

Journal of Contemporary Health Law & Policy (1985-2015)

Volume 26 | Issue 2

Article 8

2010

The Effect of Metropolitan Life v. Glenn on ERISA Benefit Denials: Time for the "Treating Physician Rule"

James Goodley

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

Recommended Citation

James Goodley, *The Effect of Metropolitan Life v. Glenn on ERISA Benefit Denials: Time for the "Treating Physician Rule"*, 26 J. Contemp. Health L. & Pol'y 403 (2010).

Available at: <https://scholarship.law.edu/jchlp/vol26/iss2/8>

This Comment is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

THE EFFECT OF METROPOLITAN LIFE V. GLENN ON ERISA BENEFIT DENIALS: TIME FOR THE “TREATING PHYSICIAN RULE”

*James Goodley**

I. INTRODUCTION

Consider the following hypothetical: imagine you become ill or injured and your longtime family doctor determines that you are unable to return to your job as a result of this illness or injury. Fortunately, in the course of your thirty years of service to your employer, you secured a disability benefit plan. You apply to the insurance company which your employer contracts with to administer its disability benefits. Despite strong evidence from your treating physician concluding that you are disabled and unable to continue working, the insurance company denies your disability benefit, relying solely on the evidence of its hired consulting physician. The insurance company’s physician, with whom you have no prior medical history, reviewed your medical records, rejected your family doctor’s opinion, and determined that you are able to work.

In consideration of your physical condition, you believe that you cannot return to work. Determining that your social security disability is not sufficient to support your family absent the sale of your home, you spend thousands of dollars of your savings in attorney’s fees to appeal the insurance company’s decision to deny your claim in federal district court. The court determines that the insurance company operated under a conflict of interest because it makes the benefit determinations and pays out the benefits. However, in weighing the conflict of interest against the insurance company’s benefit determination, the court decides that the circumstances presented by your case are insufficient to reverse the insurance company’s decision because the insurance company’s decision was not an *abuse of discretion*. You lose. Your attorney informs you that a further appeal will not succeed. Faced with few options, you give up, sell your home, and move in with your twenty-five year-old newly married son and his wife in a small, crowded apartment. Stories like these are entirely possible under employee benefits law today.

In *Black & Decker v. Nord*,¹ Kenneth Nord consulted with his personal treating physician about hip and back pain he was experiencing.² The doctor,

* J.D. candidate, May 2011, at The Catholic University of America, Columbus School of Law. The author would like to thank his parents for their support and Professor Jack Leary for his advice on this Comment and ERISA law.

in concurrence with Nord's three other treating orthopedic physicians, determined that Nord suffered from lumbar disc syndrome and would be unable to return to work until he made a full recovery.³ Relying on the evidence of its own hired non-treating physician, the insurance company reversed the opinion of the treating physicians.⁴ The Supreme Court found that the insurance company "was not obligated to accord special deference to the opinions of treating physicians."⁵ The Fifth Circuit followed the precedent set forth in *Nord*, and stated "[c]ourts cannot second guess the weight that [the insurer] gave to the treating physician's and the [insurance company hired] independent expert's respective opinions."⁶

This Comment will demonstrate the failure of the Court in *Metropolitan Life v. Glenn*⁷ to adequately address the problem of conflicts of interest in The Employee Retirement Income Security Act of 1974 (ERISA) benefit determinations. The Comment focuses almost exclusively on disability cases.⁸ It considers situations where a claimant has been denied a benefit from an insured plan in which an insurance company makes ultimate benefit decisions, or where the employer retains the right to reverse the insurer's decision.⁹ This Comment will begin by analyzing the background of ERISA¹⁰ and relevant court decisions, including *Glenn*. These cases have

-
1. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002).
 2. *Id.* at 826-27.
 3. *Id.* at 826.
 4. *Id.* at 827.
 5. *Black & Decker v. Nord*, 538 U.S. 822, 825 (2003).
 6. *See Young v. Wal-Mart Stores, Inc.*, 293 F.App'x. 356, 363 (5th Cir. 2008) (citing *Corry v. Liberty Life Assurance Co. of Boston*, 499 F.3d 389, 401 (5th Cir. 2007); *Gothard v. Metro. Life Ins. Co.*, 491 F.3d 246, 249 (5th Cir. 2007)).
 7. *Metro. Life v. Glenn*, 128 S. Ct. 2343 (2008).
 8. The analysis included in this Comment can be extended into other welfare benefits, such as health and death benefits.
 9. Additionally, the analysis in this Comment can be extended into self-insured plans, where an insurer is not involved.
 10. *See infra* Part II.

determined the judicial standard of review with respect to benefit determinations made by conflicted ERISA fiduciaries, as well as the method of applying the standard of review. This Comment will synthesize general rules from post-*Glenn* cases by considering the role that the conflict of interest factor plays, as well as the facts that courts have determined are probative in reversing a conflicted fiduciary’s decision. This synthesis will also highlight when determinations have been made by a plaintiff’s treating physician, and when that determination can legally be overridden by a physician hired by an insurance company for a one-time examination (or even no actual physical examination at all). This Comment will then argue that the *arbitrary and capricious* standard has been inappropriately imported into court review of ERISA benefit determinations without the corresponding checks and balances that exist in the public-sector administrative law setting. It will demonstrate that greater checks and balances are needed to counter the damage that a conflict of interest may cause with respect to the integrity of the benefits determination process. Finally, this Comment will demonstrate why the “Treating Physician Rule” (TPR) is a proper rule to impose on ERISA fiduciaries and, while noting potential problems with the rule, counter arguments against its adoption.

II. BACKGROUND

A. *The Employee Retirement Income Security Act*

ERISA provides certain procedural safeguards for workers with respect to their employer-provided pension and welfare plans. ERISA states:

It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.¹¹

Employee benefit plans covered under ERISA include, *inter-alia*, pension plans¹² and employee welfare benefit plans, such as medical, disability, and death benefit plans.¹³ ERISA provides that a plan fiduciary¹⁴ “shall

11. Employee Retirement and Income Security Act of 1974, 29 U.S.C. § 1001(b) (2006).

12. *Id.* at § 1002(2)(A).

13. *Id.* at § 1002(1).

discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries.”¹⁵ ERISA also provides that a “civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan.”¹⁶ Finally, ERISA sets out the internal claims procedures that plan fiduciaries must follow in making benefit determinations by stating:

In accordance with regulation of the Secretary, every employee benefit plan shall- (1) provide adequate written notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied a *full and fair review* by the appropriate named fiduciary of the decision denying the claim.¹⁷

Although the Secretary of Labor has further defined what constitutes a “full and fair review” under Department of Labor regulations,¹⁸ the judicial standard of review regarding benefit denials (i.e. *de novo* or *arbitrary and capricious*) had not been defined in either the statute or regulations.¹⁹

B. The Bruch Standard of Review

In *Firestone Tire v. Bruch*,²⁰ the controlling case establishing the boundaries of judicial review with respect to denials of benefits made by ERISA plan fiduciaries, the Supreme Court held that the standard of review for benefit denials would be *de novo*.²¹ However, if plan administrators

14. *Id.* at § 1002(21)(A) (defining a fiduciary).

15. *Id.* at § 1104(a)(1).

16. *Id.* at § 1132(a)(1)(B).

17. *See* Employee Retirement and Income Security Act of 1974, 29 U.S.C. § 1133 (2006) (emphasis added).

18. Employee Retirement and Income Security Act of 1974, 29 C.F.R. § 2560.503-1(h)(2) (2006) (defining “full and fair review”).

19. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989).

20. *Id.*

21. *Id.* at 115.

agreed,²² they could establish a deferential standard of review, *abuse of discretion*, through controlling plan documents.²³ This is essentially identical to the *arbitrary and capricious* standard.²⁴ Employers and unions administering ERISA plans wanted more control of, and deference to, their decision making.²⁵ Consequently, and in response to *Bruch*, many plans provided provisions including the abuse of discretion standard of review in controlling plan documents.²⁶ *Bruch* stated in dicta that if an ERISA plan administrator operates under a conflict of interest, that conflict of interest must be weighed as “a factor in determining whether there is an abuse of discretion.”²⁷ However, *Bruch* did not comment on what a conflict of interest is, when it is present, or how the factor is to be weighed in such determinations.

C. Rejection of the Treating Physician Rule: *Black & Decker v. Nord*

In 1991, the Social Security Administration (SSA), responding to circuit court opinions and widespread allegations that the agency was biased towards denying disability benefits, adopted a “treating physician rule” (TPR).²⁸ The TPR required Social Security administrative judges to “give more weight to opinions from [the claimant’s] treating sources.”²⁹ In 2002,

22. The term “plan administrator,” as used in this comment, refers to the type of plan administrator that falls within the definition of “fiduciary,” not the non-fiduciary types of administrators such as the employees who merely write benefit checks to participants and do not have discretionary control over administering the plan. 29 U.S.C. § 1002(21)(A).

23. *Firestone*, 489 U.S. at 102.

24. See, e.g., *Ladd v. ITT Corp.*, 148 F.3d 753, 754 (7th Cir. 1998) (noting that the arbitrary and capricious standard and the abuse of discretion standard are “different ways of saying the same thing”).

25. Roy F. Harmon III, *The Debate Over Deference in the ERISA Setting—Judicial Review of Decisions by Conflicted Fiduciaries*, 54 S.D. L. REV. 1, 11 (2009).

26. *Id.*

27. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).

28. Rachel Schneider, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 391-400 (1996).

29. Social Security Administration, 20 C.F.R. § 404.1527(d)(2) et seq. (2006).

following the lead of the SSA, the Ninth Circuit imported a similar TPR into ERISA disability cases, which stated that, “the plan administrator can reject the conclusions of the treating physicians only if the administrator ‘gives specific, legitimate reasons for doing so that are based on substantial evidence in the record.’”³⁰

In the Ninth Circuit case *Black and Decker v. Nord*, Kenneth Nord’s employer, Black & Decker, had established an ERISA insured disability plan (with a typical two-tier structure) which granted MetLife the authority to administer the plan.³¹ Nord applied to MetLife for disability benefits under the first tier, but his claim was denied because Nord allegedly did not meet the plan definition of “disabled.”³² Nord responded by filing an internal appeal with Metlife.³³ Metlife then hired another physician whom Nord was referred to for an “independent” evaluation.³⁴ That physician determined Nord was able to perform sedentary work.³⁵ Thereafter, Metlife recommended to Black & Decker that Nord’s claim be rejected, as assessment of which Black & Decker concurred.³⁶

The Ninth Circuit reversed the district court’s grant of Black & Decker’s motion for summary judgment and granted Nord’s motion for summary judgment, concluding that Metlife operated under a conflict of interest and did not properly follow the TPR.³⁷ The court reasoned that Metlife and Black & Decker failed to meet their burden of showing why the more

30. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002) (citing *Morgan v. Comm’r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)).

31. *Nord*, 296 F.3d at 826. The judge found that “disability” under the first tier is “complete inability...to engage in [Participant’s] regular occupation with the Employer (during the first 30 months of Disability).” However, “disability” under the second tier is “Participant[’s] complete inability...to engage in any gainful occupation or employment with any employer for which the Employee is, as of his Disability Date, reasonably qualified by education, training, or experience”. *Id.*

32. *Id.* at 827.

33. *Id.*

34. *Id.*

35. *Id.*

36. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 827 (9th Cir. 2002).

37. *Id.* at 831-32.

favorable one-time evaluation by Metlife’s “independent” doctor should have been given more weight than the corroborated opinions of Nord’s four treating physicians.³⁸

The Supreme Court granted certiorari in *Nord*. It reversed the Ninth Circuit by reasoning that nothing in the ERISA statute, nor in the Labor Department’s ERISA regulations, requires ERISA plan administrators to give greater weight to the opinions of treating physicians than to the opinions of other physicians when making benefit eligibility determinations.³⁹ Former Secretary of Labor Elaine Chao opposed the TPR arguing in an *amicus curiae* brief that such a rule would, “unduly interfere with the ability of employers to establish and design plans that confer on plan administrators the discretion to weigh conflicting evidence.”⁴⁰ However, the Court noted in dicta that if the Secretary of Labor wanted to promulgate a TPR, any court challenge to the rule would be reviewed under the deferential *Chevron* standard.⁴¹ This dicta strongly suggests that Secretary of Labor Hilda Solis could promulgate a TPR without having it overturned in federal court.

D. Conflict of Interest Factor Weighed: Metropolitan Life v. Glenn

The 2008 Supreme Court case *Metropolitan Life v. Glenn* attempted to clarify how the conflict of interest was to be weighed by the district courts in plaintiff challenges to benefit denials.⁴² A conflict of interest exists when the plan administrator both determines eligibility for benefits and pays the benefits out of its own pocket.⁴³ This situation is quite common in ERISA plans today, where an employer may start a disability, life, or health insurance plan and contract with an outside insurance company to administer

38. *Id.*

39. *Black & Decker v. Nord*, 538 U.S. 822, 825 (2003).

40. Brief for United States as Amicus Curiae Supporting Petitioner at 7, *Black & Decker v. Nord*, 538 U.S. 822 (2003) (No. 02-469).

41. *Nord*, 538 U.S. at 831-32 (citing *Chevron U.S.A. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984)). The *Chevron* analysis will be addressed further in Part V.

42. See *infra* Part II.D.2.

43. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2346 (2008).

the plan logistics, including benefit eligibility determinations and the payment of benefits from the insurance company's funds.⁴⁴

1. Glenn's Facts

Wanda Glenn was an employee of Sears, which offered a typical two-tiered disability benefit, administered by the Metropolitan Life Insurance Company (MetLife).⁴⁵ Under Sears' disability benefit system, an employee was eligible for disability benefits during the first twenty-four months under the first tier if the employee could not "perform the material duties of [the employee's] own job" but was only eligible for benefits after twenty-four months under the second tier if the employee could not perform "the material duties of any gainful occupation for which . . . [the employee was] reasonably qualified."⁴⁶ While covered through her employment with Sears, Glenn was diagnosed with severe dilated cardiomyopathy by her personal treating physician.⁴⁷ Glenn applied for and was granted disability benefits, but after twenty-four months, was denied benefits because MetLife determined she was "capable of performing full time sedentary work" under the second tier inquiry.⁴⁸

Glenn appealed MetLife's determination in federal court under 29 U.S.C. § 1132 (ERISA § 502).⁴⁹ After the district court dismissed Glenn's claim, the Sixth Circuit reversed MetLife's determination because MetLife operated under a conflict of interest and did not take into account the SSA's determination that Glenn could not work.⁵⁰ The Court also found that MetLife selectively relied on a treating physician's report that bolstered MetLife's position, without noting a contrary, more detailed treating physician's reports that showed Glenn could not work.⁵¹ Furthermore,

44. *See infra* Part III.

45. *Glenn*, 128 S. Ct. at 2346.

46. *Id.* at 2346-47.

47. *Id.* at 2346 (cardiomyopathy is "a heart condition who symptoms include fatigue and shortness of breath").

48. *Id.* at 2346-47.

49. *Id.* at 2347.

50. *Id.*

51. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2347 (2008).

Metlife did not disclose all treating physician reports to those making the benefit determination.⁵² Finally, Metlife did not consider evidence that Glenn suffered from stress that aggravated her condition.⁵³

2. Glenn's Holdings

The Supreme Court ruled that MetLife operated under a conflict of interest because it both determined eligibility of disability benefits and paid benefits from its own finances,⁵⁴ creating a conflict of interest in the employer and in the insurer.⁵⁵ The Court affirmed the Sixth Circuit's opinion.⁵⁶ However, it held that the *Bruch* standard⁵⁷ was still applicable and that even when a court finds a conflict of interest to be present, the *abuse of discretion* standard still applies, rather than the *de novo* standard.⁵⁸ The Court rejected any special burdens of proof or evidentiary rules and directed that lower courts take the conflict of interest into account with all other relevant factors to determine whether the plan administrator abused its discretion.⁵⁹ The Court noted:

any one factor will act as a tiebreaker when the other factors are closely balanced . . . The conflict of interest . . . should prove more important . . . where an insurance company has a history of biased claims administration . . . It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to

52. *Id.*

53. *Id.*

54. *Id.* at 2348-50.

55. *Id.* at 2349-50 (2008) (stating "[f]or one thing, the employer's own conflict may extend to its selection of an insurance company to administer its plan. An employer choosing an administrator in effect buys insurance for others and consequently (when compared to the marketplace customer who buys for himself) may be more interested in an insurance company with low rates than in one with accurate claims processing.").

56. *Id.* at 2352 (finding "[w]e can find nothing improper in the way in which the court conducted its review").

57. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 102 (1989).

58. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2350 (2008).

59. *Id.* at 2351.

reduce potential bias and to promote accuracy, for example by walling off claims administrators from those interested in firm finances or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits.⁶⁰

Justice Roberts concurred with the judgment, but argued that the conflict of interest factor should only be considered “where there is evidence that the benefit denial was motivated or affected by the administrator’s conflict.”⁶¹ Justice Scalia, in his dissent, disagreed with the emphasis that the majority placed on the *Bruch* conflict of interest dicta⁶² and argued that employers should not be subject to the conflict of interest analysis, which he thought should be reserved for third party insurers.⁶³ Scalia warned that the majority’s opinion will result in uncertain application.⁶⁴

III SURVEY OF POST-*GLENN* CIRCUIT OPINIONS

A. Opinions Reversing Benefit Denials

The Second Circuit in *McCauley v. First Unum Life Ins. Co.*⁶⁵ reversed a denial of long-term disability benefits by an insurance company plan administrator.⁶⁶ Before *Glenn*, Second Circuit precedent required review of a benefit denial *de novo* where a plan administrator operated under a conflict

60. *Id.*

61. *Id.* at 2353-54 (2008) (Roberts, J., concurring in part and concurring in the judgment) (stating “[i]t is the actual motivation that matters in reviewing benefits decisions for an abuse of discretion, not the bare presence of the conflict itself”).

62. *Id.* at 2357 (2008) (Scalia, J., dissenting) (finding “[t]he Court takes that throwaway dictum [referring to the conflict of interest dictum in *Firestone*] literally and builds a castle upon it. But the dictum cannot bear that weight”).

63. *Id.* at 2356-57.

64. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2358 (2008) (noting “[t]here are degrees of respect for the decisionmaker, perhaps-but the court either defers, or it does not. “Some deference,” or “less than total deference,” is no deference at all.”).

65. *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126 (2d Cir. 2008).

66. *Id.*

of interest and the conflict could affect reasonable interpretation by the administrator.⁶⁷

The court noted that previous Second Circuit case law was no longer applicable in the wake of *Glenn*, which required the court to consider the conflict of interest as one factor in determining whether there was an abuse of discretion.⁶⁸ In reaching its conclusion that the insurer acted in an arbitrary and capricious manner by denying the benefit, the court considered that the insurer had a “well-documented history of abusive claims processing,” the company relied on the medical opinion of an internal appeals specialist over the more detailed and contrary medical opinion by the plaintiff’s treating physician, falsely stated that the appeals specialist was a physician, and mischaracterized its reason for denying the benefits.⁶⁹

The Sixth Circuit in *Johnson v. Connecticut General Life Ins. Co.*⁷⁰ reversed a death benefit denial by an insurance company administrator, classifying the determination as arbitrary and capricious. The court determined that the administrator had relied on treating physician reports after the insured-decedent had increased her life insurance coverage, to the exclusion of a more relevant and timely contrary treating physician reports before the coverage was increased.⁷¹

67. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996).

68. *McCauley*, 551 F.3d at 133 (citing *Metro. Life v. Glenn*, 128 S. Ct. at 2348-51).

69. *McCauley*, 551 F.3d at 138.

70. *Johnson v. Connecticut General Life Ins. Co.*, 324 F. App’x 459 (6th Cir. 2009).

71. *Id.* at 461-62, 468-70 (finding that the plan administrator granted the lower level of death benefits, but denied the added level because the insured, “made material misrepresentations in the supplemental enrollment form.” The insurer claimed had it known of insured’s full medical history, including alleged hypothyroidism, hypertension, and palpitations, it would not have approved additional coverage. Although the decedent’s death certificate included cardiac arrest and pulmonary embolism as causes of death and hypertension as a contributing condition, the decedent had not been diagnosed with hypertension until after the higher level insurance took effect. The administrator’s reasoning in denying the benefits relied on reports that came out after the hypertension diagnosis, ignoring earlier reports that did not reference hypertension as being the cause of decedent’s erratic blood pressure. The insurer also supplied shifting reasons as to what it was that the insured failed to disclose about her medical history that would have led insurer to not approve a higher level of coverage.).

The Eighth Circuit in *Chronister v. Unum Life Insurance Co.*⁷² reversed an insured plan's Long-Term Disability (LTD) benefit denial as being an abuse of discretion, where the insurer's plan administrator failed to follow the procedures in its own disability manual.⁷³ These procedures required Unum to "give 'significant weight' to the SSA's disability determination and to reject that determination only if there is compelling evidence" contrary to that decision.⁷⁴ Unum's denial letter to Chronister did not even mention the SSA's disability ruling, and did not explain why the SSA's opinion was not given significant weight.⁷⁵

B. Opinions Upholding Benefit Denials

The Third Circuit in *Doroshow v. Hartford Life and Accident Ins. Co.*⁷⁶ upheld the denial of LTD benefits by an insurance company administrator based on the administrator's reading of a "pre-existing condition."⁷⁷ Employee Jay Doroshow saw his personal physician during the three month pre-existing condition period.⁷⁸ The physician who diagnosed Doroshow with lumbrosacral plexitis, stated that he did not believe Doroshow had amyotrophic lateral sclerosis (ALS).⁷⁹ However, the administrator denied Doroshow's LTD claim because he was diagnosed with ALS by his treating

72. *Chronister v. Unum Life Ins. Co.*, 563 F.3d 773 (8th Cir. 2009).

73. *Id.* at 776-77.

74. *Id.* (noting that the "procedures were put in place pursuant to settlement agreements and consent decrees between Unum and various state insurance commissioners and the Department of Labor after investigations into Unum's claims-handling practices.").

75. *Id.*

76. *Doroshow v. Hartford Life & Accident Ins. Co.*, 574 F.3d 230 (3d Cir. 2009)

77. *Id.* at 231-32 (finding that the LTD plan documents stating disability benefits were not available for an (exempt) employee whose disability is pre-existing three months before employee's beginning date for coverage, where "pre-existing condition" is one, "for which medical treatment or advice was rendered, prescribed, or recommended within . . . [three months] prior to effective date of insurance.").

78. *Id.*

79. *Id.* at 232 (ALS is a type of motor neuron disease).

physician specialist more than ten months *after* his effective coverage date.⁸⁰ The court found the administrator's reading that Doroshow's doctors "considered ALS as, at least, a possible explanation of his symptoms" to be a reasonable basis for denying the claim, even though Doroshow was not actually diagnosed with ALS during the pre-existing condition period.⁸¹ Judge Rendell filed a vigorous dissent, stating, "[t]he majority's conclusion that his doctor's *negative* diagnosis of ALS during the relevant three-month period somehow renders his later-diagnosed ALS a 'pre-existing condition' under [insurer's] policy rests upon a seriously flawed reading of . . . [the policy] as well as [Third Circuit precedent]."⁸²

The Fourth Circuit in *Champion v. Black & Decker*⁸³ upheld an insured plan's denial of LTD benefits, where the treating physician's determination was held ambiguous and the plan's reviewing physician diagnosed participant's pseudoseizures as a "Mental Health Disability" (and not epilepsy alone).⁸⁴ This decision took the disability out of the plan's coverage after thirty months.⁸⁵ The court cited eight *Booth* factors,⁸⁶ including the conflict of interest factor, which it weighed in determining whether the plan administrator abused its discretion in denying the benefit:

- (1) the language of the plan; (2) the purposes and goals of the plan;
- (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan; (5) whether the decisionmaking process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive

80. *Id.*

81. *Id.* at 235.

82. *Doroshow v. Hartford Life & Accident Ins. Co.*, 574 F.3d 230, 236-37 (3d Cir. 2009) (Rendell, J., dissenting) (citing *Lawson v. Fortis Ins. Co.*, 301 F.3d 159, 165-66 (3rd Cir. 2002) (noting that such a doctrine "might open the door for insurance companies to deny coverage for any condition the symptoms of which were treated during the exclusionary period.")).

83. *Champion v. Black & Decker*, 550 F.3d 353 (4th Cir. 2008).

84. *Id.* at 360-61.

85. *Id.*

86. *See Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 201 F.3d 335 (4th Cir. 2000).

requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have.⁸⁷

The Fourth Circuit held that under the first seven *Booth* factors, the plan did not abuse its discretion.⁸⁸ Regarding the last factor, although the court did determine that the plan operated under a conflict of interest, the Fourth Circuit relied on the district court's finding that "the Plan did not act in a biased manner" and found "no evidence of bad faith or improper intent."⁸⁹ The Circuit also found it persuasive, under *Glenn*, that Champion's "initial claim was denied by a third-party administrator" (insurer CIGNA) and the plan also provided a second internal appeal, to which Champion brought her lawyer.⁹⁰ The court found that these two voluntary acts by the plan "increased the likelihood of an accurate final decision, thereby also reducing the conflict factor 'to the vanishing point.'"⁹¹

In *Young v. Wal-Mart Stores, Inc.*,⁹² the Fifth Circuit considered both *Nord* and *Glenn* in reversing the district court and upholding a life insurance plan administrator's denial of death benefits to a plan participant. This case involved a situation where the administrator relied on a non-examining physician's response to administrator's questions, which conflicted with the treating physician's report.⁹³ The court was heavily influenced by administrative law standards from *Citizens to Preserve Overton Park, Inc. v.*

87. *Champion*, 550 F.3d at 359 (citing *Booth*, 201 F.3d at 342-33).

88. *Champion*, 550 F.3d at 361-62.

89. *Id.*

90. *Id.* (citing *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2351 (2008)). Although the plan was an insured plan, Black & Decker retained ultimate authority to grant or deny benefits. *Champion v. Black & Decker*, 550 F.3d 353, 356 (4th Cir. 2008).

91. *Champion v. Black & Decker*, 550 F.3d 353, 361-62 (4th Cir. 2008).

92. *Young v. Wal-Mart Stores, Inc.*, 293 F. App'x 356, 356 (5th Cir. 2008).

93. *Id.* at 357-58, 362. The court found that the treating physician's opinion, listed on the husband's death certificate, that the death was an "accident" as opposed to a "sickness, disease, or infection," was consistent with the requirements for receiving benefits under the plan documents. *Id.* The consulting physician determining that cause of death was due to a history of hypertension disease. *Id.*

*Volpe*⁹⁴ and *Universal Camera Corp. v. National Labor Relations Board*,⁹⁵ and justified its reversal of the district court based on these earlier cases.⁹⁶ The Fifth Circuit stated, "[c]ourts cannot second guess the weight that [the insurer] gave to the treating physician's and the independent expert's respective opinions."⁹⁷

The Tenth Circuit, in *Waugh v. The Williams Companies, Inc. Long Term Disability Plan*,⁹⁸ upheld a disability benefit denial by a self-funded plan,⁹⁹ where a conflict of interest was not alleged by plaintiff.¹⁰⁰ Defendant TWC's board of directors appointed a benefits committee, who appointed an administrative committee, who delegated full discretionary authority to a claim administrator, with the administrative committee reserving authority to decide on the final appeals process.¹⁰¹ The court noted, "[t]he Administrative Committee was not compensated for its service and there was no evidence presented that [administrator's] compensation was tied to the amount of claims approved or denied."¹⁰²

94. See generally *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1971) (noting that the concluding administrator's decision was not "arbitrary, capricious, or an abuse of discretion.").

95. See generally *Universal Camera Corp. v. NLRB*, 340 U.S. 474 (1951) (stating that the decision was based on "substantial evidence on the record considered as a whole.").

96. *Young v. Wal-Mart Stores, Inc.*, 293 F. App'x 356, 360-62 (5th Cir. 2009) (citing *Citizens to Preserve Overton Park, Inc.* 401 U.S. at 415-17; *Universal Camera Corp.*, 340 U.S. at 474).

97. *Young*, 293 F. App'x. at 363 (citing pre-*Glenn* Fifth Circuit precedent in *Corry v. Liberty Life Assurance Co. of Boston*, 499 F.3d 389, 401 (5th Cir. 2007); *Gothard v. Metro. Life Ins. Co.*, 491 F.3d 246, 249 (5th Cir. 2007)).

98. *Waugh v. The Williams Companies, Inc. Long Term Disability Plan*, No. 08-5123 (10th Cir. April 23, 2009).

99. See *Waugh v. The Williams Companies, Inc. Long Term Disability Plan*, No. 07-CV-0446-CVE-SAJ at 1 (N.D. Okla. June 27, 2008).

100. *Waugh*, No. 08-5123 at 2-3. The court also failed to allow a remand to the district court to allow plaintiff to establish a conflict of interest. *Id.*

101. *Id.* at 4.

102. *Id.*

C. Synthesizing the Circuit Opinions: The Weighing of Factors Process, Although Resulting in Consistency, Has Not Been Adequate to Counter Conflicts of Interest

Of all nine post-*Glenn* cases examined in this comment, only *McCauley*, *Johnson*, and *Chronister* reversed the ERISA plan benefit denial. Common to all of these reversing cases, as well as to *Glenn*, was the fact that each case involved an insured plan, where the insurance company, operating under a conflict of interest, selectively relied on certain medical reports over *contrary, more detailed reports* by plaintiff's treating physicians.¹⁰³ Also common to each was that *multiple other factors* existed that caused the court to determine that the conflict of interest resulted in an arbitrary and capricious actions by the insurer.¹⁰⁴ Both *McCauley* and *Chronister* involved the infamous insurer Unum (or "First Unum" in *McCauley*).¹⁰⁵ In *McCauley*, Unum falsely stated that its appeals specialist was a licensed physician.¹⁰⁶ In *Chronister*, Unum did not follow the clear and specific plan procedures requiring that there be compelling contrary evidence if an administrator rejected an SSA's disability determination.¹⁰⁷ The insurer in *Johnson* kept changing its reasoning for supporting the denial, and selectively relied on evidence that was based on untimely and irrelevant information.¹⁰⁸ The insurer in *Glenn* selectively ignored the SSA's determinations, did not disclose all reports to the employer who made final appeals decisions, and did not take into account evidence that the plaintiff's condition aggravated stress.¹⁰⁹

103. See *supra* Parts II.D.1, 2, III.A.

104. *Id.*

105. See *supra* Part III.A. For a description of the notorious reputation of the insurer Unum, see generally John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, 101 Nw.U. L. REV. 1315 (2007).

106. *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126, 138 (2d Cir. 2008).

107. *Chronister v. Unum Life Ins. Co.*, 563 F.3d 773, 776-77 (8th Cir. 2009).

108. *Johnson v. Connecticut General Life Ins. Co.*, 324 F. App'x. 459, 461-62, 468-70 (6th Cir. 2009).

109. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2351-52 (2008).

Of the six remaining cases, each of which upheld the benefit denial, every case except *Jenkins*¹¹⁰ involved a plan administrator who consulted with and relied on a non-examining physician's opinion to reject or render irrelevant the plaintiff's treating physician's determination.¹¹¹ *Doroshov* went even further by upholding the decision of the plan administrator despite his characterization of a negatively diagnosed condition (claimant was

110. See *Jenkins v. Price Waterhouse Long Term Disability Plan*, 564 F.3d 856 (7th Cir. 2009). This case upheld an LTD benefit denial where an independent medical examination (IME) doctor and insurance company's reviewing doctor disagreed with the findings of plaintiff's treating physician regarding plaintiff's HIV disease and his continuing ability to carry out work under the LTD plan's second tier of benefits. *Id.* at 858-60. In 1988, plaintiff was diagnosed with HIV and plaintiff filed for and was granted LTD and Social Security benefits beginning in 1994. *Id.* at 858. After the first tier benefit period of five years expired, the insurance company administrator granted continuing benefits under the second tier, lasting from 1999 to 2006, at which point the benefits were terminated. *Id.* In 1993, Jenkins' treating physician determined that Jenkins' blood count (155) was within the range of an AIDS patient (below 200) and that Jenkins was incapable of "even minimal sedentary activity;" his second treating physician agreeing in 1997, adding his "condition was deteriorating with no chance of improvement." *Id.* at 858-59. In 2005 a non-examining insurance company doctor stated, "the HIV would not prevent [Jenkins] from performing full time light duty or sedentary work," and that Jenkins maintained a weight of above 200 pounds and a T-cell count of about 100, although a person with a T-cell count below 200 is considered to have AIDS. *Id.* Jenkins soon went for an IME, the examining doctor concluding that Jenkins "was at least able to attempt full-time employment." *Jenkins v. Price Waterhouse Long Term Disability Plan*, 564 F.3d 856, 859-60 (7th Cir. 2009). Although Jenkins' second treating physician maintained his opinion that Jenkins could not perform a full-time sedentary job, the insurance company's reviewing physician disagreed and benefits were dropped. *Id.* at 860. In reviewing whether the insurer's decision to drop LTD benefits was arbitrary and capricious under *Glenn*, the court stated:

Measured against this standard of review, Jenkins's appeal stands little chance. We emphasize that the question isn't whether *we* would have terminated Jenkins's benefits, but whether [insurer's] decision to do so finds "rational support in the record." It surely does . . . this is not the kind of case where the conflict-of-interest factor plays an important role . . . *This is not one of those borderline cases.*

Id. at 861-62 (emphasis added). Anecdotally, the court discounted the idea that IME's are necessarily truly independent, adding "that is not always the case, especially when the professional's bill is paid by an insurance company (or a self-insured employer) with an interest in receiving a report that minimizes, or discounts, a disability claim." *Id.* at 859-60.

111. See *supra* Part III.B.

diagnosed as *not having* ALS) as constituting a “pre-existing condition.”¹¹² *Champion* held that the plan “increased the likelihood of an accurate decision” by volunteering an extra internal appeal and by having a “third party administrator” (CIGNA Integrated Care) deny the claim, per *Glenn*.¹¹³

These opinions make no inquiry into the relative weight given to the plaintiff’s treating physician’s report and to insurance company hired physician’s report. The opinions also make no distinction between whether the physicians hired by the insurance company actually examined the plaintiff or merely reviewed paper medical records. *Young* strongly relied on *Nord* and other pre-*Glenn* Fifth Circuit precedent to hold that the insurer’s reviewing physician does not even need to physically examine the claimant.¹¹⁴ *Doyle*,¹¹⁵ like *Glenn*, involved an LTD benefit denial where the plan administrator credited the opinions of non-treating physicians who disagreed with the plaintiff’s treating physician, and who disregarded plaintiff’s complaints of pain and suffering.¹¹⁶ Although *Doyle* did not involve a situation where SSA determinations were ignored or where the

112. *Doroshov v. Hartford Life and Accident Ins. Co.*, 574 F.3d 230, 235 (3rd Cir. 2009).

113. *Champion v. Black & Decker*, 550 F.3d 353, 362 (4th Cir. 2008) (citing *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2351 (2008)). See also, generally CIGNA homepage, <http://www.cigna.com/index.html> (last visited March 5, 2010) (noting that CIGNA also operates as a for-profit insurer).

114. *Young v. Wal-Mart Stores, Inc.*, 293 F.App’x. 356, 363 (5th Cir. 2008) (citing *Gothard v. Metro. Life Insurance Co.*, 491 F.3d 246, 249 (5th Cir. 2007); *Black & Decker v. Nord*, 538 U.S. 822, 831 (2003)).

115. See *Doyle v. Liberty Life Assurance Co. of Boston*, 542 F.3d 1352, 1358, 1363 (11th Cir. 2008), which upheld an LTD benefit denial by an insurance company plan administrator, who consulted two non-examining independent physicians to review Doyle’s medical records from her treating physicians, and disregarded Doyle’s “subjective” complaints of pain and suffering. *Id.* The policy required that modes of proof of disability include “chart notes, lab findings, test results, x-rays and/or other forms of *objective medical evidence* in support of a claim for benefits. *Id.* Although Doyle’s treating physicians reported that Doyle “could not perform the material duties of her ‘Own Occupation’” (under the second tier of the LTD benefit structure), the court held that the insurer did not abuse its discretion because there was sufficient objective medical evidence from the independent physicians to reach the conclusion that Doyle could work and was thus not eligible for LTD benefits. *Id.* at 1362-63. The court held that, “[b]ecause the evidence is close, we cannot say, even accounting for the conflict, that Liberty Life abused its discretion in denying Doyle’s benefits.” *Id.*

116. *Id.* at 1358.

administrator failed to disclose reports between the plan and insurer, plaintiff Doyle appeared to have a stronger case with respect to the fact that the plan administrator consulted with non-examining physicians,¹¹⁷ while *Glenn* involved consultation with treating physicians.¹¹⁸ Nonetheless, the law has not recognized this distinction.

For these reasons, at a minimum, the following is needed to reverse a benefit denial: either *bad faith* (such as making false statements, failing to disclose all the evidence, or shifting and illogical reasoning) or failure to follow plan procedures *in addition to* a conflicted plan administrator selectively relying on certain medical reports over contrary, more detailed reports by plaintiff’s treating physicians.¹¹⁹ This is quite a high threshold for an ERISA plaintiff to overcome. An insurer can subjectively intend to deny benefits to boost company profits and merely go through the required procedural motions to justify an erroneous denial (as long as the insurer followed all formal procedures under ERISA and under the plan, did not explicitly lie, disclosed all required evidence, and stuck to its story).¹²⁰ The insurer will very likely not be reversed if there is some evidence, even barely more than a scintilla, to support its position. It stretches the imagination to claim that this scenario can be reasonably viewed as a close case, where the conflict of interest factor serves the role of a mere “tiebreaker” as set forth in *Glenn*. It seems that plaintiffs in this area do not really win cases. Rather plan administrators lose cases through procedural mishaps. This is an unjust result for plaintiffs who seek ERISA’s protection.

IV. WHY THE ADMINISTRATIVE LAW DEFERENTIAL STANDARD IN THE ERISA SETTING IS NOT APPROPRIATE WITHOUT PROTECTIONS AGAINST BIAS AND CONFLICTS OF INTEREST

Administrative law analogies to ERISA are inappropriate, especially given the problems of conflicts of interest and the unwillingness of courts to make adequate inquiries into the benefit denial process. As benefit denials by ERISA plan administrators have not been held to constitute “state

117. *Doyle v. Liberty Life Assurance Co. of Boston*, 542 F.3d 1352, 1358 (11th Cir. 2008).

118. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2347 (2008) (stating that Metropolitan life emphasized one of Glenn’s treating physician’s opinions to the exclusion of other, more detailed treating physician’s opinions).

119. *See supra* Part III.C.

120. *Id.*

action,” there are no constitutional protections for the claimant, such as due process.¹²¹ Yet, although ERISA regulates private sector benefits, determinations by ERISA fiduciaries are reviewed under the public-sector administrative law “arbitrary and capricious” standard.¹²² *Glenn* relied on *Universal Camera*¹²³ and *Citizens to Preserve Overton Park*¹²⁴ to apply administrative law standards of review in the ERISA setting.¹²⁵

However, the Supreme Court in *Glenn* has overlooked some of the reasoning behind the deference given to agency adjudicators. With respect to findings of fact under the substantial evidence standard of *Universal Camera*, a “mere scintilla” is not enough evidence for an agency appeals board to reverse the opinion of an agency adjudicator, such as an Administrative Law Judge (ALJ).¹²⁶ Rather, substantial evidence is

121. See Paul R. Verkuil, *Privatizing Due Process*, 57 ADMIN. L. REV. 963, 964 (2005) (“the term private due process is an oxymoron. Under our constitution there must be a ‘state action’ to trigger the Due Process Clause.”). *But see* Mark D. DeBofsky, *What Process is Due in the Adjudication of ERISA Claims?*, 40 J.MARSHALL L. REV. 811, 837-38 (2007) (arguing “whether or not Congress intended such a delegation [of adjudicative authority to a private party], the manner in which courts give deference to the findings of ERISA plan administrator that internally review their own decisions is indistinguishable from the adjudicative functions granted to administrative agencies under laws such as the Social Security Act and the Administrative Procedure Act. . . the delegation. . . has created a significant due process deprivation of the right to a statutorily guaranteed full and fair review.”).

122. Harmon III, *supra* note 25, at 2 (noting that although due process and APA procedural requirements do not apply to the private ERISA setting, “[n]onetheless, in virtually every important procedural aspect of judicial review in ERISA cases, the federal courts have resorted to administrative law principles in judicial review of benefit denials.”).

123. See generally *Universal Camera Corp. v. NLRB*, 340 U.S. 474 (1951) (discussing agency fact finding).

124. See generally *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415-17 (1971) (explaining agency discretion).

125. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2351 (2008) (citing *Citizens to Preserve Overton Park, Inc.*, 401 U.S. at 415-17; *Universal Camera Corp.*, 340 U.S. at 495).

126. *Universal Camera Corp.*, 340 U.S. at 495 (quoting *Consolidated Edison Co. v. N.L.R.B.*, 305 U.S. 197, 229 (1938) (stating that “[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.”)).

required.¹²⁷ In rejecting the NLRB’s reversal of the hearing examiner’s opinion and implying that the NLRB did only have “a mere scintilla” of evidence to support its conclusion, the court in *Universal Camera* stated:

[n]othing suggests that reviewing courts should not give to the examiner’s report such probative force as it intrinsically commands. To the contrary, §11 of the Administrative Procedure Act contains detailed provisions designed to *maintain high standards of independence and competence in examiners*.¹²⁸

The Supreme Court relied on the standards of the Administrative Procedure Act as it existed in 1951 to require substantial evidence in internal agency appeals.¹²⁹ Today, ALJs operate with even greater independence. For example, ALJs cannot be removed except “for good cause” and only by a determination of the Merit Systems Protection Board (outside of their adjudicating agency) on the record after opportunity for a hearing.¹³⁰ An ALJ’s pay is set by statute and by the Office of Personnel Management, and is not set according to the adjudicating agency’s evaluation of the ALJ’s performance.¹³¹ These provisions help insulate the ALJ from agency pressures to decide cases in conformance with agency preferences.

Agency heads, such as board members of the NLRB, as in *Universal Camera*, are also held to high standards of independence and may be found to violate the constitutional rights of parties to their adjudication. One example is of this type of situation is *Gibson v. Berryhill*.¹³² The federal district court determined that an Alabama board of optometrists—who were all optometrists in their own private practice—intended to revoke the licenses of half of Alabama’s practitioners so as to appropriate business for themselves.¹³³ Optometrist plaintiffs claimed that the board of optometrists violated their due process rights to a fair and impartial hearing.¹³⁴ The U.S.

127. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 495 (1951).

128. *Id.*

129. *Id.*

130. *Government Organizations and Employees*, 5 U.S.C. § 7521(a) (2006).

131. *See Government Organizations and Employees*, 5 U.S.C. § 5372 et seq. (2006).

132. *Gibson v. Berryhill*, 411 U.S. 564, 570 (1973).

133. *Id.*

134. *Id.*

Supreme Court upheld the district court's determination that the board was "constitutionally disqualified from hearing the charges filed against the appellees" merely on the grounds that the Board had a *possible* personal interest in the case.¹³⁵

Title 28 U.S.C. § 455¹³⁶ requires justices, judges, and magistrate judges to disqualify themselves from adjudicating cases where they may have personal bias or direct financial interest.¹³⁷ The American Bar Association (ABA) has stated an "adjudicative decisionmaker must disqualify him or herself, or be disqualified, from deciding any case in which the decisionmaker is biased."¹³⁸ Both Congress and professional groups, like the ABA, seem to believe that it is of such importance to maintain a high level of trust and integrity in the judiciary, that additional mandatory standards beyond due process are necessary.

It is reasonable to give government agency adjudicators wide discretion because there are so many existing checks and balances in the system to ensure there is no undue abuse of judicial authority.¹³⁹ Additionally, adjudicators should have a presumption of expertise in their legal specialty. Their decisions should be considered valid because, as in the case of ALJs, they examine the evidence directly and can scrutinize the demeanor of

135. *Id.* at 578-79 (citing *Tumey v. Ohio*, 273 U.S. 510 (1927) (finding that "[i]t is sufficiently clear from our cases that those with substantial pecuniary interest in legal proceedings should not adjudicate these disputes.")). *See also* *Caperton v. A.T. Massey Coal Co., Inc.*, 129 S. Ct. 2252, 2256-58 (2009). In this case, the jury awarded petitioners \$50 million in compensatory and punitive damages against respondent coal company. *Id.* at 2265. The West Virginia Supreme Court voted 3-2 to reverse the jury verdict. *Id.* One of the judges in the majority was supported by the coal company's CEO in his election before the case was heard in the state's Supreme Court. *Id.* The CEO gave almost \$2.5 million in contributions through a political organization that supported this judge, which was over two-thirds of the funds the organization raised. *Id.* The U.S. Supreme Court held five to four that the influence the coal company exerted constitutionally required the judge to recuse himself. *Id.* The Court based its inquiry on an objective theory of potential bias, and did not require a finding of actual bias. *Caperton v. A.T. Massey Coal Co., Inc.*, 129 S. Ct. 2252, 2265 (2009).

136. *See* *Judiciary and Judicial Procedure*, 28 U.S.C. § 455 et seq. (2006).

137. *Id.*

138. *See* AMERICAN BAR ASSOCIATION, A BLACKLETTER STATEMENT OF FEDERAL ADMINISTRATIVE LAW 9 (2004), <http://www.abanet.org/adminlaw/BlkLettSt/TOC.pdf>.

139. *See supra* Part IV.

witnesses to accurately assess credibility in ways that reviewing courts cannot. However, the constitutional and statutory checks on the power of agency adjudicators stand in sharp contrast to the lax statutory and judicial scrutiny imposed on ERISA fiduciaries. If anyone under the ERISA regulatory framework has the independence of an agency adjudicator, it is the treating physician. Only the treating physician has little conflict of interest, directly examines the claimant, and is an expert in the field.¹⁴⁰ Yet strangely, under ERISA, the treating physician is given little deference. However, the insurance company administrator, who has an inherent conflict of interest and is not an expert in the relevant field of medicine, does not need to examine the patient, and is given wide deference.

With respect to court review of ERISA benefit denials, the Seventh Circuit held that, “[d]eferential review is not no review” and “deference need not be absent.”¹⁴¹ The Supreme Court stated in *Nord*:

[p]lan administrators, of course, may not arbitrarily refuse to credit a claimant’s reliable evidence, including the opinions of a treating physician. But, we hold, courts have no warrant to require [on] administrators...a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician’s evaluation.¹⁴²

But in practice, how does this standard mean anything other than “no review”? This inconsequential standard reduces the courts, in applying the arbitrary and capricious test, to rubber stamping the decisions of the administrators. As long as plan administrators “credit” (by merely acknowledging or making mention of) the claimant’s evidence from a treating physician, without explaining why they disregarded its weight, they may not be reversed.¹⁴³ An administrator is merely required to provide formalistic lip-service to the claimant. As the AARP noted in *Nord*, the “plan’s response [that it need not explain why it did not rely on the treating physician’s opinion] is extremely disturbing and disingenuous. . . . [The plan’s] viewpoint leads inexorably to the conclusion that a plan could grant

140. See, e.g., *Bowman v. Heckler*, 706 F.2d 564, 568 (5th Cir. 1983) (noting that in the Social Security context, “[o]ur reliance on the opinion of the treating physician is based not only on the fact that he is employed to cure but also on his greater opportunity to observe and know the patient as an individual.”).

141. See *Hess v. Hartford Life & Accident Ins. Co.*, 274 F.3d 456, 461 (7th Cir. 2001) (citing *Gallo v. Amoco Corp.*, 102 F.3d 918, 922 (7th Cir. 1996)).

142. *Black & Decker v. Nord*, 538 U.S. 822, 834 (2008).

143. See *supra* Part III.C.

or deny benefits at will. This is no standard at all.”¹⁴⁴ Professor John Langbein noted the inconsistency between applying a deferential standard of review and ERISA’s purpose of protecting participants and beneficiaries,¹⁴⁵ and also contrasted this discrepancy with traditional trust law.¹⁴⁶ Citing “law and economics” guru and Seventh Circuit Judge Richard Posner, and his pre-*Bruch* remarks for support, Professor Mark DeBofsky argues that the administrative law’s “arbitrary and capricious” deference given to ERISA administrators is inappropriate.¹⁴⁷ The congressional intent of ERISA to give claimants a “full and fair review” could not have been this superficial, for such a reading would render ERISA § 503 meaningless.

This Comment does not seek to re-interpret the Constitution or drastically rewrite ERISA to declare that ERISA fiduciaries are state actors required to give claimants due process. Rather, it seeks to propose a common-sense regulation as one possible way to counter the serious conflict of interest that undermines the integrity of benefits determinations by ERISA fiduciaries. Selectively using the administrative law paradigm to give conflicted ERISA fiduciaries deference over their decisionmaking, while preventing the administrative law paradigm from being used to protect claimant’s rights is both asymmetrical and unjust.

144. Brief for the AARP as Amicus Curiae Supporting Respondent at 8, *Black & Decker v. Nord*, 538 U.S. 822 (2003).

145. See Langbein, *supra* note 105, at 1336 (arguing that ERISA’s statutory purpose under Section 404 is to protect participants and beneficiaries and that the regulatory standards should be mandatory, rather than waiveable or “default” as they are under *Firestone v. Bruch*).

146. *Id.* at 1342 (arguing that “[a]lthough the drafter of a private trust may indeed insist on greater judicial deference to trustee decisionmaking...to give maximum effect to the wishes of the transferor—that is, to *private autonomy*. In ERISA, by contrast, Congress employed trust law concepts for regulatory purposes, in order to *limit private autonomy*.”) (emphasis added).

147. See Mark D. DeBofsky, *The Paradox of Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV 727, 728-30 (2004) (arguing against the importation of administrative law deference into the ERISA trust setting, noting the remarks of Posner, J. in *Van Boxel v. The Journal Co. Employees’ Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987) (stating that “pension rights are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of ‘arbitrary and capricious’ review.”)).

V. THE LABOR DEPARTMENT SHOULD ADOPT THE TPR

One way to establish stability in the law and to treat benefit claims fairly is to require insurers to follow the treating physician's report, absent strong evidence countering the physician's accuracy, integrity, or judgment. The TPR does not mandate benefits, but rather establishes *procedural rights* if and when employers choose to offer disability plans.¹⁴⁸ This rule would simulate some effects of due process, and would lead to more accurate decisions commensurate with social security adjudications. The TPR aligns with ERISA's purpose of procedurally protecting employees who receive benefits from their employer.¹⁴⁹ Under *Nord*, the change needs to come from the executive branch, or from Congress, but cannot come from the judiciary alone.

If TPR were part of the law, the outcomes in *Doroshov*, *Champion*, *Young*, and *Doyle* would likely be different.¹⁵⁰ Such a rule would actually direct the plan administrator in how to weigh the evidence. Instead of having "substantial evidence" to justify a denial by weighing evidence in any direction, the plan administrator could "reject the conclusions of the treating physicians only if the administrator 'gives specific, legitimate reasons for doing so that are based on substantial evidence in the record.'"¹⁵¹ Other variations on this standard could require the plan administrator to have specific legitimate reasons for rejecting the opinions of the treating physician, based on either a preponderance of evidence or clear and convincing evidence. These variations would remove doubts about the administrator's ability to find some small bit of evidence (beyond a "mere scintilla") to discredit the treating physician and justify an erroneous denial. Either of these rules should maintain (or create even greater) consistency in the law, reduce litigation, and ultimately provide greater justice for those erroneously denied benefits.

The Labor Department under President George W. Bush argued as *amicus curiae* in *Nord*:

148. See *infra* Part V.

149. See Employee Retirement and Income Security Act of 1974, 29 U.S.C. § 1001(b) (2006).

150. See *supra* Part III.B.& C. (arguing that the plaintiffs' treating physicians' opinion would have to be followed by the ERISA fiduciary, absent some evidence discounting the integrity of that opinion).

151. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002) (citing *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)).

In the absence of a regulation requiring a treating physician rule, courts should not impose such a rule under their authority to fashion a “federal common law” under ERISA. . . . *Such a rule would unduly interfere* with the ability of employers to establish and design plans that confer on plan administrators the discretion to weigh conflicting evidence.¹⁵²

Nonetheless, a primary purpose of regulating welfare plans under ERISA is to ensure certain minimum disclosure and review standards to protect participant rights under plans voluntarily set up through their employer.¹⁵³ To the extent that ERISA “interferes” with the establishment and design of these plans, it does so only procedurally, not substantively.¹⁵⁴ In the same way that the independent physician rule “interferes” with the operation of ERISA plans by requiring fiduciaries to consult with an outside health care professional,¹⁵⁵ a treating physician rule would likewise interfere with plan operation by requiring administrators to give greater weight and deference to the opinion of a treating physician. The independent physician regulation has not been struck down in federal court and there is nothing to suggest that if the labor department enacted the more stringent “treating physician rule,” it would be struck down under *Chevron*¹⁵⁶ or any other federal court

152. See Brief for the United States as Amicus Curiae Supporting Petitioner at 6, *Black & Decker v. Nord*, 538 U.S. 822 (2003) (emphasis added).

153. 29 U.S.C. § 1001(b).

154. *Black & Decker v. Nord*, 538 U.S. 822, 833 (2003) (quoting *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996)) (stating that “[i]n contrast to the obligatory, nationwide Social Security program, ‘nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.’”).

155. See Employee Benefits Security Administration, Department of Labor, 29 C.F.R. § 2560.503-1(h)(3)(iii, v) (2006) (noting that “in deciding an appeal of any adverse benefit determination . . . the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field . . . [and] shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.” The health care professional must be a different person than was involved in the initial benefit denial. It is in this sense only that there is any independence required in the internal appeals process).

156. See *Chevron U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-43 (1984) (holding that where a statute is ambiguous as to a particular issue, an agency’s

precedent. The ERISA statute itself does not directly address whether a treating physician's opinion is to be given controlling weight. Therefore, the statute is ambiguous on that point. There is no reason to think that if the DOL promulgated a TPR, a federal court would hold the DOL's regulation to be an impermissible or unreasonable construction of ERISA. To the extent that the administrator's discretion has been undermined, the result is fair. Insurance companies profit by making as many benefit denials as possible and thus should not be trusted to make accurate benefit determinations without effective oversight.

The Bush Labor Department went on to argue:

Moreover, a *treating physician rule* is not necessary to guard against arbitrary decisionmaking by plan administrators, as courts may review plan administrators' decisions to determine whether the administrator acted unreasonably in disregarding evidence of a claimant's disability, including the opinions of treating physicians.¹⁵⁷

However, as demonstrated by this comment's survey of post-*Glenn* circuit opinions, court review of the reasonableness of a plan administrator's decision, short of failure to follow plan or ERISA procedures or acting in bad faith, is wholly inadequate because "[c]ourts cannot second guess the weight that [the insurer] gave to the treating physician's and the independent expert's respective opinions."¹⁵⁸

ERISA commentator Roy Harmon has argued that the treating physician rule is not necessary, despite the Supreme Court's reversal in *Nord*¹⁵⁹ and that "it seems the courts have *de facto* turned the treating physician rule into

construction addressing that issue will be upheld if it is a reasonable "permissible construction of the statute.").

157. See Brief for the United States as Amicus Curiae Supporting Petitioner at 7, *Black & Decker v. Nord*, 538 U.S. 822 (2003) (emphasis added).

158. *Young v. Wal-Mart Stores, Inc.*, 293 F.App'x. 353, 363 (5th Cir. 2008) (citing pre-*Glenn* Fifth Circuit precedent in *Corry v. Liberty Life Assurance Co. of Boston*, 499 F.3d 389, 401 (5th Cir. 2007); *Gothard v. Metro Life Ins. Co.*, 491 F.3d 246, 249 (5th Cir. 2007)). See also *supra* Part II.D.2 - Part III.C.

159. Roy F. Harmon et al., *Weighing Medical Judgments: Explaining Evidentiary Preferences for Treating Physician Opinions in ERISA Cases After Black & Decker Disability Plan v. Nord*, 13 MICH. ST. U. J. MED. & L. 157, 158 (2009) (stating "the Supreme Court's rejection of the treating physician rule in ERISA cases does not imply that district courts must disregard the superior probative value of treating physicians opinions when appropriate.").

an “examining physician” factor.”¹⁶⁰ However, the “examining physician” factor alone does not constitute sufficient grounds to reverse a benefit denial because, as already demonstrated, *Doroshow*, *Champion*, *Young*, and *Doyle* were all upheld despite the fact that the plan administrator consulted with and relied on a *non-examining* physician’s opinion to reject or render irrelevant the plaintiff’s treating physician’s opinion.¹⁶¹ Thus, the administrators were ultimately permitted to deny the benefit.¹⁶² All of the surveyed cases that reversed a benefit denial involved the administrator’s selectively relying on more-favorable medical evidence to the exclusion of plaintiff’s treating physician’s opinion, and additional bad faith or failure to follow explicit plan procedures.¹⁶³ It is apparent that anything short of mandating that special weight be given to the treating physician’s opinion, with appropriate exceptions,¹⁶⁴ causes unsatisfactory results for claimants.

Although the Bush Labor Department argued “nothing in the common law of trusts requires plan administrators, in making factual determinations, to give special weight or deferential consideration to particular evidence,”¹⁶⁵ the *Restatement (Second) of Trusts* lists six specific factors for courts to use in ruling on whether a trustee has abused its discretion:

- (1) the extent of the discretion conferred upon the trustee by the terms of the trust;
- (2) the purposes of the trust;
- (3) the nature of the power;
- (4) the existence or nonexistence, the definiteness or indefiniteness of an *external standard* by which the reasonableness of the trustee’s conduct can be judged;
- (5) the motives of the trustee in exercising or refraining from exercising the power;
- (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.¹⁶⁶

160. *Id.* at 186.

161. *See supra* Part II.B.-C.

162. *Id.*

163. *Id.*

164. *See* Social Security Administration, 20 C.F.R. § 404.1527(d)(2) et seq. (2006).

165. Brief for the United States as Amicus Curiae Supporting Petitioner at 12, *Black & Decker v. Nord*, 538 U.S. 822 (2003).

166. *See* RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d. (emphasis added).

The factors are quite similar to the *Booth* factors noted in Part II B., with element seven of *Booth* being nearly identical to element four of the Restatement.¹⁶⁷ Although the Restatement does not specifically call for the TPR, the National Employment Lawyers Association (NELA) argued in 2003, as amicus curiae in *Nord*, that the circuits were "in a state of confusion when determining how a conflict affects the standard of review."¹⁶⁸ Thus, it concluded that adoption of the treating physician rule would provide an external standard that is consistent with the Restatement and would allow for greater consistency in the ERISA common law.¹⁶⁹ NELA's arguments have proven true today, as *Nord* and *Glenn* have overruled the weight and burden-shifting methods of review previously used in the Ninth and Eleventh Circuits, leaving the courts to weigh evidence more freely and unpredictably.¹⁷⁰ Even if *Nord* and *Glenn* have made ERISA disability cases more consistent and predictable, it is only because the cases have had the effect of trivializing the role of the conflict of interest to the point where it is considered a mere "tie-breaking" factor.¹⁷¹ Consequently, the hurdle has become so great that plaintiffs will probably lose and many would-be plaintiffs simply will not bother taking their cases to court.

A. Treating Physician Opinions are More Reliable than Other Medical Evidence

The treating physician's medical opinion is the most reliable opinion and is deserving of weight in a benefit determination.¹⁷² The Social Security regulations adopting the treating physician rule offer common-sense

167. See *supra* Part II.B.

168. See Brief for the National Employment Lawyers Association as Amicus Curiae Supporting Respondent at 14, *Black & Decker v. Nord*, 538 U.S. 822 (2003).

169. *Id.* at 6, 15.

170. *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1566-68 (11th Cir. 1990). See also *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995).

171. *Metro. Life v. Glenn*, 128 S. Ct. 2343, 2350-51 (2008).

172. See James A. Maccaro, *The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits*, 64 N.Y. ST. B. J. 28, 43 (1992) (finding that "[e]vidence from an unbiased and competent treating physician is usually the best reflection of a claimant's medical condition. It is therefore improper for an Administrative Law Judge to ignore such evidence.").

reasoning as to why the rule is sound and practical policy, by providing that the SSA will generally:

[g]ive more weight to *opinions from your treating sources*, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that *cannot be obtained from the objective medical findings alone or from reports of individual examinations*. When we do not give the treating source's opinion controlling weight, we apply [factors including (i) length of the treatment relationship and the frequency of examination; (ii) nature and extent of the treatment relationship; (iii) supportability of an opinion; (iv) consistency; (v) specialization; and (vi) other factors] (emphasis added).¹⁷³

If the treating physician's opinion is more credible than a one-time examining physician, it is far more credible than a *non-examining* physician hired by an insurance company who merely reviews paper medical records to make a benefit determination. The treating physician rule recognizes that treating physician opinions are more trustworthy than other pieces of evidence because they are based on a professional and fairly disinterested expert who is rendering an opinion by direct examination over a long period of time.¹⁷⁴

A physician who is paid only occasionally for treating a plaintiff should be viewed as more trustworthy than an insurance company, due to the inherent incentives and payment designs of each group. The insurer's goal is profit maximization,¹⁷⁵ despite that fact that under ERISA, it is supposed to act "solely in the interest of the participants and beneficiaries."¹⁷⁶ Physicians are licensed by state boards of medicine and thus are subject to higher ethical standards than insurers, as they may lose their license for violating certain standards.¹⁷⁷ The American Medical Association has also

173. Social Security Administration, 20 C.F.R. § 404.1527(d)(2) et seq. (2006).

174. *Id.*

175. *See generally* 2 Fletcher Corp. Forms § 1883.52 (2009) ("Management's first priority should be to continuously strive for maximum shareholder value.").

176. Employee Retirement and Income Security Act of 1974, 29 U.S.C. § 1104(a)(1) (2006).

177. *See e.g.*, MD. CODE ANN., HEALTH OCC. §14-404, et seq. (2009).

published specific opinions on conflicts of interest¹⁷⁸ and on standards for IEPs and IMEs,¹⁷⁹ violation of which may serve as a basis for loss of membership in the AMA.¹⁸⁰ Though physicians are no doubt subject to pressures from those that are paying them (notwithstanding their ethical and legal obligations), it would seem the pressures on a plaintiff's treating physician would be less serious than on an IME or IEP, because the IME or IEP is likely to have more repeat business with the insurer. NELA has noted that although there is some concern about the trustworthiness of a treating physician, the more pressing issue is the problem of insured plans hiring repeat IMEs and IEPs who are thus incentivized against the truly independent practice of medicine, therefore making it much more likely for insurers to "essentially serve as judge and jury for claims against themselves."¹⁸¹

Finally, those who are in need of disability payments, as demonstrated by treating physician evidence, should be able to receive those payments without constant petty suspicions that their claim is frivolous or

178. See American Medical Association Code of Medical Ethics, Opinion 8.03, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion803.shtml> (last visited Feb. 27, 2010) (noting that "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patient. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.").

179. See American Medical Association Code of Medical Ethics, Opinion 10.03, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1003.shtml> (last visited Feb. 27, 2010) (finding that Industry Employed Physicians and Independent Medical Examiners "should not be influenced by the preferences of the patient-employee, employer, or insurance company when making a diagnosis during a work-related or independent medical examination.").

180. See American Medical Association Rules for Review of Membership, <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs/governing-rules/rules-review-membership.shtml> (last visited Feb. 27, 2010) (stating that the AMA Council on Ethical and Judicial Affairs may "issue appropriate sanctions, including denial of membership to an applicant or expulsion, probation, or suspension of a member. Denial of membership to an applicant or expulsion of a member is imposed only when the Council determines that the physician under review has seriously violated the Principles of Medical Ethics and that it would discredit the AMA to have that physician as a member.").

181. Brief for the National Employment Lawyers Association as Amicus Curiae Supporting Respondent at 11, 18, *Black & Decker v. Nord*, 538 U.S. 822 (2003).

fraudulent.¹⁸² It is better to err on the side of giving out too many benefits than to deny benefits to people who qualify and need it.

B. "Physician Advocacy" Does Not Justify Rejecting the Treating Physician Rule

Social Security Administrative Law Judge Kevin Foley has argued that "[d]octors often are not the independent, objective, and impartial professionals they were once thought to be . . . [for they] frequently become patients' advocates and, on occasion, the purveyors of deception."¹⁸³ Because it is possible that the treating physician's opinion is not credible due to physicians acting as their patients' advocates, the TPR allows the plan administrator to "reject the conclusions of the treating physicians [where] the administrator 'gives specific, legitimate reasons for doing so that are based on substantial evidence in the record.'"¹⁸⁴ Where there is legitimate deviation from the general rule, there is a relatively small and discrete set of reasons for supporting that deviation.¹⁸⁵

Judge Foley himself specifically recommends that the medical profession police itself much more stringently, by enacting and enforcing ethical provisions, and instructing medical students against being "patient advocates."¹⁸⁶ This is a sensible recommendation. Physician groups such as the AMA could help in this regard by amending their bylaws so that in cases where a physician engages in fraud, the AMA Council on Ethical and Judicial Affairs would have to "issue appropriate sanctions, including denial of membership to an applicant or expulsion . . . when the Council determines

182. See George Szary, *The Treating Physician Rule: Morgan Presumption in Social Security Disability Insurance and Supplemental Security Income Cases*, 17 N.Y.U. REV. L. & SOC. CHANGE 303, 338 (1990) (arguing that "individuals with disabilities seeking assistance from the government should not be faced with a system which operates on the assumption that all those who approach it are attempting to perpetuate fraud unless they prove otherwise.").

183. See Kevin F. Foley, *Physician Advocacy and Doctor Deception A Double-Edged Attack on Due Process*, FED. LAW, July 2001, at 24, 25-27 (2001).

184. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002) (citing *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)).

185. See generally Employee Retirement and Income Security Act of 1974, 20 C.F.R. § 404.1527 et seq. (2006).

186. Foley, *supra* note 183, at 28.

that the physician under review has *seriously* violated the Principles of Medical Ethics and that it would discredit the AMA to have that physician as a member."¹⁸⁷ The Council should take a more stringent position on the level of wrongdoing needed to "discredit the AMA to have that physician as a member."¹⁸⁸

Judge Foley also recognizes that laws exist prohibiting disability fraud by physicians, but that those laws are ineffective.¹⁸⁹ Accordingly, such laws should be more aggressively enforced by states,¹⁹⁰ or more stringent laws enacted.

C. Fraudulent Collusion Does Not Justify Rejecting the Treating Physician Rule

A step beyond physician advocacy is the collusion between physician and claimant to fraudulently obtain benefits. Opponents of TPR might contend that the rule would incentivize dishonest physicians to make an agreement with the claimant to fraudulently make a disability finding and share in the proceeds.¹⁹¹ However, as argued by Szary, disability recovery, which is usually only a fraction of the claimant's pre-injury income¹⁹² and which the claimant will probably need to survive on, is simply too small an enticement for a dishonest physician.¹⁹³ Most doctors are already well-compensated and even dishonest ones would not take on the great risk of injuring their professional, medical, and business reputation for such a small return.¹⁹⁴

187. American Medical Association Rules for Review of Membership, *supra* note 180 (emphasis added).

188. *Id.*

189. Foley, *supra* note 183, at 28.

190. *See generally* MD. CODE ANN., HEALTH OCC. §14-404 (2009).

191. Szary, *supra* note 182, at 338-39.

192. *See e.g.*, Jenkins v. Price Waterhouse Long Term Disability Plan, 564 F.3d 856, 858 (7th Cir. 2009) (noting that the LTD plan provided for payment of sixty percent of pre-disability income level).

193. Szary, *supra* note 182, at 338-39.

194. *Id.*

D. Avoidance of a Chilling Effect Does Not Justify Rejecting the Treating Physician Rule

Undoubtedly, any time new or more stringent regulations are proposed, those opposed to them will argue that the regulations will have unintended negative consequences. Arguments under *Glenn* are no exception, even given *Glenn*'s very limited inquiry into benefit denials.¹⁹⁵ As the argument goes, the regulated party (such as an employer) might be chilled from hiring more workers or offering benefits, due to cost of compliance with the rule.¹⁹⁶ Thus, the regulation would ultimately hurt the class of people that it was intended to protect.¹⁹⁷ However, in the context of LTD and death benefits, this argument fails. Disability and death benefits are much less costly to an employer than are pension and health benefits. To the extent that employers are not hiring or are cutting back on benefits due to cost, it is because of the high expense of health benefits, a major and perennial subject of debate in Congress.¹⁹⁸ Disaster benefits, like death and LTD benefits, are less costly than health and pension benefits due to the fact that workers use health care and their retirement savings at a much greater rate. To be sure, there are industries with high levels of workplace disability and death.¹⁹⁹ However, those industries are nearly all covered under state worker's compensation

195. See e.g., Katie Day, *Can Scalia Save Employer-Provided Health Plans? An Analysis of Metropolitan Life Insurance Co. v. Glenn*, 62 TAX LAW. 915, 927-28 (2009) (arguing that "[t]he majority's approach [in *Glenn*] of assigning a level of significance to a conflict subjects employers and insurers to increased litigation costs, or, in the alternative, abandonment of their cost containment structures" and "gives employers one less incentive to provide ERISA-governed health care plans.").

196. *Id.*

197. *Id.*

198. See, e.g., Christopher Lee, *Rise in Cost of Employer-Paid Health Insurance Slows*, THE WASH. POST, Sept. 12, 2007, A4, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/09/11/AR2007091100666.html> (finding that the "[i]ncrease [t]his [y]ear [s]till [o]utpaces [w]age[r] [g]rowth, as [p]ercentage of [p]eople [c]overed [s]hrinks").

199. See Steven L. Willborn, et al., EMPLOYMENT LAW: CASES AND MATERIALS 866-67 (4th ed. 2007).

systems,²⁰⁰ with the more dangerous industries paying more into the system, based on their “experience rating[s].”²⁰¹

Welfare benefits such as LTD and death might be thought of as deferred compensation, in that the employee is presumably willing to be paid less in current compensation in exchange for the greater security that welfare benefits bring. The disabled employee should be due what was promised to him: a portion of previous pay in the case of permanent disability, or survivor benefits to the employee’s spouse. The employee is impliedly promised that when he is disabled, he will actually receive the benefit promised, not merely a statement that there is substantial evidence to support an insurer’s denial, stretching the concept of reasonableness. Anything less than a truly full and fair hearing on disability is a broken promise. A sense of false security discourages the claimant from demanding more in current compensation, from saving more in case of such tragedies, or from attempting to buy better disability coverage on his own.

E. The Treating Physician Rule was Implemented to Counter Government Adjudicator Bias and is Even More Necessary Under ERISA

Prior to SSA’s rulemaking adopting the TPR, the circuit courts of appeal were using varying versions of the rule in court challenges to SSA disability benefit denials.²⁰² The circuits developed these rules in response to public perception that the SSA held a political bias in favor of denying benefits, at a time of “dramatic cuts in the disability rolls during the Reagan administration [which have been] well documented.”²⁰³ SSA noted in its final rulemaking that it adopted the rule in response to the decisions by the circuits.²⁰⁴

200. *Id.* at 863 (finding that “nationally, about 96% of workers are covered”).

201. *Id.* at 866-67.

202. *See* Schneider, *supra* note 28, at 396. *See also, e.g.* Frey v. Bowen, 816 F.2d 508, 513 (10th Cir. 1987) (arguing that the SSA “must give substantial weight to the testimony of a claimant’s treating physician, unless good cause is shown to the contrary.”). *See also, e.g.*, Coffman v. Bowen, 829 F.2d 514, 517 (4th Cir. 1987) (finding that “the opinion of a claimant’s treating physician [must] be given great weight and may be disregarded only if there is persuasive contradicting evidence.”).

203. *See* Schneider, *supra* note 28, at 391.

204. *Id.* at 400.

As already explained, government agencies theoretically operate under high standards of independence, with protections against bias.²⁰⁵ Although these stringent standards were in place and “[b]ias is not established merely because the decisionmaker has rejected the claims or the testimony of a party or because the decisionmaker has fixed views about law, policy or factual propositions not related to specific parties,”²⁰⁶ the courts still felt that SSA’s bias towards rejecting disability benefits warranted the countering TPR rule.²⁰⁷

If government adjudicators who have stringent protections against conflicts of interest and bias must be reigned in with further restrictions like the TPR, then private sector ERISA administrators, who inherently operate under a conflict of interest and who do not have any of the protective insulation that government adjudicators do, should be subject to the TPR. Although political pressure is real, financial pressure to maximize profits and meet the financial bottom line is at least as great, if not greater.

F. The Treating Physician Rule is the Least Drastic Way to Ensure Accurate Decisionmaking

Throughout ERISA’s history, plaintiffs and their supporters have argued that the standard of court review for benefit denials should be *de novo*, rather than *arbitrary and capricious*.²⁰⁸ Some have argued that Congress delegated executive authority to ERISA administrators in passing the act, and therefore due process should attach.²⁰⁹ A colorable argument can even be made that ERISA just doesn’t work, its pre-emption clause²¹⁰ has done more harm than good, and Congress should let the states take over regulating this area. Despite the merit of these arguments, federal courts have not followed any of them.²¹¹ The TPR is a modest, yet still effective rule that will likely

205. *See supra* Part IV.

206. American Bar Association, A Blackletter Statement of Federal Administrative Law, *supra* note 138.

207. *See generally* Schneider, *supra* note 28.

208. Langbein, *supra* note 105, at 1336, 1342.

209. DeBofsky, *supra* note 121, at 837-38.

210. *See generally* Employee Retirement and Income Security Act of 1974, 29 U.S.C. § 1144 (2006).

211. *See supra* notes 208-210.

accomplish much of the goals of this comment's suggestions, at least in the disability and life insurance arenas. There is no measure less drastic than TPR which would be effective, especially in view of the failure of *Glenn*'s non-binding weighing process. An Examining Physician Rule (EPR) would be inadequate because insurance companies already employ examining physicians as well as non-examining physicians and improperly weigh the evidence based on their conflicting financial interests.²¹² An ERISA administrator should be required to have at least a preponderance of evidence, or even clear and convincing evidence to deviate from the treating physician's opinion, so as to make it harder for an ERISA administrator to invent faulty reasons to deny benefits.

VI. CONCLUSION

Administrative law not only gives agency adjudicators wide discretion in deciding cases, but also imposes high standards of integrity and independence on those adjudicators.²¹³ Under ERISA, only half of the story is true: ERISA fiduciaries have wide discretion but very little in the way of standards for independence.²¹⁴ Insurers should not be able to have it both ways. If their decisions are to be reviewed deferentially, as are decisions of government agencies, then claimants need to have some similar procedural protections that simulate the protections they have in dealing with the government. Otherwise, insurers should be reviewed *de novo*. If the kind of bias that insurance companies operate under were found to exist in an Article I or III²¹⁵ adjudication, the decision-maker would likely be violating judicial rules of conduct and the rights of the parties to the case.²¹⁶ *Glenn* has done little to remedy this problem and has trivialized the poisoning impact that conflicts of interests play in the benefit review. The Department of Labor should issue a regulation requiring the use of the TPR by insurers; it represents a practical way to ensure more integrity and independence in ERISA benefit decisions because the rule relies on the opinion of the more

212. See, e.g. *Jenkins v. Price Waterhouse Long Term Disability Plan*, 564 F.3d 856, 861 (7th Cir. 2009) (finding an examining physician's opinion sufficient evidence). See also *Doyle v. Liberty Life Assurance Co. of Boston*, 542 F.3d 1352, 1358, 1363 (11th Cir. 2008) (noting a non-examining physician's opinion is sufficient evidence).

213. See *supra* Part IV.

214. *Id.*

215. U.S. CONST. art. I; U.S. CONST. art. III.

216. See *supra* Part IV.

independent expert who actually examines the patient, has been doing so over a substantial period of time, and lacks the profit motive to deny benefits. The rule does not require rigid application, and has several discrete exceptions. Any negative effect that the regulation may incur on employer benefit packages should be minimal. It is time to make ERISA's promise of protection of employee benefits a reality.