trust law and it would effectively preclude any reliance upon insurance contracts in any substantive form. John Langbein commented that the *Firestone* opinion effectively invites administrators to introduce common “boilerplate language” that removes the plan from de novo review:

The Court in [*Firestone*] may have thought it was being prudential in resting its decision on a narrow ground, but in conditioning its requirement of de novo review on the language of the plan document, the Court may have found a ground so narrow as to be self-defeating. The Court’s emphasis . . . on the trust instrument as the basis for deferential review raises the prospect that an ERISA plan may opt out of [*Firestone*’s] de novo review and back into the pre-*[Firestone]* world of judicial deference merely by inserting some boilerplate to that effect in the plan instrument. Indeed . . . the Court seems to invite plan drafters to trump the decision by instrument.⁹⁷

Langbein goes on to cite several possible scenarios that would trigger this effect, effectively arguing that plan drafters will begin to develop language that will function as an opt-out provision and essentially subvert the purpose of trust law.⁹⁸

Although this concern is legitimate, there is a myriad of examples that demonstrate that these detractors do not describe the reality of the situation. It must be recognized that in a system that employs trust law principles in terms of allocating discretion, there is a narrow opportunity for abuse.

this letter. See *Burotto v. Cont’l Cas. Co.*, 163 F. App’x 565 (9th Cir. 2006). This is in addition to the other commentators who have criticized the use of deferential standards of review. See *supra* note 93 and accompanying text.

⁹⁵ Circular Letter No. 14, *supra* note 19; see also California Insurance Letter, *supra* note 94, at 1 (“[T]he discretionary clause makes those payments contingent on the unfettered discretion of the insurer, thereby nullifying the promise to pay and rendering the contract potentially illusory.”).

⁹⁶ Circular Letter No. 14, *supra* note 19.

⁹⁷ Langbein, *supra* note 86, at 220.

⁹⁸ See *id.* at 220–22.

Nevertheless, out of the millions of decisions made annually with regard to disbursement of benefits, only a tiny percentage are disputed. In the face of this reality, it is difficult to imagine that the current system does not provide adequate protection, especially when the administrators remain accountable on several grounds.

Importantly, a deferential standard of review does not automatically accord complete affirmation of decisions. A majority of cases that arise in the federal court system uphold the decisions of plan administrators; however, this is merely indicative of a system grounded in trust principles functioning appropriately. As mentioned previously, one of the primary functions of trust law is to accord significant discretion to a party while maintaining the appropriate review mechanisms in place to guard against systemic abuses.⁹⁹ In fact, certain trust principles explicitly guard against these abuses.¹⁰⁰ These safeguarding provisions essentially leave two options: find an adequate violation of public policy, or illegality.¹⁰¹ It appears as though the Second Circuit has opted to pursue the illegality route as opposed to vesting their argument solely on public policy grounds. Courts across the country have consistently upheld the legality of discretionary clauses in insurance contracts in the absence of legislation to the contrary.¹⁰² The nearly unanimous judicial acceptance of discretionary clauses also indicates that they should not be void against public policy since *Firestone* does not mandate use of deferential standards. Thus, the adoption of the deferential standard of review has been an affirmative decision on the part of the federal judiciary after weighing the factors for and against utilizing this scheme. Ultimately, judicial

⁹⁹ See *supra* text accompanying notes 73–78.

¹⁰⁰ See RESTATEMENT (SECOND) OF TRUSTS § 60 (1959) (providing that “a provision in the terms of a trust is invalid if illegal”); see also *id.* § 61 (stating that a trust provision is invalid if its enforcement would render it contrary to public policy).

¹⁰¹ *Id.* § 60 cmt. a (“An intended trust or a particular provision in the terms of the trust may fail for illegality where . . . the enforcement of the intended trust or provision would be against the public policy, even though its performance does not involve the commission of a criminal or tortious act by the trustee . . .”).

¹⁰² For a general overview of the acceptance of plan language in the various circuits, see ERISA SURVEY OF FEDERAL CIRCUITS, *supra* note 87. The editor of the text has specifically delineated the plan language that has been used, circuit by circuit. The common vein among all circuits is that discretionary language has been accepted in every circuit, although the specific language that has been deemed acceptable may differ.

adoption and continued use of this method should be accorded significant weight.

Additionally, although there are rare circumstances in which it might be argued that the result of a decision is inequitable, on the whole the current scheme provides more than sufficient protection against abuses of discretion. Time and time again the current system affording significant discretion has proven to be a just standard leading to equitable results.¹⁰³ Proponents of rendering discretionary clauses illegal in their respective states undoubtedly are trying to advance their legitimate interests in ensuring that the policyholders in their states are afforded as much protection as possible while maintaining as much control at the state regulatory level. Without discounting the legitimate purpose that they have in mind, adjusting the current scheme is unnecessary and would simply serve to undermine many years of clearly established federal judicial practice in enforcing agreements.

B. State Law Is Not Sufficiently Impacted

Some commentators suggest that discretionary clauses run afoul of New York insurance law because they are unjust and intended to deceive the policyholder.¹⁰⁴ It is argued that, taken together, the fact that discretionary clauses allow administrators to sidestep agreements made in the insurance policy and may be

¹⁰³ In addition to the myriad of benefit determinations made by plan administrators daily that are ultimately equitable, in those rare circumstances when the benefit determinations are manifestly unfair, the courts have overturned the determination. *See, e.g.*, *Carolina Care Plan, Inc. v. McKenzie*, 467 F.3d 383, 384–90 (4th Cir. 2006) (upholding the district court's determination that an insurance company abused its discretion in denying a cochlear implant despite repeated authorizations from plaintiff's physician); *DeGrado v. Jefferson Pilot Fin. Ins. Co.*, 451 F.3d 1161, 1174–76 (10th Cir. 2006) (holding that a plan administrator's decision to treat the beneficiary's disability as recurrent rather than new was arbitrary and capricious).

¹⁰⁴ Circular Letter No. 14, *supra* note 19. This is also raised in the case of *Burotto v. Continental Casualty Co.*, 163 F. App'x 565 (9th Cir. 2006), in which the claimants allege that discretionary clauses violate California insurance law because the policies are rendered fraudulent. California employs a similar paradigm as New York in its insurance law. Specifically, like New York, it provides that an Insurance Commissioner cannot approve an insurance policy that fails to "conform in any respect with any laws of this state." CAL. INS. CODE § 10291.5(b)(13); *cf.* N.Y. INS. LAW § 3201(b)(1) (McKinney 2000) ("No policy . . . shall be delivered or issued . . . unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law.").

deceptive in nature serves to effectively erode the protections that are afforded by insurance laws.¹⁰⁵ In other words, the detailed state insurance scheme is largely rendered ineffective if the plan administrator has sole discretion over interpretation of the terms of an agreement and the judicial system affords him significant discretion, even though the policy must be crafted within the body of relevant insurance law. The appellants in *Burotto v. Continental Casualty Co.* argued that the state law protections that are built into the insurance laws would be rendered inapplicable to the policies although the policies purport to comply with applicable state regulations.¹⁰⁶ Specifically, they argue that discretionary language deprives the insured of protections of California law, because courts reviewing benefits decisions for abuse of discretion will not apply state law principles such as the rule of *contra preferentem* and the doctrine of reasonable expectations, under which ambiguities are resolved in the insured's favor. Policy language that allows the insurer to evade these state-law protections "fails to conform" to state law within the meaning of California Insurance Code section 10291.5(b)(13).¹⁰⁷ Thus the California Insurance Department's current judicial scheme for reviewing claims of adverse policy decisions not only violates public policy, but also sanctions a subversion of well-established principles of state law.¹⁰⁸

What this position overlooks is that most applications of state law are rendered irrelevant by ERISA's sweeping preemption provision.¹⁰⁹ Unless the state law is specifically aimed at regulating insurance, ERISA governs.¹¹⁰ This in turn means that unless there is a state law on point that is saved from preemption, trust law principles will govern interpretation. Even if there are state laws that are saved from preemption, these protections would only be sacrificed in the rare circumstances

¹⁰⁵ See California Insurance Letter, *supra* note 94, at 1 ("[Discretionary] clauses effectively deprive California insureds of protections under California law."). In New York, the protections afforded by the insurance scheme are those specific provisions that protect unfair or deceptive trade practices. See Circular Letter No. 14, *supra* note 19.

¹⁰⁶ Opening Brief of Appellant at 29–32, *Burotto*, 163 F. App'x 565 (No. 04-55180).

¹⁰⁷ *Id.* at 33 (citations omitted).

¹⁰⁸ See *supra* note 19.

¹⁰⁹ 29 U.S.C. § 1144(a) (2000).

¹¹⁰ 29 U.S.C. § 1144(b)(2)(A).

where a court could not determine that a decision by a plan administrator that allegedly violates a state insurance provision was not an abuse of discretion. When the beneficiary of an insurance policy has been unfairly deprived of the benefits that flow from their policy, more often than not, the administrative record will suffice for a fair and adequate judicial determination.

C. *Adverse Determinations Will Be Mitigated by Business Self-Interest*

Finally, the Department also argues that perhaps the biggest injustice achieved by utilizing this scheme is that it deprives the policyholder of effective access to fair judicial review, and essentially condones a potentially severe injustice.¹¹¹ In effect, they assert that the current paradigm denies the policyholder of his statutorily required right to appeal.¹¹² The underlying assumption with this argument is that policyholders should be afforded the same degree of judicial review as any other suit for breach of contract. In essence, the right to judicial review under ERISA standards would be truncated by the undue deference afforded to plan administrators in contravention of the stated policy to protect policyholders.¹¹³ The alleged result is that without significant judicial oversight and the threat of a serious adverse decision, the system lends itself to abuse at the hands of plan administrators.

In addition to the protections that are afforded by trust law and the adequate safeguard offered by the judicial system mentioned previously, this argument overlooks one important factor that provides an additional safeguard against serious abuses. Namely, every insurance company has a vested interest in ensuring that its customers are satisfied with their coverage. If an insurance company develops a reputation for being ineffective or unreliable, that insurance company will likely not find success within an industry teeming with other providers. While an occasional adverse determination might not have a drastic impact on its business outlook, the company will be

¹¹¹ See Circular Letter No. 14, *supra* note 19.

¹¹² *Id.* For an example of a statutorily defined right "to recover benefits due to [an insured] under the terms of his plan," see 29 U.S.C. § 1132(a)(1)(B).

¹¹³ See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983) ("ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans.").

seeking to ensure that it does not become a regular phenomenon. Thus, allocating discretion to plan administrators works efficiently because the administrators have a concurrent interest in ensuring the livelihood of their business.

Closely tied to this concern are the economic ramifications of increased litigation. Additional litigation ultimately means that the insurance company, along with the beneficiaries, will have additional costs. Unfortunately, these costs will not be quietly absorbed by the company. Rather, they will be passed along to the plan participants. With insurance costs already extremely high, both sides should be interested in keeping costs down. Plan participants often find it difficult to make payments already, and insurance companies do not want the negative business implications of rising costs. The scheme currently in place provides the appropriate balance between ensuring that the beneficiaries are protected from arbitrary or unjust benefit determinations, while simultaneously stemming the tide of potential litigation and keeping costs down on many fronts. Altering the current system without the benefit of significant congressional study and debate would prove an unwise departure from established practice and precedent.

D. Additional Factors Warrant Maintaining the Current Approach

A primary benefit to the judicial system of the current standard of review scheme based on trust law is the increased judicial efficiency. This efficiency is accomplished by placing discretion in the hands of an appropriate, responsible figure, which requires minimal judicial oversight, and thus less of the court's time and energy. The trust principles that led the *Firestone* Court to establish a potentially deferential standard of review go hand-in-hand with the discovery rules under ERISA, which provide a similar increase in efficiency and conservation of resources.¹¹⁴ Regulations limit discovery in ERISA cases significantly when a deferential standard applies. Reducing the scope of review to the administrative record decreases the cost to

¹¹⁴ An ERISA plan administrator is required to comply with the procedural requirements set forth in 29 U.S.C. § 1133 and the regulations in 29 C.F.R. § 2560.503-1. See *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1007 n.4 (4th Cir. 1985).

litigants and conserves judicial resources by significantly decreasing the amount of review required.

Likewise, the efficiency goals of the judiciary go hand-in-hand with the explicit efficiency goals of ERISA. One stated goal of ERISA is to encourage the private resolution of disputes:

Within the labor context federal courts have consistently favored internal resolution procedures in order to promote orderly settlement of disputes . . . and to avert whenever possible the expense and delay incident to resort to the courts. ERISA also endorsed this policy by conferring broad managerial discretion upon the pension plan trustees, who are primarily responsible for devising and implementing claims procedure.¹¹⁵

Thus, requiring the courts to conduct a thorough, *de novo* review of every adverse administrative decision arising under ERISA could subvert the stated policies of internal resolution.¹¹⁶ It is argued that a deferential standard of review discourages parties from resorting to the court to seek judicial remedy. With the federal court system already strained, "[p]ermitting district courts to consider evidence not presented to the plan administrator would 'seriously impair' ERISA's efficiency goals"¹¹⁷ and increase the burden on an already over-burdened system.¹¹⁸ While the *Firestone* Court noted that "the threat of increased litigation is not sufficient to outweigh the reasons for a *de novo* standard,"¹¹⁹ when considered in conjunction with the public policy arguments already noted, it warrants consideration. By allowing courts to alleviate their burden by affording discretion to plan administrators, the courts serve the two-fold function of reducing their own caseload and time constraints and promoting ERISA's goals of private resolution.

As mentioned previously, a deferential standard of review also results in less time and money spent in litigating decisions of the administrator. Mandating a *de novo* review of the record

¹¹⁵ *Grossmuller v. Local 813, Int'l Union, United Auto., Aerospace and Agric. Implement Workers*, 715 F.2d 853, 857 (3d Cir. 1983) (citations omitted).

¹¹⁶ *See id.* (discussing the endorsement of internal resolution procedures of adverse benefit claims in the legislative history of ERISA).

¹¹⁷ *Stanley v. Metro. Life Ins. Co.*, 312 F. Supp. 2d 786, 790 (E.D. Va. 2004).

¹¹⁸ Under an abuse of discretion standard the court is limited to reviewing the administrative record. A *de novo* review would expand the scope of permissible review, allowing the court to consider matters outside of the administrative record and to substitute its own judgment for the plan administrator's. This obviously requires a great deal more time, effort, and expense to accomplish.

¹¹⁹ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

could potentially “involve far-reaching, open-ended, nearly limitless discovery.”¹²⁰ Additionally, the extra incurred costs and time would “frustrate the [policy of] prompt and affordable resolution of benefit claims.”¹²¹ Thus, the system of deferential treatment saves all of the parties the costs associated with time-consuming litigation in favor of simply passing on the administrative record for review and emphasizing significant trust in the plan administrators making the initial decision giving rise to the litigation.

Additional consideration should be given to congressional inaction when confronted with this very issue in a bill that was introduced in 1982, before the *Firestone* case had been decided.¹²² The *Firestone* Court noted that although the bill failed to pass, such failure may not be indicative of a legislative intent to acquiesce to the deferential standard.¹²³ Furthermore, the fact that Congress has not revisited the issue in any subsequent sessions indicates that the issue is not of sufficient priority to warrant drastic action. This is particularly true considering the explicit recognition of the importance of ERISA,¹²⁴ and the clear movement by many parties, including those in state governments, to advocate for a change. While congressional silence does not necessarily equate with acquiescence, the nearly twenty-five year silence since H.R. 6226 was proposed in 1982 provides some indication that Congress does not feel it necessary to address at this time.

Finally, as evidenced by the extensive treatment that the *Firestone* Court gave the topic,¹²⁵ the federal court system has consistently construed issues arising out of ERISA litigation in terms of the stated emphasis and reliance upon principles drawn from trust law.¹²⁶ With this in mind, passing legislation that would eliminate the use of discretionary clauses in insurance contracts would directly subvert the explicit intent of Congress in enacting ERISA. The appropriate paradigm for considering

¹²⁰ *Newman v. Standard Ins. Co.*, 997 F. Supp. 1276, 1280 (C.D. Cal. 1998).

¹²¹ *Stanley*, 312 F. Supp. 2d at 791.

¹²² H.R. 6226, 97th Cong. (2d Sess. 1982).

¹²³ *Firestone*, 489 U.S. at 114.

¹²⁴ See WOOTEN, *supra* note 5, at 1 (“[T]he pension reform bill,’ [Senator Jacob Javits] told his Senate colleagues, ‘is the greatest development in the life of the American worker since social security.’” (first alteration in original)).

¹²⁵ *Firestone*, 489 U.S. at 110–15.

¹²⁶ See *supra* notes 87–90 and accompanying text.

issues raised through ERISA litigation is through the lens of trust law, which not only allows for discretionary authority but also encourages it.¹²⁷ In fact, allowing discretionary authority is one of the mainstays of trust law.¹²⁸ Eliminating this feature of insurance regulation would strip a major characteristic from the trust relationship between plan administrators and beneficiaries and effectively neuter the trust aspects of the ERISA scheme. State courts should be prevented from taking these matters into their own hands because the interpretations at the state level could directly contravene the explicit intent of Congress. If a change should be deemed necessary, it should occur at the federal level to ensure congressional control over the statute that Congress took great pains to pass in the first place. In addition, this would ensure continued uniformity with regard to judicial review under ERISA and allow insurance companies to be completely cognizant of the risks and rewards of policy language they choose to include.

CONCLUSION

ERISA's passage was the product of many years of failed attempts to regulate the private pension system through various mechanisms.¹²⁹ The result was a comprehensive statute that has effectively regulated the insurance industry since its passage, providing much needed guidance and uniformity in the system. The current movement toward eliminating the use of discretionary clauses represents an unnecessary departure from the system that Congress established and the principles that provide its foundation. This action would significantly alter the landscape of both ERISA litigation and the insurance industry as a whole, with far-reaching implications. Removing the ability of the judicial system to defer to plan administrators unnecessarily handcuffs the courts into reviewing adverse claims in increasing amounts.

To quote the old adage, "if it ain't broke, don't fix it." There is no pressing need to alter the current state of ERISA litigation due to the many safeguards present explicitly in the statute and impliedly in the business of insurance. In the end, any alteration

¹²⁷ See generally RESTATEMENT (SECOND) OF TRUSTS § 187 (elaborating on the extent of discretionary powers in trust relationships).

¹²⁸ *Firestone*, 489 U.S. at 111 (discussing the principles of trust law).

¹²⁹ See *supra* notes 23–33 and accompanying text.

would be a costly mistake, both to the judiciary and to all of the future insurance beneficiaries upon whom the economic burden of this action would fall.

