Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans

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> [Benefits] 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, relying on the company's interest in its reputation to prevent it from acting on its bias.[1]
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> —Richard Posner, U.S. District Court Judge

I. INTRODUCTION

In November 2004, the UnumProvident Corporation ("Unum"), the largest disability insurer in the United States,[2] signed a landmark agreement with the insurance directors of Massachusetts, Maine, and Tennessee, and the United States Department of Labor.[3] The Attorney General of the State of New York, Elliot Spitzer, endorsed the agreement.[4] The agreement, made after Unum had lost several high-profile cases,[5] calls

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1. Van Boxel v. The Journal Company Employees' Pension Trust, 836 F.2d 1048, 1052 (7th Cir. 1987).

2. Lisa Girion, *Suit Says Insurer Wrongly Denied Disability Claims*, L.A. TIMES, Apr. 17, 2004, at C1.

3. Press Release, Maine Bureau of Insurance, Multi-State Settlement Addresses Concerns Regarding Unum-Provident Claims Handling (Nov. 18, 2004), http://www.state.me.us/pfr/press/ins_unum_settlement.htm (last modified Nov. 18, 2004) [hereinafter *Multi-State Settlement Addresses Concerns*].

4. *Id.*

5. *See* Dishman v. Unum Life Ins. Co. of Am., No. 96-0015 JSL, 1997 U.S. Dist. WL 906146, at *11–13 (C.D. Cal. May 9, 1997) (bad faith "suspension" of disability benefits used as attempted strategy to settle for substantially less than the amount owed); Radford Trust v. First Unum Life Ins.

for sweeping changes in the way Unum and the companies it owns[6] handle disability insurance claims. In part, the agreement consisted of a $140 million settlement and a $15 million penalty against Unum.[7] Most importantly, Unum agreed to reexamine more than 200,000 claims[8] it denied since January 1, 1997, to institute new claims handling procedures and benefit determination practices, to improve accountability and oversight, and to enhance its own corporate governance.[9] Forty other states have signed on to the agreement.[10] If Unum fails to improve its practices in accord with the agreements, an additional $145 million fine will be imposed.[11]

Many of the disability policies that Unum sells find their way into employer-sponsored benefit packages covered by the Employee Retirement Income Security Act of 1974 (ERISA).[12] Under ERISA, Unum is a fiduciary with a conflict of interest because it both determines the fact of a claimant's disability and pays out of its own purse to resolve claims.[13]

Co. of Am., 321 F. Supp. 2d 226, 249 n.20 (2004) (citing numerous circuit decisions to show pattern of erroneous and arbitrary denials, bad faith contract interpretations, and other unscrupulous practices). Things have been bad for Unum lately, and a sampling of headlines shows how bad: Dateline NBC Airs Allegations Against UnumProvident (Oct. 2002); Class Action Lawsuit Filed In New York Against UnumProvident (Nov. 2002); Judge Upholds $7.67 Million Award Against Insurer (Nov. 2002); Japan Penali[z]es Unit of UnumProvident (Jan. 2003); Calif. Jury Orders UnumProvident to Pay Policyholder $31.7 Million (Jan. 2003); Second Class Action Lawsuit Brought Against UnumProvident (Feb. 2003) (alleged securities violations); Hundreds Sue Largest Disability Insurer (Mar. 2003); UnumProvident Fined $1 Million By Georgia (Mar. 2003) UnumProvident Hit with $84.5M Verdict (Apr. 2003) (Arizona lawsuit); Manhattan Judge Declines to Dismiss Suit Against UnumProvident, Chandler (Apr. 2003); UnumProvident Loses Court Ruling (July 2003); Suit Says Insurer Wrongly Denied Disability Claims (Apr. 2004) (whistleblower suit under ERISA); UnumProvident Gets Subpoena from New York (Aug. 2004); Spitzer Subpoenas Large Insurers in Probe (Oct. 2004); UnumProvident Shareholder Sues Officers, Directors (Jan. 2005), http://www.yourlawyer.com/practice/news.htm?topic=Unum%20Provident%20Fraud (last visited Mar. 20, 2005).

6. Unum Life Insurance Company of America, The Paul Revere Life Insurance Company, First Unum Life Insurance Company, and Provident Life and Accident Insurance Company. http://www.unum.com/aboutus/ourcompanies/upbrandedcompanies.aspx (list of companies) (last visited Jan. 16, 2005).

7. Press Release, Maine Bureau of Insurance, Landmark Multi-State Settlement Takes Effect; National Remedy Grants Claims Review for Thousands (Dec. 21, 2004), http://www.state.me.us/pfr/press/ins_UnumProvident_settlement.htm (last modified Dec. 22, 2004) [hereinafter *Landmark Multi-State Settlement Takes Effect*].

8. At a cost of $120 million. *Multi-State Settlement Addresses Concerns*, *supra* note 3.

9. *Landmark Multi-State Settlement Takes Effect*, *supra* note 7.

10. *Id.*

11. *Id.*

12. "The terms 'employee welfare benefit plan' and 'welfare plan' mean any plan . . . which . . . is . . . maintained by an employer . . . to the extent that such plan . . . is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . *disability* . . . benefits . . . ." 29 U.S.C. § 1002(1)(A) (2004) (emphasis added). Church plans and governmental plans are exempt from ERISA. § 1003(b)(1)–(2).

13. *See infra* Part III.D.

Additionally, Unum probably has language in each of its disability policies that gives it discretion to construe the terms of its policies and decide which claimants get paid. Because Unum is a fiduciary exercising discretion, under current ERISA jurisprudence, its reasons for denying a disability claim are reviewed at the district court level only for an abuse of that discretion.[14]

The Unum settlement exposed Unum's claim denial practices that, because of generally limited discovery, ordinarily would not come to light in a disability claim in federal court under ERISA.[15] The settlement showed the lengths to which a conflicted fiduciary would go in order to benefit its own bottom line over the needs of disabled employee-beneficiaries. If the Unum settlement had been an ERISA case that had been reviewed de novo, additional discovery could take place that would take a plaintiff beyond the record to search for evidence of such denial practices.[16]

In most circuits, however, evidence of abusive practices will not come to light; so long as the plan document explicitly gives the fiduciary discretion to make benefit determinations, courts ordinarily must defer to the fiduciary's decisions.[17] Because discretionary clauses can hide the kind of abuse seen in the Unum settlement, in order to remedy the plight of employees who have obtained bargained-for benefits under ERISA, all ERISA fiduciaries that are also insurance companies should be deemed to have an inherent conflict of interest. Federal courts reviewing these conflicted decisions should then apply a "presumptively void" rule to the conflicted decision, necessitating de novo review.[18] Broad discovery then should be granted under de novo review in order to search for a fiduciary's actual conflict of interest. This approach would help employee-beneficiaries recover benefits due them under the plan free of the conflict of interest.

Part II of this article will introduce the reader to disability insurance. Part III will examine how ERISA is a mixture of different law and how that mixture led to discretionary clauses being inserted and the re-

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14. *See infra* text accompanying note 29.

15. *See infra* Part VI.

16. For example, when an insurance company provides financial rewards as an incentive to claims representatives to improve financial results, and terminating a plaintiff's claim would save forty percent of the projected revenue shortfall, clearly, the conflict of interest determines more than just standard of review. *See* Plaintiff-Appellant's Motion for Limited Remand to the District Court to Allow Full Consideration of a Fed. R. Civ. P. 60(b) Motion Based on Newly Discovered Evidence, Feibusch v. Integrated Device Tech., Inc. Employee Benefit Plan (9th Cir. 2005) (No. CV-03-00265-SOM).

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

18. Although this analysis would apply with equal force to ERISA health insurance plans, only ERISA disability plans will be examined in this Comment.

sulting severe conflicts of interest. Part IV will look at *Firestone Tire & Rubber Co. v. Bruch*, the seminal ERISA case on conflicts of interest. Part V will examine the contributions that the Ninth Circuit has made to ERISA conflict of interest law. Part VI will treat scope of review and discovery and Part VII will conclude that insurers should be strictly regulated in ERISA plans.

II. ERISA DISABILITY BASICS

Disability insurance is designed to be replacement income for an employee when illness or injury makes it difficult or impossible to work, and is one type of insurance that is frequently part of an employee's compensation package. The administration of such a plan is regulated by ERISA if the plan "was established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . disability . . . benefits . . . ."[19] If the employee then gets disabled such that he or she cannot work, the payments from the insurance company can often constitute a major portion of the employee's income. Disability insurance is an eminently compassionate way for an employer to treat its employees. If an employee is totally disabled and cannot work at any occupation, he is useless to an employer.

When determining the fact of an employee's disability, the plan administrator[20] examines the so-called administrative record that the administrator itself has compiled. The employee submits an initial disability claim to the administrator, who has the discretion to request doctors' reports, opinions, and other medical evidence to show whether the employee can perform certain tasks essential to his job. Often, the employee will do job-performance studies and work studies with a specialist, reports of which, when combined with reports from the employee's treating physician, form the basis of the administrative record. In addition to the employee's treating physician, the administrator also has the option of independently examining the claimant with its own medical personnel. If the plan document has granted discretion to the administrator, the administrator holds ultimate power to make decisions, based on the record, on whether the employee is disabled. The employee can ask for further review if at first denied, but once the internal review process is ex-

19. 29 U.S.C. § 1002(1)–(A) (2004).

20. Administrators, fiduciaries, and trustees are all creatures of ERISA and are vested with fiduciary powers. *See* §§ 1102(c)(1), 1002(21)(A). Generally, "fiduciary" will be used in this Comment to refer to the entity exercising fiduciary power.

hausted,[21] the employee must make out a complaint against the insurer or the plan itself in federal court under ERISA.

Although ERISA sets out causes of action and remedies for participants and beneficiaries of benefit plans,[22] the statute is silent on the judicial standard of review to be applied to fiduciaries' decisions;[23] this has lead to wide discrepancies in courts' treatment of challenged disability plans. Before the landmark *Firestone Tire & Rubber Co. v. Bruch* decision, courts typically borrowed the "arbitrary and capricious" standard from labor law[24] or used contract law's de novo review.[25] Trust law was also a natural choice because of the fiduciary duties involved. Since the funding vehicles in ERISA disability plans are often insurance contracts, state insurance law was relevant as well. In other words, no single body of law could be called upon to adjudicate ERISA cases.[26]

In 1989, the United States Supreme Court decided *Firestone Tire & Rubber Co. v. Bruch*, which set a de novo standard of review for ERISA fiduciaries' decisions to deny benefits.[27] Unless the terms of the plan document give the fiduciary discretion to make eligibility decisions or to construe the terms of the plan, the standard of review is de novo.[28] If an

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21. § 1133 requires plans to provide claimants with notice of claim denial, with specific reasons for the denial, and to afford claimants a reasonable opportunity for a "full and fair review" by the plan fiduciary.

22. The typical cause of action under § 1132(a)(1)(B) is brought to "recover benefits due to him . . . to enforce his rights . . . or to clarify his rights to future benefits . . . ." Note the mix of legal and declaratory relief. Two other causes of action are available, one for breach of fiduciary duty by the fiduciary, § 1132(a)(2), and one as a catch-all equitable remedy, § 1132(a)(3). However, the United States Supreme Court has stringently limited the scope of remedies to ERISA's civil enforcement scheme. *See, e.g.*, Aetna Health, Inc. v. Davila, 124 S. Ct. 2488, 2499–2500 (2004) (precluding other extracontractual recovery); Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 221 (2002) (precluding monetary damages); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52 (1987) (precluding state bad faith claims for improper processing of a claim for benefits).

23. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989) ("ERISA does not set out the appropriate standard of review for actions . . . challenging benefit eligibility determinations.").

24. *See, e.g., id.* at 109–10. Federal courts had adopted the arbitrary and capricious standard as a way of asserting jurisdiction over suits under the Labor Management Relations Act ("LMRA") by beneficiaries of LMRA plans who were denied benefits by trustees. But since ERISA authorizes suits against trustees, the jurisdictional basis for the arbitrary and capricious standard falls away and yields to the trust law abuse of discretion standard. *Id.*

25. *See* Matthews v. Sears Pension Plan, 144 F.3d 461, 465 (7th Cir. 1998). The problem with using contract law is that rarely is one party granted the power to interpret and define the terms of a unilateral contract—which is what the plan document amounts to—such that the other party is bound.

26. An excellent survey of ERISA cases can be found in Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Cases*, 50 AM. U. L. REV. 1083, 1096–108 (2001).

27. *Bruch*, 489 U.S. at 115.

28. *Id.* Furthermore, de novo review is applicable whether the plan is funded or unfunded, and whether the fiduciary is operating under a potential or actual conflict of interest. *Id. See also infra* note 94 and accompanying text.

employee can obtain de novo review, discovery can take place outside the administrative record and that evidence can be admitted. If a fiduciary has drafted discretionary authority into the plan document, however, a court will review the fiduciary's decision only for an abuse of that discretion and will not inquire beyond the record.[29]

As important as discretionary authority is to an abuse of discretion analysis, any fiduciary that operates under a conflict of interest[30] will find that conflict also weighed by the reviewing court.[31] The federal circuits have weighed conflicts into their standard of review analyses in at least seven different ways.[32] The problem, however, is that conflicts are not properly weighed because, in an abuse of discretion analysis that looks at the record alone, conflicts that are not evident in the record cannot be properly examined.[33] Agreements such as the Unum settlement should make the rest of the circuits more willing to adopt the Ninth Circuit's "presumptively void" standard in order to apply de novo review when the insurer of an ERISA disability plan is also its fiduciary.

During the multi-state market conduct investigation that led to the Unum settlement, it became clear that what Unum had been doing only scratches the surface of what is wrong with the state of disability insurance, and highlights why courts should apply a de novo review standard more often. Unum relied excessively on the opinions of in-house medical professionals rather than using an independent medical examiner ("IME");[34] when it did use the report of an IME or an employee's attending physician, its own medical professionals' bias resulted in misconstruction of the IME's or attending physician's reports.[35] Unum also failed to evaluate the totality of the claimant's medical picture by not properly considering comorbid[36] conditions that give rise to the disability, and by inappropriately placing the burden on claimants to justify their eligibility for benefits, such as imposing a requirement on the in-

29. *See* Taft v. Equitable Life Assurance Soc'y, 9 F.3d 1469, 1471 (9th Cir. 1993).

30. *See infra* notes 77 and 78 and accompanying text.

31. *Bruch*, 489 U.S. at 115.

32. *See infra* notes 105–111 and accompanying text.

33. *See infra* note 135 and 136 and accompanying text.

34. *See* Report of the Targeted Multistate Market Conduct Examination: Maine Bureau of Insurance, Massachusetts Division of Insurance, Tennessee Department of Commerce and Insurance and Forty-Nine Participating Jurisdictions of Unum Life Insurance Company of America, The Paul Revere Life Insurance Company and Provident Life and Accident Insurance Company, http://www.state.me.us/pfr/ins/Unum_Multistate_ExamReport.htm (last visited Mar. 20, 2005) [hereinafter *Report of the Targeted Multistate Market Conduct Examination*].

35. *Id.*

36. Comorbidity is "[t]he presence of coexisting or additional diseases with reference to an initial diagnosis or with reference to the index condition that is the subject of study." THE CANCERWEB PROJECT, ON-LINE MEDICAL DICTIONARY, UNIVERSITY OF NEWCASTLE UPON TYNE, *at* http://cancerweb.ncl.ac.uk/omd (last visited March 24, 2005).

sured to submit objective proof of disability even though the policy contained no such requirement.[37]

III. THE ORIGINS OF ERISA & ITS ODD DOCTRINAL DEVELOPMENT

A. The Genesis of ERISA

In 1963, the Studebaker-Packard Corporation went bankrupt and could not afford to fully fund its pension plan.[38] Consequently, employees under the age of sixty, some of whom had spent their entire lives working for Studebaker, received lump-sum payments of about fifteen percent of the value of their pensions.[39] What happened to these unfortunate Studebaker employees kindled public outcry and congressional hearings that resulted in ERISA.[40]

B. Trust Law Not Uniformly Applied

ERISA legislation overcame the conflicting interests of employees and employers, unions and management, and the Treasury Department and the Labor Department to become an incomplete body of law.[41] It was incomplete because Congress contemplated that the federal court system would develop a federal common law.[42] Federal common law was required because ERISA expressly preempts most state laws regarding

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37. *See Report of the Targeted Multistate Market Conduct Examination*, *supra* note 34.

38. 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, 683–84 (2001).

39. *Id.* at 731.

40. *See* Michael Allen, *The Studebaker Incident and Its Influence on the Private Pension Plan Reform Movement*, *in* PENSION & EMPLOYEE BENEFIT LAW 68 (John H. Langbein & Bruce A. Wolk eds., 3d ed. 2000); DENNIS E. LOGUE & JACK S. RADER, MANAGING PENSION PLANS: A COMPREHENSIVE GUIDE TO IMPROVING PLAN PERFORMANCE 71 (1998).

41. JAY CONISON, EMPLOYEE BENEFIT PLANS IN A NUTSHELL 71–74 (1993). ERISA reflects the two different types of legislation of which it consists: the labor bills and the tax bills. The labor bills emphasized employee benefit expectation and were largely adopted with enforcement authority vested in the Secretary of Labor. *See also* 29 U.S.C. § 1132(a)(2), (4)–(6), (8)–(9) (2004). The tax bills were also adopted, but primarily as encouragement for the employers to adopt plans. The statute also overcame a late charge from some business interests intent on killing the legislation.

42. *See* S. REP. NO. 4904, *reprinted in* 1974 U.S.C.C.A.N.:

> It is necessary to take into account additional costs from the standpoint of the employer. If employers respond to more comprehensive coverage, vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans.

Id. See also 120 CONG. REC. 29942 (remarks of Sen. Javits) ("[I]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans."); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 55–56 (1987) (comparing ERISA with the LMRA to show that state law remedies were contemplated by the drafters of ERISA).

benefit plans.[43] Federal common law at the circuit level has since flourished,[44] but even with the United States Supreme Court hearing about two benefit cases per term, the Court has not made consistent ERISA law. Part of the problem is that the statute itself encourages inconsistency because it grants discretion to conflicted fiduciaries.

Under ERISA, the fiduciary is central.[45] The fiduciary is responsible for managing plan assets, determining eligibility for plan benefits, and construing plan terms.[46] A fiduciary is required because Congress contemplated that ERISA funds would be held in trust,[47] thus ensuring protection of those funds should a business dissolve, as happened to Studebaker. A fiduciary can entrust its duties to others,[48] and employer-fiduciaries frequently do just that when they outsource the administration and the funding of the disability plan to an insurance company.[49]

In trust law, the settlor of a trust may confer broad discretionary powers on a trustee, and a court generally will not substitute its own judgment for that of a trustee's when the trustee is acting pursuant to such a grant of power.[50] Under ERISA, however, a person becomes a

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43. *See* § 1144(a); Bast v. Prudential, 150 F.3d 1003, 1007 (9th Cir. 1998). ERISA does not preempt state laws regulating insurance, banking, and securities law, but it does prevent states from construing benefit plans as insurers, banks, or investment companies. § 1144(b)(2)(A). See also § 1144(b)(2)(B) for the following:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Where ERISA is silent, state laws could be used as gap fillers. Since *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), however, courts have been more willing to find state laws not preempted. *See, e.g.*, De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 809 (1997); Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc., 519 U.S. 316, 319 (1997).

44. For example, the circuits have been busy developing rules for treating conflicts of interest. *See infra* notes 105–111 and accompanying text.

45. *See* § 1002(21)(A) ("[A] person is a fiduciary with respect to a plan to the extent he exercises any discretionary authority or discretionary control respecting management . . . or disposition of its assets . . . .").

46. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) (fiduciary with plan-granted discretionary authority can construe terms of plan).

47. *See* § 1103(a) ("[A]ll assets of an employee benefit plan shall be held in trust . . . .").

48. §§ 1102 (a)(2)(A), 1105(c)(1)(B).

49. *See* § 1002(1)(A). "Through the purchase of insurance or otherwise . . . ." *Id.* If an employer self-insures a short-term disability plan without establishing a trust, the plan is likely to be a "payroll practice" not subject to ERISA because of 29 C.F.R. 2510.3-1(b)(2) (2005) (stating that "employee welfare benefit plan" does not include payment to employee, out of employer's general assets, when employee is physically or mentally unable to perform job).

50. *See, e.g.*, Stratton v. E.I. DuPont de Nemours & Co., 363 F.3d 250, 253 (2004) (holding that a court may not substitute its own judgment for that of the administrator's when the court is reviewing under a deferential or heightened arbitrary and capricious standard). Note that this is a

fiduciary whenever that person exercises *any* discretionary authority or control.[51] The difference between trust law and ERISA law is thus enormous: Under ERISA, a person can be a fiduciary and can exercise trustee-like authority whenever he or she exercises any trust management powers, even though the express or implied grant of authority ordinarily required under trust law is absent.

Because ERISA fiduciaries do not need a grant of power, using trust law to adjudicate ERISA disability cases poses two major problems. First, it is a foreign concept to trust law that a fiduciary becomes a fiduciary because of the function that he or she performs. Settlors *name* trustees under trust law; trustees do not simply arise because they act like trustees. ERISA has thus expanded the scope of liability by broadening the definition of a trustee.[52]

Second, although a trust will not fail for lack of a trustee, a trustee will fail for lack of a trust. Thus, when plan assets are not held in trust, they are not under a trustee's authority, yet the trustee's decisions still get deference, even though the rationale for such deference has dropped out.[53]

For example, treatment of insurance contracts are exceptions to the ERISA rule that plan assets must be held in trust.[54] Because insurance contracts do not fall under ERISA's trust requirements, disability insurance contracts thus raise special concerns insofar as deference is concerned. If a court used only trust law when evaluating a disability insurance claim, it would have to conclude that no trust means no trustee, and no trustee means no deference. While some courts understand the unique suspension of trust law as applied to ERISA and insurance companies,[55] many others prove themselves unable to properly apply the needed law.

C. Problems with Discretionary Language

ERISA jurisprudence is problematic both because insurance contracts do not fall under ERISA's trust requirements and because fiduciar-

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basic question in level-of-review analysis in administrative law. *See, e.g.*, Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416 (1971) (holding that a court is not empowered to substitute its judgment for that of an administrative agency).

51. § 1002(21)(A) ("[A] person is a fiduciary with respect to a plan to the extent he exercises any discretionary authority or discretionary control . . . .").

52. *See* KENNEDY, *supra* note 26, at 1107.

53. *See* Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556, 1561 (11th Cir. 1990) (noting that since "[t]he basis for the deferential standard of review in the first place was the trust nature of most ERISA plans, the most important reason for deferential review is lacking." (citation omitted) (internal quotation marks omitted) (alteration in original)).

54. § 1103(b)(1) ("The requirements . . . shall not apply to any assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State.").

55. *E.g.*, Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377 (3d Cir. 2000).

ies of insurance-funded plans have nearly unbridled discretionary authority.

As the fiduciary is central to ERISA, so discretionary authority is central to the fiduciary. Discretionary power defines the fiduciary's relationship to the plan and its participants,[56] letting ERISA fiduciaries control plan assets[57] decide who qualifies for benefits, and construe the terms of the trust.[58]

Discretionary authority is not ordinarily a problem, and indeed, granting discretion to fiduciaries has many benefits. Without discretion, plan assets might not be managed responsibly and fiduciaries might not be able to resolve claims in the cost-effective manner envisioned as a major policy goal of ERISA.[59] Fiduciaries need discretion to deny unworthy claims that, if paid, would unfairly reduce benefits to all other participants and would thus violate ERISA's exclusive benefit rule.[60] Fiduciaries are also in the best position to construe the terms of their particular plans because they are accustomed to operating under the terms of their plans. Furthermore, employers as fiduciaries are motivated to treat beneficiaries fairly and to avoid getting a reputation for sharp dealing, which, among other negatives, would reduce morale among workers.[61] Finally, if employer-fiduciaries did not have discretion to control plan costs, fewer would offer plans to employees.[62]

Yet plan terms that confer discretionary power upon a fiduciary are often detrimental to disability claimants because, with unfettered discretion to deny benefits unilaterally, fiduciaries can turn disability contracts into contracts of adhesion. A contract is not rooted in bilateralism when one party dictates the terms.[63] Basic procedural safeguards are missing when ERISA claims are "adjudicated" by conflicted fiduciaries who are

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56. § 1002(21)(A) ("[A] person is a fiduciary with respect to a plan to the extent he exercises any discretionary authority or discretionary control respecting management . . . or disposition of its assets . . . ."). Every plan document must name a fiduciary. § 1102(a).

57. *See* § 1103(a).

58. As long as such discretion is written into the plan. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) (holding that the arbitrary and capricious standard of review will be applied if the plan document confers discretionary authority upon the fiduciary). *See* Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio, 982 F.2d 1031 (6th Cir. 1993) (finding that when an insurance company has authority to grant or deny such claims, the insurance company has discretionary authority).

59. *See* § 1001b(c)(5) ("[T]o maintain the premium costs of such system[s] at a reasonable level . . . .").

60. *See* § 1103(c)(1).

61. John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 216 (1990).

62. *Id.*

63. *See* Jay Feinman, *Un-Making Law: The Classical Revival in the Common Law*, 28 SEATTLE U. L. REV. 17 (2004) (discussing how "classical revival" in law treats contracts of adhesion).

less-than-impartial arbiters. Disability claimants must first exhaust the fiduciary's review process before they can bring a suit in federal court, and even then a federal judge will be reviewing the administrator's decision only for abuse of discretion.[64] Add a conflicted fiduciary and disability claimants face a tough go.

An insurance company will frequently act as fiduciary, a fearsome creature because it lacks the reputational incentive that employers have to avoid sharp dealing with employees. An insurer's incentive is to keep the employer as a customer, and it does that by keeping costs down, resulting in denied claims. When a claim is denied, employers are insulated from employees' ire by the insurer. If it is true that an employer-fiduciary's reputational interest wanes as the employment relationship dissolves,[65] the insurer-fiduciary may be one of the least motivated creatures in the legal world. If the insurer-fiduciary cannot even muster the motivation to avoid sharp dealing when dealing with ex-employees, one can only guess as to its other lackluster interests.

Given the conflict of interest inherent in an insurance company acting as a fiduciary, discretionary language in disability insurance contracts is, not surprisingly, under heavy attack. In February 2004, citing state law,[66] the California Department of Insurance began voiding disability insurance contracts that contain discretionary terms.[67] Pursuant to this action, the Department has withdrawn its previous approval from disability form contracts that contain discretionary terms.[68] California is taking a distinctly contractual approach to the problem of discretionary terms,[69] and *Bruch* does not speak to the enforceability, under state insurance law, of discretionary terms; *Bruch* only sets the standard of review for

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64. "[T]he practical effect of allowing discretionary clauses in insurance policies is contrary to every principle of insurance law and civil procedure developed over the past 100 years." Committee on Consumer Protection, Nat'l Ass'n of Ins. Comm'rs, (Dec. 8, 2003) *at* http://www.naic.org/government_relations/health_policy/docs/DeBofsky_TESTIMONY.doc (testimony of Mark D. DeBofsky).

65. *See infra* text accompanying notes 102–103.

66. *See* CAL. INS. CODE §§ 10291.5(f), 12957 (2005).

67. Letter Opinion from Gary M. Cohen, General Counsel, State of California Department of Insurance, to Teresa S. Renaker, Esq., Lewis and Feinberg, P.C. (Feb. 26, 2004) at 1, http://www.insurance.ca.gov/LGL/Letter-Opinion-per-CIC-12921-9-Discretionary-Clauses.htm (last visited Mar. 15, 2005) ("[A]ll such discretionary clauses in disability insurance contracts violate California law and deprive insureds of protections to which they are entitled . . . .").

68. Memorandum Notice to Withdraw Approval and Order for Information from John Garamendi, California Insurance Commission, to All Disability Insurers Doing Business in California (Feb. 27, 2004), http://www.insurance.ca.gov/docs/FS-Legal.htm (withdrawing any approval of any disability forms known to contain discretionary clauses).

69. *Id.* ("Although the contract contains the insurer's promise to pay benefits under the stated conditions, the 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.").

those plans that do have discretionary terms. Recent United States Supreme Court decisions on insurance contracts and ERISA preemption have affirmed this,[70] the Court reasoning that ERISA's savings clause[71] entrusts the states with the regulation of insurance and thus state laws that mandate insurance contract terms are saved from ERISA's preemption provisions.[72] The lack of preemption of state insurance laws governing discretionary clauses and ERISA's lack of a trust requirement for insurance contracts means that little stands in the way of continued invalidation of discretionary language by state insurance commissioners.

The mounting attack upon discretionary language followed a 2002 announcement by the National Association of Insurance Commissioners' ("NAIC") that it had adopted the "Prohibition on the Use of Discretionary Clauses Model Act,"[73] aimed at health insurers. A similar model act, aimed at disability insurers, was recently approved by the NAIC.[74]

To further understand why discretionary language is so bad for ERISA beneficiaries, we must understand how ERISA has actually provided for conflicted fiduciaries.

D. Conflicts of Interest

An ERISA fiduciary's relationship with plan participants is at the heart of much of ERISA jurisprudence. ERISA fiduciaries are supposed to act exclusively for the benefit of a trust's beneficiaries[75] because of the duty of loyalty under trust law.[76] If a fiduciary's interest conflicts with a beneficiary's interest, the fiduciary is to consider the beneficiary's interest alone, else a conflict of interest exists. If the fiduciary is conflicted,

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70. *See* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 386 (2002) for the following:

> Nothing in ERISA, however, requires that these kinds of decisions be so "discretionary" in the first place; whether they are is simply a matter of plan design or the drafting of an [insurance] contract . . . . [State statutes] prohibit[] designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract's terms.

See also Aetna Health, Inc. v. Davila, 124 S. Ct. 2488, 2502 (2004) (holding that a denial of benefits under ERISA-regulated benefit plans is removable to federal district court).

71. 29 U.S.C. § 1144(a) (2004) (ERISA supersedes any and all state laws insofar as they relate to any employee benefit plan).

72. *See, e.g.*, Unum v. Ward, 526 U.S. 358, 375 (1999) (holding that state laws mandating insurance contract terms are saved from preemption under § 1144(b)(2)(A)).

73. Press Release, Nat'l Ass'n of Ins. Comm'rs, NAIC Members Adopt Discretionary Clause Model Act (June 9, 2002), http://www.naic.org/pressroom/releases/rel02/061002_adoption_of_discretionary.htm (last visited Dec. 27, 2004).

74. *See* PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT (Nat'l Ass'n of Ins. Comm'rs, Draft, July 8, 2004), http://www.naic.org/models_papers/models/models.htm (last visited Dec. 27, 2004).

75. §§ 1103(c)(1), 1104(a)(1). *See also* RESTATEMENT (SECOND) OF TRUSTS § 170(1) (1992) (trustee is under a duty to administer the trust solely in the interest of the beneficiaries).

76. RESTATEMENT (SECOND) OF TRUSTS § 170(1) (trustee is under a duty to administer the trust solely in the interest of the beneficiaries).

the possibility exists that the fiduciary's self-interest will enter into the decision to deny benefits; if this denial unduly profits the fiduciary, and if a breach of loyalty occurs, a court will face a problematic calculation in determining how much deference it should grant the conflicted fiduciary's denial decision.

Conflicts of interest typically happen in three circumstances: (1) An employer of an unfunded plan[77] is the fiduciary; (2) an insurer in a pay-as-you-go plan is the fiduciary; and (3) an internal benefits committee on the employer's side is the fiduciary. Any benefit denial obviously reduces the cost of benefits under the plan. Herein lies the conflict: An employer or insurer must be concerned about its bottom line and cannot both fund the plan and fairly determine benefits. Such an arrangement is, in the majority of the circuits, a presumptive or inherent conflict of interest.[78] Instead of asking whether a meaningful review of disability claims is even possible when employer or insurer that stands to lose money if it pays the claim is the same party that has the discretion to pay the claim, ERISA law has simply continued with this uneasy alloy. Unfortunately, federal courts have dealt with the problem of review by conceding to the employer's interests.[79]

The passage of ERISA in 1974 signaled a congressional concession to employers' interests. Congress, it seems, actually expected conflicted fiduciaries to be running plans;[80] if employer fiduciaries could not run plans, plans would be fewer and benefits lower.[81] Yet ERISA does not say how much of a conflict or what kind of a conflict would be required for a court to adjust (if at all) the level of deference it affords a conflicted fiduciary's denial decision. It is in dealing with conflicted fiduciaries, whether employer-fiduciaries of self-funded plans or insurer-fiduciaries

77. An unfunded, or pay-as-you-go, plan is one where assets are put into the plan on a demand basis.

78. *See, e.g.*, Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 387 (3d Cir. 2000) (heightened form of arbitrary and capricious standard of review required when an insurance company both funds and administers benefits because of potential self-dealing); Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., 125 F.3d 794, 797 (9th Cir. 1997) (citing Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1561 (11th Cir. 1990) for the statement that "[b]ecause an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business"). Any other arrangement, such as if the administrator is the insurance company while the employer is the funding source, see *Brown* 898 F.2d at 1561, or vice versa, would not be an inherent conflict of interest.

79. For an analysis of the employers' and employees' interests involved, see John H. Langbein & Daniel Fischel, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1119–25 (1988).

80. *See* § 1102(c) (any person may serve in more than one fiduciary capacity, including service both as trustee and as administrator).

81. Langbein, *supra* note 61, at 213.

of insurance plans, that ERISA left a gap that the federal courts have struggled to fill. As we will see, that gap was at best inexpertly filled by *Bruch*.

IV. *BRUCH*: WHY IT WAS SEMINAL AND WHAT IT HAS MEANT FOR ERISA JURISPRUDENCE

A. The Elevation of Discretionary Language

Discretionary language in ERISA plans, though well intentioned, turned out to be very negative for employers. Though *Bruch* seems to have advanced the interests of employees by subjecting benefit denials to de novo review and by forcing fiduciaries to explicitly craft language into plans before exercising discretion, the result was a narrowing of employee benefits. By so elevating discretionary language, *Bruch* walled off a search for conflicts of interest.

Recall the standard of review from *Bruch*: A fiduciary's decision to deny benefits will be reviewed by a federal judge de novo unless the plan grants the fiduciary discretion to determine eligibility for benefits or construe the terms of the plan.[82] Prior to this, the old arbitrary and capricious standard from labor law had been functioning well as a standard of review without specific plan terms granting discretion. Under that standard, a plan fiduciary could deny benefits to an employee as long as the fiduciary was not acting arbitrarily or capriciously in denying the claim for benefits. It remains unknown why the *Bruch* court thought it necessary to change this standard so radically by making the standard de novo. After all, some courts were responsive in applying a more stringent standard when they saw evidence that a fiduciary's decisions were less than impartial.[83] The *Bruch* court did not need to impose an entirely new framework for formulating a standard of review in benefit denial situations.

1. Plan-Granted Discretion

Justice O'Connor, who authored the unanimous *Bruch* opinion, wrote at length about the importance of trust law when dealing with ERISA questions, particularly as to the fiduciary's power to construe the

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

83. *See* Van Boxel v. The Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1052–53 (7th Cir. 1987) (applying a sliding scale of deference); Jung v. FMC Corp., 755 F. 2d 708, 711–12 (9th Cir. 1985) (applying the same sliding scale of deference); *see also* ERISA: A COMPREHENSIVE GUIDE 227, 228 (Martin Wald & David E. Kenty eds., 1991).

terms of the plan.[84] Referring to the Restatement (Second) of Trusts, she explained that a fiduciary's discretion to exercise powers is not subject to the control of the court, except to prevent an abuse of that discretion.[85] So far, so good; this is the familiar arbitrary and capricious standard. Yet then she takes a hard right turn in her trust law analysis: Courts are to defer to fiduciaries' decisions, she says, "[I]n the exercise of a *discretion vested in them by the instrument* under which they act."[86] This is a subtle but powerful move. The plan document has gone from being a source of terms guiding the grant of discretion to being the font of discretion itself. If the font does not allow discretion, the ERISA fiduciary has no discretion, and benefit denial decisions will be reviewed accordingly—de novo.

ERISA, paradoxically, nevertheless granted that discretion with the following: "[T]he trustee . . . shall have exclusive authority and discretion to manage and control the assets of the plan."[87] ERISA's "functional" approach to defining a fiduciary seems, additionally, to have granted discretion by describing a "fiduciary" as anyone who exercises "discretionary authority or . . . control" with respect to the plan.[88] Yet Justice O'Connor's opinion now restricts discretionary powers to what the text of the plan document confers,[89] rather than referring to ERISA's text or the fiduciary rules already being used in trust law.[90]

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84. *Bruch*, 489 U.S. at 112 (citing G. BOGERT & G. BOGERT, LAW OF TRUSTS & TRUSTEES (2d rev. ed. 1980), 3 W. FRATCHER, SCOTT ON TRUSTS (4th ed. 1988), and RESTATEMENT (SECOND) OF TRUSTS (1959)).

85. *Id.* at 111. *See* RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1992) (a court is not to intervene in a fiduciary's decisions where the fiduciary has had discretionary power conferred upon it, except to prevent an abuse of that discretion).

86. *Id.* (quoting Nichols v. Eaton, 91 U.S. 716, 724–25 (1875).

87. 29 U.S.C. § 1103(a) (2004).

88. § 1002 (21)(A)(i). *See also supra* note 51 and accompanying text.

89. The test for plan-granted discretion has become extremely formalistic. *See, e.g.*, Mizzell v. Paul Revere Ins. Co., 278 F. Supp. 2d 1146, 1148 (C.D. Cal. 2003) (memorandum of decision regarding standard of review and related issues stating that plan documents must "unambiguously say in sum or substance that the Plan Administrator or fiduciary has authority, power, or discretion to determine eligibility or to construe the terms of the Plan . . . .").

90. *Bruch*, 489 U.S. at 115. Another commentator has made the argument more clearly that an express grant of discretionary authority in a plan document is not required by the very section of the Restatement from which Justice O'Connor was working. Langbein, *supra* note 61, at 219. "*The exercise of a power is discretionary except* to the extent to which its exercise is required by the terms of the trust or by the principles of law applicable to the duties of trustees." Restatement (Second) of Trusts, § 187 cmt. a (emphasis added). Thus, after *Bruch*, to go from an abuse of discretion standard to a de novo standard just because ten words of boilerplate are missing violates trust law. *See also* Langbein & Fischel, *supra* note 79, at 1114–17 (arguing that fiduciary rules restrict discretion).

2. The Elevation of Plan-Granted Discretion

If discretion is now both required by and restricted to the plan document, the Court has narrowed the idea of ERISA discretion by throwing out the two fonts of discretion already used, fiduciary rules and the statute itself. In effect, the Court has elevated discretionary plan language to be the primary, if not the sole, font of discretion, rather than making the plan language a restraint on discretion. The Court did not stop there. When Justice O'Connor used the Restatement, she should have looked at the same section from which she plucked her other trust principles, namely, section 187, a section that puts her text-granted discretion on the same footing as conflicts of interest. Comment d to section 187[91] is a list of "circumstances [that] may be relevant" to a court when determining whether a fiduciary has abused its discretion. One of those circumstances is the extent of discretion conferred upon a trustee by the terms of the trust; another is whether the fiduciary has an interest that conflicts with beneficiaries' interests.

Though both of these circumstances demand consideration, the *Bruch* Court has elevated but one of them to dispositive weight: "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'"[92] Fiduciaries can now easily ensure that their acts will be adjudged under an abuse of discretion standard simply by adding a line or two of boilerplate to every plan they oversee. In an abuse of discretion review, only the administrative record is ever reviewed.[93] If only the record is reviewed in isolation—that is, without the factors such as those in Comment d—evidence about conflicts will likely remain hidden, especially when it comes to the structural conflicts that insurer-fiduciaries routinely experience.

Thus, by elevating the textual grant of discretion above the other Comment d factors, the Court has functionally stated that a conflict of

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91. RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1992). Comment d states the following:
In determining the question whether the trustee is guilty of an abuse of discretion in exercising or failing to exercise a power, the following circumstances may be relevant: (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.

Id.

92. *Bruch*, 489 U.S. at 115 (citing RESTATEMENT (SECOND) OF TRUSTS, § 187, cmt. d. (1959)).

93. Taft v. Equitable Life Assurance Soc'y, 9 F.3d 1469, 1471 (9th Cir. 1993).

interest is no longer an independent factor of equal weight with a textual grant of discretion. At the same time, the textual grant makes abuse of discretion review easier to obtain simply by adding boilerplate language; it is thus easy to confine the conflict of interest inquiry to the administrative record. Such undetected (and undetectable) conflicts can harm employees' interests as beneficiaries because the conflicts are simply not properly weighed in ERISA standard of review analysis. And insurer-fiduciaries that are inherently conflicted because of their financial incentives and motivated toward sharp practices are especially potent sources of undetected conflicts.

Justice O'Connor gave insurer-fiduciaries an additional boost when she said that the analysis does not hinge on whether or not the plan is funded.[94] As long as the text of the plan grants discretion, the fiduciaries of unfunded, pay-as-you-go plans can make the same kinds of fiduciary decisions even though there is no corpus to protect. Just a bit of boilerplate will give conflicted fiduciaries of unfunded plans complete discretion to deny claims.

This freedom of discretion is but one of myriad points where federal common law on ERISA has departed from a consistent approach to identifying interests in the employment context, and again demonstrates how ERISA trusts are fundamentally different from gratuitous trusts.[95] Insurer-fiduciaries are insulated doctrinally from a searching conflicts analysis because the easily obtained abuse of discretion standard preserves most conflicts from judicial inquiry.

The *Bruch* rule should have been narrowly tailored to Firestone Tire's specific situation. Firestone had sold five plastics plants to Occidental Petroleum Company,[96] and several employees who had been working for Firestone were "rehired" by Occidental with no interruption in their essential jobs.[97] Firestone had maintained three unfunded[98] "employee welfare benefit plans"[99] under ERISA, one of them a termination

94. *Bruch*, 489 U.S. at 115.

95. *See* Langbein, *supra* note 61, at 211 (stating that reciprocity makes benefit plans arise as a matter of contract law, not private trust law). See also Brief for the United States as Amicus Curiae Supporting Respondents at 8–10, Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) (No. 87-1054), in which the Solicitor General urged the Court to use contract law as the ground for de novo review. Contract law would interpret benefits plans as contracts bargained at arms' length. Such bilateralism best achieved the twin ERISA goals of insulating benefit plans from employers' interests and ensuring that employees who become eligible for benefits actually receive them.

96. Bruch v. Firestone Tire & Rubber Co., 640 F. Supp. 519, 520 (1989).

97. *Id.* at 521 (following the sale, plaintiffs and most of the other employees continued, without interruption, to perform their same jobs at the same rates of pay as employees of the new owner, Occidental).

98. *Id.* at 522.

99. 29 U.S.C. § 1002(1) (2004).

pay plan.[100] When the employees sought severance pay from the termination plan after being hired by Occidental, Firestone claimed that the sale of the plastics division did not constitute a "reduction in work force" as defined in the plan document[101] and flatly refused to pay.

Where the tie between employee and employer is dissolving, as was the case with Firestone, the same incentives employers have for fair dealing are not present, opening the door to dual loyalties. The same safeguards[102] that would protect employees from conflicted employers are not present with conflicted insurer-fiduciaries.[103] Disability claims are like dissolving companies: If the employee is totally disabled, he is lost to the employer, and employer incentives begin to drop out. The insurer-fiduciary's interest is in retaining the employer as a client. Employers recruit and retain employees with these benefits; if benefit plans do not deliver as promised because the insurer-fiduciaries can interpret the plan as they go, then the disability contract becomes one of adhesion. Such blurred focus is detrimental indeed, as employees most need protection from the conflict of interests that an insurer-fiduciary operates under as a matter of course.

B. Abolition of Discretionary Terms

Now that we have seen how conflicts of interest are hidden from a reviewing court in an abuse of discretion analysis, we can begin to appreciate what the California Insurance Commissioner is doing by banning disability contracts that contain terms that confer discretion. If disability insurance contracts are stripped of discretionary language, a strict reading of *Bruch* would call for de novo review because abuse of discretion review is available only for fiduciaries operating under a textual grant of discretion. Without the boilerplate, fiduciaries are cut off from their font of discretion; thus, standard of review determinations will become more of a fight for fiduciaries. Because employers, acting as settlors under trust law, confer discretionary power on insurer-fiduciaries, these insurer-fiduciaries will naturally argue to maintain the abuse of discretion standard of review. A federal court can then make a factual determination outside the record and will take into consideration whether the first factor of Comment d has been met. Under California

100. *Bruch*, 640 F. Supp. at 521.

101. *Id.* at 525.

102. Such as an employer's reputational interest, union monitoring, and costliness of judicial review as a substitute for routine deference. *See* Langbein & Fischel, *supra* note 90, at 1132.

103. *See* Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 378 (3d Cir. 2000) (employer incentives missing when insurer is fiduciary).

law, a court could find that this first factor has not been met because the terms of the trust will not have conferred discretion to any "extent" at all.

To go from a protected abuse of discretion review to de novo just because of ten to twenty words of boilerplate seems harshly formal and is but one of the questionable ways a fiduciary can get discretion; background trust principles already operate without the limitations of textual grants of discretion, so the boilerplate is arguably extraneous. The *Bruch* analysis is an unnecessary analysis, and does not change the result. If discretionary language is in the plan document, the fiduciary is evaluated for abuse of his discretion, just as if he had followed the background law of trusts where discretionary power is the default (and where a conflict and a textual grant would be evaluated as independent factors). Now, to get that same abuse of discretion review, the fiduciary has to be *sure* to draft it in the boilerplate. The boilerplate does not cure the conflict, however, and a lack of boilerplate will not work against the non-conflicted fiduciary. Additionally, if the boilerplate confers discretion, conflicts likely will not be weighed properly because they cannot be properly examined if the inquiry is confined to the record.

If discretionary language is widely abolished by states, and if *Bruch* is gutted of significance and exposed as an unnecessary decision that prevents a clear view of trust law from developing in ERISA doctrine, conflicts of interest will resurface as factors demanding renewed consideration by courts. A clear view of trust law would have required a larger role for a conflict of interest analysis in the standard of review determination. The outlawing of discretionary terms in ERISA disability plans funded and administered by insurance companies exposes *Bruch* as inadequate and reorients ERISA jurisprudence toward a rigorous conflict of interest approach. The approach that should be applied is that of the Ninth Circuit. For conflicts involving insurer-fiduciaries, the Ninth Circuit approach exposes conflicts best and at the lowest cost.

V. THE NINTH CIRCUIT'S CONFLICT OF INTEREST RULES

A. How the Ninth Circuit Treats Conflicts of Interest

All the circuits have adjusted *Bruch*'s simple distinction between de novo review and abuse of discretion review when a conflict is involved.[104] The result of a conflict of interest ranges from making the fi-

104. *See* Kennedy, *supra* note 26, at 1153–62 (surveying adjustments to the standard of review).

duciary's decision presumptively void,[105] to being evidence of bias,[106] to requiring a "more bite" analysis,[107] to being a "smoking gun,"[108] to a sliding scale analysis,[109] to creating a burden shift to the administrator,[110] or to establishing a "neutral" presumption.[111] The *Bruch* Court, however, held that a conflict of interest was to be weighed as only a *factor* in determining whether there was an abuse of discretion. Under *Bruch,* courts are not allowed to review conflicted fiduciaries' decisions de novo if the plan gives the fiduciary discretion, even in the face of the conflict.[112] Un-

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105. *See* Atwood v. Newmont Gold Co., 45 F.3d 1317, 1323 (9th Cir. 1995) (stating that actions taken by a trustee in violation of a fiduciary duty are presumptively void); *see also* Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556, 1568–68 (11th Cir. 1990).

106. *See Atwood,* 45 F.3d at 1323.

107. Doe v. Travelers Ins. Co., 167 F.3d 53, 57 (1st Cir. 1999).

108. Sullivan v. LTV Aerospace & Def. Co., 82 F.3d 1251, 1259 (2d Cir. 1996).

109. *See* Elliott v. Sara Lee Corp., 190 F.3d 601, 605 (4th Cir. 1999).

110. In *Fought v. Unum Life Ins. Co. of Am.*, 357 F.3d 1173 (10th Cir. 2004), *vacated on reh'g*, 379 F.3d 997, 1007 (10th Cir. 2004), the Tenth Circuit improved upon the sliding scale standard by using a burden shift to mark a point along a sliding scale under an arbitrary and capricious analysis. In this analysis, if the plaintiff can prove a conflict, or if the insurer and administrator are one and the same, or if there is a serious procedural irregularity, an additional reduction in deference is due. *Id.* at 1007 This additional reduction manifests itself as a burden upon the administrator to prove that its decision to deny benefits was both reasonable and supported by substantial evidence. *Id.* at 1014. Note that the burden is not on the administrator to rebut the conflict of interest (as in the Ninth Circuit), but once the plaintiff has shown a "serious" conflict, the administrator has to show a reasonable decision based on substantial evidence.

The burden shift to the administrator is the simplest and most straightforward way to deal with conflicts. It comports with ERISA, 29 U.S.C. § 1106 (2004), on prohibited transactions. Furthermore, the substantial evidence standard in this decision, on petition for rehearing, was a cutback on the language in the initial Court of Appeals case, 357 F.3d 1173, which would have required the administrator to use a *preponderance* of evidence to support its decision. 379 F.3d at 1007. That preponderance standard would have replaced the substantial evidence standard and moved ERISA claims adjudication further away from an administrative law model. Nonetheless, the rehearing decision in *Fought* left the core intact: A conflicted third-party insurer has to justify its decision by substantial evidence in order to retain the deferential standard of review. *Id.* at 1006. Yet does it really matter? The Tenth Circuit, using the substantial evidence standard, reached the same result as the district court did using the preponderance standard. So it is still difficult to say how much deference is too much. Finally, it is not clear whether this burden shift should apply to all insured plans, or just circumstances involving policy limitations or exclusions.

111. *See* Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir. 1998) (fiduciary acts neutrally unless a claimant shows by "specific evidence of actual bias that there is a significant conflict"); Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan, 195 F.3d 975, 981 (7th Cir. 2000) (although the insurer-administrator stands in a conflicted position, it is "unsound" to impute to first-level administrative decisionmaker such conflicted position).

112. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). Note that the mere existence of a conflict of interest does not change the standard of review, but rather determines whether there has been an abuse of discretion under the abuse of discretion standard. This is an important distinction that is easy to miss and one that some would say the lower federal courts since *Bruch* have missed in their conflict of interest formulations. A conflict of interest does not, for the *Bruch* Court, invoke the de novo standard. *Id.* at 115. Only a lack of a grant of discretionary author-

der *Bruch*, there are only two standards of review: de novo and abuse of discretion. *Bruch* establishes that conflicts of interest only play a part in determining whether there has been an actual *abuse* of discretion.[113] In every circuit but the Ninth and the Eleventh, when a court finds a conflict, the fiduciary's decision gets neither de novo nor abuse of discretion review, but something in between.[114]

The rule in the Ninth and Eleventh Circuits preserves the simple distinction between de novo and abuse of discretion without taking a "sliding scale" approach, but finds the conflict of interest, if there is one, as *determinative* of the standard of review.[115] Both these circuits focus on the conflict, not on the terms in the plan document.

The Ninth Circuit takes a stricter approach than the Eleventh Circuit by hewing more to the letter of *Bruch*. Under the Ninth Circuit's trust law approach, any denial by a conflicted fiduciary is treated as a violation of fiduciary responsibilities and is thus void.[116] If the decision is void, there is no point deferring to it.[117] The Ninth Circuit requires the plaintiff to come forward with "material, probative evidence" of a conflict before it will shift the burden to the fiduciary.[118] If the evidence tends to show that the fiduciary's self-interest caused a breach of fiduciary obligation to the beneficiary, then a rebuttable presumption arises that the fiduciary did breach its obligation.[119] If the fiduciary cannot rebut the presumption by producing evidence showing that the conflict, while present, did not affect its decision, then an actual conflict of interest

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ity in the plan document invokes de novo review. *Id.*; *see also* Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1014 (5th Cir. 1992) (alleged conflict does not change the standard of review).

113. *Bruch*, 489 U.S. at 115.

114. The circuits decide the existence of a conflict of interest in different ways. The First, Second, and Seventh Circuits require that the plaintiff prove an actual conflict of interest before the court will adjust the standard of review. *See, e.g.*, Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995) (even after a conflict of interest is shown, it is only a factor to be considered in modifying the standard of review, and even then, the plaintiff has to show that the conflict of interest affected the reasonableness of the decision).

115. *See, e.g.*, Atwood v. Newmont Gold Co., 45 F.3d 1317, 1323 (9th Cir. 1995); Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556, 1566–67 (11th Cir. 1990).

116. *See Atwood*, 45 F.3d at 1322–23.

117. *See id.*

118. *See* Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc., 125 F.3d 794, 798 (9th Cir. 1997) (when plaintiff has presented "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self interest caused a breach of the administrator's fiduciary obligations to the beneficiary," the court will give less deferential review). Examples of material, probative evidence include a change of the plan administrator's position with no new evidence to support that change, *id.*, or bias, bad faith, or personal motivation on the part of the administrator. LaPrease v. Unum Life Ins. Co. of Am., 2004 WL 2800954, at *7 (W.D. Wash. Dec. 2, 2004).

119. Tremain v. Bell Industries, Inc., 196 F.3d 970, 976 (9th Cir. 1999).

arises, and judicial review of the decision is de novo.[120] So long as the conflicted fiduciary can show that its decision was free from an actual conflict of interest, the Ninth Circuit will not invoke the de novo standard, even if the plaintiff can shift its burden.

The conflicted fiduciary can relatively simply rebut the presumption of a conflict of interest by showing that it was operating in the best interests of the beneficiaries by, for example, showing that to not deny benefits in a disputed case would have unnecessarily depleted resources for other plan participants.[121] If the fiduciary can carry its burden, the court will apply the arbitrary and capricious standard rather than the de novo standard.[122] This does not mean that a court could not ultimately conclude that the fiduciary acted arbitrarily and capriciously, but such actions could have been for reasons other than the influence of the conflict on the fiduciary's decision. Only if the fiduciary cannot carry its burden or did not include administrative discretion in the plan will a court engage in de novo review.

B. Critical Differences Between Bruch *and the Ninth Circuit*

Under *Bruch*, a conflict is relevant only to determining whether an *abuse of discretion* has occurred, a notable divergence from the Ninth Circuit. Unlike *Bruch,* the Ninth Circuit's approach meets the problem of conflicts of interest head on: If the conflict of interest tainted the decision to deny benefits, and the defendant could not prove that it did not taint it, then the decision is reviewed de novo.[123] Because a conflict of interest is the default under *Bruch*, the *Bruch* rule makes it irrelevant to de novo review entirely.

Analytically, the bit of boilerplate is no longer dispositive in the Ninth Circuit; instead, the fiduciary's conflict is dispositive. The conflict has gone beyond being a factor in determining abuse of discretion to being instead a factor in determining de novo review. In an abuse of discretion review, even a conflicted fiduciary still has discretion, but the inquiry is always to the abuse of discretion arising from the fiduciary's self-interest. The Ninth Circuit's rule, however, provides the maximum protection for ERISA beneficiaries when the insurer-fiduciary is unmindful of beneficiaries' interests.

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120. *Id.*

121. *See Lang*, 125 F.3d at 798. Note the protection of the corpus as the reason to deny benefits—a distinctly trust law approach.

122. *See* Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556, 1567 (11th Cir. 1990).

123. Obviously, the relevance of the conflict can go beyond standard of review to the merits if the conflict taints the entire claim review process. But that is analytically separate from the function of the conflict in determining the standard of review.

Whether viewed through the lens of de novo review or abuse of discretion review, the ultimate decision for the judge remains centered on how grievously the conflicted fiduciary in question really acted. Disability and health care claimants already suffer from a lengthy and inexpert administrative review process. The disabled are often without income and are counting on monies paid on their disability insurance contract. Delayed health care claims can mean the difference between life and death. The federal courts need a rule that actually facilitates the judicial review process; because de novo review allows more evidence of a conflict of interest with an insurer-fiduciary, de novo review is of paramount concern. Additionally, because conflicts of interest among insurer-fiduciaries are the ones employees most need protection against, more effective review not only makes sense but is necessary.

The Ninth Circuit rule does the best job of consciously setting the standard of review to best protect the interests of beneficiaries who are being evaluated by a conflicted fiduciary. To best effectuate this review, the Ninth Circuit has created a "presumptively void" rule for managing conflicts and has implemented broad discovery rules in de novo review. Such a progressive stance is enviable as we head toward the future because the Supreme Court has generally avoided conflicts analysis.

C. Supreme Court Treatment of Conflicts of Interest

To illustrate how unwilling the Supreme Court is to demystify conflicts of interest, consider the Court's stance in *The Black & Decker Disability Plan v. Nord.* The issue was whether an ERISA fiduciary should accord special weight or deference to the opinions of a disability claimant's treating physician.[124]

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124. The Black & Decker Disability Plan v. Nord, 538 U.S. 822, 825 (2003). The treating physician rule developed initially in the Social Security Administration context. *See* James A. Maccaro, *The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits*, 41 SOC. SEC. REP. SERV., 833, 833–34 (1993). Administrative law judges ("ALJs") used the rule to determine the fact of disability when a claimant's treating physician submitted evidence. In those cases, the treating physician's opinion was granted greater weight in the adjudicative process. *See, e.g.*, Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130, 1139 (2001). The treating physician rule does not simply give deference to the plaitiff's doctor—deference is only given if the doctor is a specialist and gives an opinion consistent with the objective test results and the record as a whole. The rationale was that the treating physician knew the claimant better and could make a more accurate determination of the claimant's disability. This grant of deference to the treating physician thus forced the ALJ who rejected the treating physician's opinions to come forward with substantial evidence from the medical record, see Donaho v. FMC Corp., 74 F.3d 894, 900 (8th Cir. 1996) (holding that substantial evidence as a "quantified reformation of reasonableness"), as to why the ALJ was rejecting the treating physician's opinion. *Regula*, 266 F.3d at 1139. In *Regula*, the court noted that the grant of deference to the treating physician was a theoretical move that invoked the adversarial burden shifting coupled with the hoped-for result of more accurate determinations. *Id.* The *Nord* Court rejected this move categorically by noting the exceptional case of a treating physician who has begun care of the plaintiff only recently, or where a

The treating physician rule was one of the myriad ways the circuits were trying to find conflicts of interest.[125] Recall that, in the Ninth Circuit, the plaintiff has to produce "material, probative evidence" to shift the burden to the conflicted fiduciary. The treating physician rule was being used in the Ninth Circuit[126] and elsewhere[127] as that "material, probative evidence," evidence commonly employed by the plaintiff to show a conflict of interest.[128] When an employee makes a disability benefit claim, he submits medical evidence, including his treating physician's and other specialists' medical opinions and tests, to the plan administrator. The administrator will often require the employee to be examined either by the insurance company's own physician or by an independent medical examiner ("IME"), usually a physician who contracts with the insurance company. When the treating physician and the IME come to different conclusions about the claimant's condition, the administrator must determine the question of disability, even if he has a conflict of interest.

In the circuits where it was being used, the treating physician rule was trumping some of the *Bruch*-encouraged fiduciary discretion granted in the plan document. Granting deference to such a nonfiduciary seems to run contrary to the very idea of the fiduciary having discretion.

D. Demise of the Treating Physician Rule in ERISA Disability

Meditate for a moment on how minor the treating physician rule was. It was one piece of evidence in the plaintiff's "material, probative evidence" prong of a proof and production inquiry in a conflict of interest analysis to determine the standard of review in a claim for denied

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tional case of a treating physician who has begun care of the plaintiff only recently, or where a specialist engaged by the plan has expertise that the treating physician lacks. 538 U.S. at 832; *see also* Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 917 (7th Cir. 2003) (observing that a treating physician's incentive of helping the claimant is offset when a private disability insurer hires a medical consultant who has an incentive of saving the insurer money). The reason for the treating physician rule in the Social Security context was to moderate the harsh effect of the deferential standard of review of administrative decisions. That was the rationale behind *Regula* as well.

125. In *Regula*, the Ninth Circuit stated the rule as follows:

> When a nontreating physician's opinion contradicts that of the treating physician—but is not based on independent clinical findings, or rests on clinical findings also considered by the treating physician—the opinion of the treating physician may be rejected only if the ALJ gives specific, legitimate reasons for doing so that are based on substantial evidence in the record.

266 F.3d at 1140 (internal quotation marks omitted).

126. *See, e.g.*, *Regula*, 266 F.3d at 1130.

127. *See, e.g.*, *Donaho*, 74 F.3d at 901.

128. Nord v. The Black & Decker Disability Plan, 296 F.3d 823, 829 (9th Cir. 2002).

benefits. The Supreme Court was adjudicating in the doctrinal hinterlands in *Nord*.[129]

The Supreme Court's grant of certiorari in *Nord* should have encompassed the conflict of interest issue[130] though the Court, it seems, did not understand the treating physician rule or how it was being used in Ninth Circuit conflict analyses. Given Ninth Circuit precedent, it would have been useful for the *Nord* Court to have written some dicta, useful in a signaling function, to give the lower federal courts some guidance on conflicts of interest. ERISA plaintiffs' attorneys, sensitive to the administrative law paradigm that the federal courts function under with ERISA benefit claims,[131] simply sought to borrow a rule from the administrative law world; though this is a tempting step to take in this position, its ramifications render it less than desirable.[132]

It is clear that the Supreme Court is not interested in spending the time to figure out conflicts of interest and will not likely decide the issue soon enough. In the meantime, if state insurance commissioners and state legislatures act to outlaw discretionary clauses and the standard of review is de novo, the *scope* of a de novo review will become an issue. If a conflicted fiduciary can get abuse of discretion review by proving that its conflict did not influence its denial decision, then scope of review should properly be limited to the record; but if de novo review is in order, the scope of that review should be as searching as necessary to find evidence of a conflict.

VI. SCOPE OF REVIEW & DISCOVERY

It is well established that the scope of discovery in a denial of ERISA benefits case is linked to the standard of review in the Ninth Cir-

129. Plaintiffs' counsel was anticipating that the Supreme Court would use the treating physician rule as a vehicle to deal with the conflict of interest issue left open after *Bruch*. E-mail from Mark DeBofsky to the author, (Jan. 12, 2005) (on file with author). The federal courts were also anticipating resolution on this issue. *See, e.g.*, Wallace v. Reliance Standard Life Ins. Co., 318 F.3d 723, 724 (11th Cir. 2003) (noting that "[c]ontentions that insurers deny claims to save money, and that judicial review should be more searching as a result even when the plan or policy confers interpretive discretion, are before the Supreme Court in *Nord*"). Such contentions have become manifest in the Unum settlement.

130. Oral Arguments to U.S. Sup. Ct. in The Black & Decker Disability Plan v. Nord, 538 U.S. 822 (Apr. 28, 2003). The Court's earliest and most earnest questions of each petitioner, respondent, and amicus counsel were about the conflict of interest question, not the treating physician rule. At one point in petitioner's argument one of the justices asked of the assembled, "Can we get back to the question that you did raise?"

131. *See, e.g.*, Mark DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727, 741 (2004).

132. *See infra* notes 152–155 and accompanying text.

cuit[133] as well as other circuits.[134] When a court reviews a discretionary decision, its review is based on the administrative record; discovery outside the record is not generally allowed.[135] To review a discretionary decision by considering evidence outside the record opens the door to fiduciary abuse because a fiduciary could easily fail to consider evidence not before it.[136]

On the other hand, there is no clear-cut authority on the ability to conduct additional discovery if the standard of review is de novo.[137] Under de novo review, some courts have allowed discovery to determine the existence of an insurer's conflict of interest,[138] though others have not. Still other courts will allow discovery for conflicts, but will disallow discovery of documentation that would not directly relate to the decision made in the claimant's claim for benefits.[139] Even courts that allow discovery will generally not inquire into third-party relationships, such as hired examiners[140] or consultants.[141]

One of the main rationales behind limiting discovery in ERISA cases is that review proceedings under ERISA are not adversarial, and thus the kind of adversarial testing that wide-ranging discovery entails is not appropriate to maintaining costs and fair and prompt resolution of

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133. *See, e.g.*, Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130, 1145 (2001); Taft v. Equitable Life Assurance Soc'y, 9 F.3d 1469, 1472 (9th Cir. 1993).

134. Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan, 195 F.3d 975, 981–82 (7th Cir. 1999) (citing cases from the 2d, 3d, 4th, 6th, 8th, and 10th circuits to show that deferential review means review only of the administrative record).

135. *Taft*, 9 F.3d at 1471.

136. *Id.*; *see also* Perry v. Simplicity Eng'g, 900 F.2d 963, 966 (6th Cir. 1990) (noting that the soundness of fiduciary's decision rises or falls with the evidence before him).

137. *See, e.g.*, *Perry*, 900 F.2d at 963 (de novo review limited to the record that the fiduciary used in making a determination, otherwise it would not be "review"); Moon v. Home Assurance, 888 F.2d 86, 89 (11th Cir. 1989) (for de novo review, district court may hold evidentiary hearing, otherwise the review is not "de novo" and would not protect plan participants). *But cf.* Luby v. Teamsters Health, Welfare, and Pension Trust Funds 944 F.2d 1176, 1185 (3d Cir. 1991) (holding that, if evidentiary record is fully developed, no evidentiary hearing is necessary).

138. Sheehan v. Metro. Life Ins. Co., 01 Civ. 9182 (CSH), 2002 U.S. Dist. LEXIS 11789, at *11–12 (S.D.N.Y. June 28, 2002) (granting protective order). *But see* Brown v. Hartford Life & Accident Ins. Co., No. C-03-02466 RMW, 2004 U.S. Dist. LEXIS 5059, at *6 (N.D. Cal. January 16, 2004) (discovery not allowed, even to try to produce evidence of actual conflict of interest).

139. Waggener v. Unum, 238 F. Supp. 2d 1179, 1185 (S.D. Cal 2002). *But see* Pulliam v. Cont'l Cas. Co., No. 02-0370, 2003 U.S. Dist. LEXIS 10010, at *11, *20 (D.D.C. Jan. 24, 2003) (discovery allowed into incentive-based compensation, education, and training of claims analysts); Woodward v. Reliance Standard Life Ins. Co., No. 1:02cv64 MMP, 2003 U.S. Dist LEXIS 19206, at *2 (N.D. Fla. Mar. 11, 2003) (discovery allowed as to breach of fiduciary duties and proper procedure).

140. Abram v. Cargill, Inc., No. 01-CV-1656, 2003 U.S. Dist. LEXIS 7027, at *11 (D. Minn. Feb. 10, 2003) (allowing deposition of examiner hired by insurer would go against the very purpose of "limited ERISA review").

141. Abromitis v. Cont'l Cas.. Co., 261 F. Supp. 2d 388, 392 (W.D.N.C. 2003) (disallowing discovery of the financial relationship between a consultant and an insurer).

claims.[142] The Unum settlement shows, however, that disability claims should be adversarial to protect beneficiaries' interests; discovery under de novo review should thus be as broad as necessary to find a conflict of interest with an insurer-fiduciary.

VII. CONCLUSION

ERISA protects the interests of employees who participate in employer-sponsored plans.[143] In ERISA's purpose section,[144] Congress focused the statute specifically on the interests of employees.[145] For example, § 1001 references the need for "adequate safeguards,"[146] for better protection of the "interests of employees"[147] and the "interests of participants in employee benefit plans,"[148] for better protection of "plan participants,"[149] and for the "guarantee of employee benefits,"[150] among others.[151]

Unfortunately, however, instead of protecting plan participants, ERISA doctrine has developed into a quasi-administrative law model where a "full and fair review" is promised,[152] yet that is not possible because ERISA allows conflicted fiduciaries. Furthermore, the so-called administrative record is limited to what the conflicted fiduciary allows into the record, and there is no opportunity to call or cross-examine witnesses.[153] For a federal law that operates with administrative law-like

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142. *See Waggener*, 238 F. Supp. 2d at 1185.

143. *See, e.g.*, 29 U.S.C. § 1001(a) (2004):

> The Congress finds that . . . the continued well-being and security of millions of employees and their dependents are directly affected by these plans . . . that owing to the lack of employee information and adequate safeguards concerning [plan] operation it is desirable in the interests of employees and their beneficiaries . . . that . . . safeguards be provided . . .

Id. The introductory sections of ERISA, §§ 1001–1001(b), are replete with references to the interests of employees as the motivating force behind the statute.

144. § 1001.

145. § 1001(c).

146. § 1001(a).

147. *Id.*

148. § 1001(b).

149. § 1001(b).

150. § 1001(c)(4).

151. *See* §§ 1001–1001b.

152. § 1133.

153. *See* DeBofsky, *supra* note 131, at 738 (highlighting the procedural protections ERISA claimants are denied); *see also* Luby v. Teamsters Health, Welfare, and Pension Trust Funds 944 F.2d 1176 (3d Cir. 1991). The Third Circuit had the following to say about plan administrators:

> Plan administrators are not governmental agencies who are frequently granted deferential review because of their acknowledged expertise. Administrators may be laypersons appointed under the plan, sometimes without any legal, accounting, or other training preparing them for their responsible position, often without any experience in or understanding of the complex problems arising under ERISA . . . .

procedures, one would expect ERISA's procedures to be governed by the Administrative Procedure Act.[154] Because ERISA specially stresses that "safeguards be provided with respect to the . . . administration" of ERISA plans, it is notably troubling that no such safeguards are enforced.[155]

Neutral fiduciaries have nothing to fear from a de novo review; de novo review only threatens conflicted fiduciaries who want to prevent a de novo review outside the record. Destructive practices such as Unum's will likely remain in the dark at the district court level unless scrutinized under a more searching standard, and the time for change is now. If more states eliminate discretionary clauses, litigation will likely increase as existing parties to disability policies deal with newly invalidated language,[156] giving rise to a dual-layered litigation: first from state insurance commissioners, second from aggrieved beneficiaries. Insurers who find this process overly burdensome may pull out of less profitable disability markets, such as those occupied by small- and medium-sized employers, leaving these employers to self-fund or not fund at all. This kind of event would be contrary to the ERISA goal that more employers establish

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Id. at 1183.

154. *See* DeBofsky, *supra* note 153, at 738.

155. If the *Bruch* Court was really serious about an administrative law approach, it would have looked at the lack of procedural safeguards and granted de novo review based on that, rather than the lack of discretionary language in the plan.

156. *See* Horn v. Provident Life & Accident Assurance Co., No. C 04-0589 MHP, 2004 WL 2862332, at *7 (N.D. Cal. Dec. 13, 2004) (a discretionary clause had not been approved in a disability insurance contract, rendering the policy only voidable at the option of the policy-holding plaintiff. Thus, the plaintiff could either rescind the policy or seek to have it voided on public policy grounds. The court pointed to the fact that the California Insurance Commissioner, in his opinion letter, reasoned that discretionary clauses rendered the insurance contract unclear and misleading under CAL. INS. CODE § 10291.5(b)(1) (2005). According to the Commissioner, if the clauses render the contract unclear and misleading, then a beneficiary might conclude that the determination was final when it was not. However, the paragraph in which the clause was found begins with the words, "if the Member is not satisfied or does not agree with the reasons for denial of the claim, the Member may appeal the decision to the Claims Fiduciary," thus undercutting the Commissioner's argument about unclear and misleading language). *See also* Firestone v. Acuson Corp. Long Term Disability Plan, 326 F. Supp. 2d 1040, 1050–51 (N.D. Cal. 2004) (where defendant insurance company's disability policy was not among those disapproved by the Commissioner, plaintiff's only remedy is writ of mandamus compelling Commissioner to withdraw her approval); Hansen v. Unum Life Insur. Co. of Am., No. CIV-S-03-1230 FCD PAN, 2004 U.S. Dist. LEXIS 22995, at *20 n.6 (E.D. Cal. Oct. 21, 2004) (even though defendant insurance company's disability policy was among those disapproved by the Commissioner, the disapproval operates only prospectively); Washington v. Standard Insur. Co., No. C-03-4287 MMC, 2004 U.S. Dist. LEXIS 22975, at *50–51 (N.D. Cal. July 27, 2004) (defendant insurance company's disability policy was not among those disapproved by the Commissioner, but even if it was, disapproval of the policy would operate only prospectively). *But see* Fenberg v. Cowden Auto. Long Term Disability Plan, No. C 03-03898 SI2004, 2004 U.S. Dist. LEXIS 22927, at *5–6 (N.D. Cal. Nov. 2, 2004) (with no discussion of whether defendant insurer's policy was among those disapproved, the discretionary clause was invalid based on the persuasiveness of Commissioner's opinion letter).

plans for their employees, and troubling for employees who have bargained for this kind of benefit as a condition to employment.

Ultimately, from a policy standpoint, it makes very little sense to allow for-profit insurers to have discretion. Recall the quotation from Judge Posner that began this article. He was not as generous about an employer's reputational interest as I have been, and he does not agree that they should get as much deference as they do. It is even less reasonable to allow insurer-fiduciaries to have the discretion they do unless they are willing to respect employee interests and not be so focused on cost containment.