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# **Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA**

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Trust Law as Regulatory Law:  
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Authoritative evidence has come to light that for a period of some years, stretching from the mid-1990s into the present decade, Unum/Provident Corporation (Unum), the largest American insurer specializing in disability insurance, was engaged in a deliberate program of bad faith denial of meritorious benefit claims. Part I of this article reviews what is known of this episode.

The Unum/Provident scandal draws attention to a major failing in how the federal courts have understood their role in reviewing benefit denials under the Employee Retirement Income Security Act of 1974 (ERISA).<sup>1</sup> Most disability insurance in the

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<sup>1</sup>Employee Retirement Income Security Act, 29 U.S.C. §§ 1000 et seq. (2005).

United States (apart from the Social Security program) is employer-provided,<sup>2</sup> hence ERISA-governed.<sup>3</sup> Many, probably most, of the victims of the Unum/Provident scandal were participants and beneficiaries of ERISA-covered disability insurance plans. As regards Unum's ERISA-governed policies, Unum's program of bad faith benefit denials was all but invited by an ill-considered passage in an opinion of the United States Supreme Court, Firestone Tire & Rubber Co. v. Bruch,<sup>4</sup> which allows ERISA plan sponsors to impose self-serving terms that severely restrict the ability of a reviewing court to correct a wrongful benefit denial.

Part II of this article reviews the Bruch decision. Part III locates Unum's program of bad faith benefit denials in ERISA's landscape of conflicted plan decisionmaking. Most ERISA plan benefit denials are the work of conflicted decisionmakers. As the

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<sup>2</sup>In 2003 employers provided short-term disability insurance for 39 percent of the workforce, and long-term disability insurance for 30 percent. American Council of Life Insurance, Life Insurance Fact Book 101 (2005) [hereinafter, ACLI Fact Book]. ERISA-covered plans also provide most of the nation's health insurance. Presently, 91 percent of private health insurance in force in the United States is employer provided, see Economic Report of the President 86 (2006), although some of those sponsoring employers, notably governmental employers, are ERISA exempt. See ERISA § 4(b), 29 U.S.C. § 1003(B). ERISA plans also supply much of the nation's life insurance. At year end 2004, there was \$7.6 trillion of group life in force, virtually all employer-provided, compared to \$9.7 trillion of individually purchased coverage. ACLI Fact Book, *supra*, at 88, 92.

<sup>3</sup>ERISA covers all employee benefit plans, see *id.* § 4(a), 29 U.S.C. § 1003(a), as defined in ERISA § 3(3), 29 U.S.C. § 1002(3), except for those excluded under ERISA § 4(b), 29 U.S.C. § 1003(b), notably the plans of federal, state, and local government employers, see ERISA § 4(b)(1), 29 U.S.C. § 1003(b), referencing ERISA § 3(32), 29 U.S.C. 1003(32).

<sup>4</sup>489 U.S. 101 (1989). In the years since it was decided, Bruch has been the most frequently cited ERISA case. See John H. Langbein, Susan J. Stabile & Bruce A. Wolk, Pension and Employee Benefit Law 657-58 (4th ed. 2006) [hereinafter cited as Langbein, Stabile & Wolk] (citation count).

Third Circuit observed of the defendant in Bruch, "every dollar saved by the [plan] administrator on behalf of his employer is a dollar in Firestone's pocket."<sup>5</sup> This article directs attention to a prominent line of Seventh Circuit cases in which that court has purported to invoke law-and-economics principles to minimize or deny the significance of these conflicts of interest. I explain why the Seventh Circuit cases are mistaken, and I point to a contrasting strand of Eleventh Circuit case law that, if more widely followed, could overcome much of the mischief that results from conflict-tainted benefit denials.

Part IV develops the view that the Unum/Provident scandal, by demonstrating the extent of the danger of self-serving plan benefit denials, should cause the Supreme Court to revisit the branch of its decision in Bruch that allows plan drafters to require reviewing courts to defer to self-serving plan decisionmaking. The Court rested its decision on analogy to "general principles of trust law ...."<sup>6</sup> The Court reasoned that because ERISA's law of plan administration derives from the law of trusts, and because the settlor of a private trust can require deferential review, an ERISA plan drafter must also be empowered to require deferential review. There is, however, a profound difference of purpose between ordinary trust law and ERISA fiduciary law. Because "[t]he normal private trust is essentially a gift,"<sup>7</sup> trust law exhibits great deference to the wishes of the

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<sup>5</sup>Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144 (3d Cir. 1987) (Becker J.).

<sup>6</sup>Bruch, 489 U.S. at 115.

<sup>7</sup>Bernard Rudden, Review, John P. Dawson, Gifts and Promises (1980), 44 Mod. L. Rev. 610 (1981).

transferor.<sup>8</sup> In ERISA, by contrast, Congress imposed trust law concepts for regulatory purposes, to limit rather than to promote the autonomy of the employer over employee benefit plans. This fundamental difference of purpose should lead the Court to restrict the power of an ERISA plan sponsor to alter the standard of judicial review. I point to provisions of ERISA not considered by the Court in Bruch that lend strong textual support to the view that Congress did not mean to empower an ERISA plan sponsor to pick and choose the standards under which its benefit denial decisions (or those of a hireling) are to be reviewed.

### I. The Unum/Provident Scandal<sup>9</sup>

Unum/Provident Corporation was assembled in the 1990s from several formerly separate companies.<sup>10</sup> Unum and its various subsidiaries dominate the market for disability insurance. In 2003 Unum companies issued 40 percent of the individual disability policies and 25 percent of the group disability policies sold in the United States, covering a total of more than 17 million persons.<sup>11</sup>

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<sup>8</sup>See *infra* TAN \_\_\_\_.

<sup>9</sup>Portions of this account draw upon sources collected in Langbein, Stabile & Wolk, *supra* note \_\_, at 669-74.

<sup>10</sup>Unum Life Insurance Co. is the demutualized successor to the former Union Mutual Insurance Co. of Maine. Unum merged in 1999 with Provident Life & Accident Insurance Co., which in 1997 had acquired Paul Revere Life Insurance Co. "Unum" is sometimes rendered in upper case, but not in this article.

<sup>11</sup>Dean Frost, "Disability Claim Denied!," *Business Week*, Dec. 22, 2003, at 62. In 2006 Unum advertised that it was the "[c]hoice of nearly one of every four U.S. employers who offer group disability insurance coverage--providing income protection

Although most benefit claims arising under policies of disability insurance are processed routinely,<sup>12</sup> a disability claim can give rise to a dispute about how impaired or how employable an insured actually is. Such cases are intrinsically factitious. The recurrent question is whether, on the facts regarding this worker's physical and occupational circumstances, he or she is unable to resume employment as defined in the policy.<sup>13</sup> Oftentimes, a reviewing court will not find close guidance on such fact-specific determinations from the policy terms, background rules of law, or prior cases. The amount at stake in a disability claim (an income stream that can endure for decades) can be quite large, even though the policy commonly integrates and thus offsets the insured's Social Security disability payments. The danger that an insured may exaggerate or falsify conditions of disability is ever present.<sup>14</sup> Moral hazard dangers are more acute with

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disability insurance to more than 11 million American workers." See <http://www.unumprovident.com/aboutus> (last visited Feb. 26, 2006). The larger figure mentioned in text includes individual and other non-employer-provided policies, and it reflects the decline in Unum's business that has resulted from publicity about the investigations and proceedings against the company.

<sup>12</sup>Unum advertises that it processed 450,000 new disability claims in 2004 and paid \$2.4 billion in disability benefits. See <http://www.unumprovident.com/aboutus> (last visited Feb. 26, 2006).

<sup>13</sup>The reported case law is surveyed in Lee R. Russ, & Thomas Segalia, Couch on Insurance chs. 147-48 (3d ed. 1995 & Supps.).

<sup>14</sup>See, e.g., the account of an insured who claimed to be totally disabled and bedridden on account of headaches, but who "continued to trade soybean contracts (both on the floor at the Board of Trade and electronically from his home)," and who was observed coaching basketball and baseball, exercising on a treadmill, and driving his children to and from school. *Shyman v. Unum Life Ins. Co.*, 427 F.3d 452, 456 (7th Cir. 2005). When insurance is provided under ERISA plans, "plan administrators have a duty to all plan participants and beneficiaries to investigate claims and make sure to avoid paying

disability insurance than with other forms of insurance, such as life insurance, in which it is more costly for the insured to qualify for the insurable event and harder to falsify it.<sup>15</sup>

The growth of what became Unum was engineered by one J. Harold Chandler, who became CEO of a predecessor entity in 1993 and ran the merged companies until he was dismissed in 2003. Under Chandler, Unum instituted cost-containment measures that pressured claims-processing employees to deny valid claims. Early in Chandler's tenure, Unum instituted the "Hungry Vulture" award as a recognition for claims review personnel who showed special determination in denying claims. The prize bore the motto, "Patience my foot, I'm gonna kill something."<sup>16</sup> Pressures on employees to deny claims peaked in the last month of each quarter, called the "scrub months," when claims managers exhorted staff to deny enough claims to meet or surpass budget goals.<sup>17</sup>

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benefits to claimants who are not entitled to receive them." *Davis v. Unum Life Ins. Co.*, 444 F.3d 569, 575 (7th Cir. 2006).

<sup>15</sup>Disability insurers commonly limit an insured's disability coverage to a sum well short of his or her full salary. "People who know that their full income will continue after they stop working may take more risks in their daily lives and will not try as hard to return to work after injury or illness ...." *Hall v. Life Ins. Co. of North America*, 317 F.3d 773, 775 (7th Cir. 2003). Sales practices, claims processing, and underwriting issues in the disability insurance industry are discussed in Charles E. Soule, *Disability Income Insurance: The Unique Risk* (5th ed. 2002).

<sup>16</sup>Frost, *supra*, at \_\_\_. The award came with a graphic depicting a pair of vultures resting on a tree branch, one of them mouthing the slogan quoted above in text. The graphic is reprinted in Ray Bourhis, *Insult to Injury: Insurance, Fraud, and the Big Business of Bad Faith* 211 (2005).

<sup>17</sup>Frost, *supra* note \_\_\_, at \_\_\_.

Word of these practices began to emerge in lawsuits brought by former Unum claims processing employees, and in investigative reports broadcast in 2002 by NBC's "Dateline"<sup>18</sup> and CBS' "60 Minutes"<sup>19</sup> news programs. Employees interviewed on the Dateline program disclosed that the claims that were "the most vulnerable" to pressures for bad faith termination were those involving "so-called subjective illnesses, illnesses that don't show up on x-rays or MRIs, like mental illness, chronic pain, migraines, or even Parkinsons."<sup>20</sup> The Dateline story pointed to an internal company e-mail cautioning a group of claims staff that they had one week remaining to "close," that is, deny 18 more claims in order to meet desired targets.<sup>21</sup>

Some claims processing employees who objected to these practices later contended that they had been intimidated into acquiescing, or dismissed for not complying. Several brought wrongful dismissal suits, which Unum defended on the ground that the dissidents had been dismissed for cause. The most prominent of the suits was that of Dr. Patrick McSharry, who had worked as a staff physician in Unum's claims review operations. He alleged that Unum made him review so many claims that he could not analyze them properly; that he was instructed "to use language [to] support the denial of disability insurance"; that he was not allowed "to request further information or

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<sup>18</sup>Dateline (NBC television broadcast, Oct. 13, 2002) (transcript on file with author).

<sup>19</sup>60 Minutes (CBS television broadcast, Nov. 17, 2002) (transcript on file with author).

<sup>20</sup>Id, transcript at \_\_\_.

<sup>21</sup>Dateline, supra note \_\_\_, transcript, at \_\_\_.

suggest additional medical tests"; and that he was "not supposed to help a claimant perfect a claim for disability insurance benefits."<sup>22</sup> A federal judge in Tennessee concluded in 2004 that "internally generated memoranda from [Unum] executives ... appear to support the plaintiff's claim that one of [Unum]'s corporate goals was to terminate as many ongoing claims and deny as many new claims as possible in order to save the company millions of dollars."<sup>23</sup>

Not all of Unum's bad faith benefit denial cases have arisen from policies issued under ERISA-covered plans, and the non-ERISA cases have escaped ERISA's various remedial disadvantages. Whereas ERISA has been interpreted to preclude the award of punitive damages,<sup>24</sup> large punitive damage awards have been made against Unum/Provident companies for bad faith claim denials in several non-ERISA cases.<sup>25</sup> In one such case, a federal judge sustained a \$5 million punitive damages award on the ground that the trial "jury heard more than enough evidence to conclude that Plaintiff was totally disabled and that Defendants in bad faith terminated her benefits and caused her damages."<sup>26</sup>

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<sup>22</sup>McSharry v. UnumProvident Corp., 237 F.Supp. 2d 875, 877 (E.D. Tenn. 2002).

<sup>23</sup>Bennett v. Unum Life Ins. Co., 321 F.Supp. 2d 925, 934-35 (E.D. Tenn. 2004).

<sup>24</sup>Discussed in John H. Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West, 103 Colum. L. Rev. 1317, 1346-48 (2003) [hereinafter Langbein, Trail].

<sup>25</sup>Frost, supra note \_\_, at \_\_.

<sup>26</sup>Hangarter v. Paul Revere Life Ins. Co., 236 F.Supp. 2d 1069, 1082 (N.D. Cal. 2002), aff'd 373 F.3d 998 (9th Cir. 2004). Counsel for the plaintiff has written a book about the case, see Ray Bourhis, supra note \_\_.

Many federal courts have now commented on Unum's aggressive claims denial practices. Published opinions speak of "selective review of the administrative record";<sup>27</sup> "lack of objectivity and an abuse of discretion by Unum";<sup>28</sup> misuse of "ambiguous test results";<sup>29</sup> and claims evaluation practices that "defie[d] common sense"<sup>30</sup> and "bordered on outright fraud."<sup>31</sup> In a notable opinion in the district court in Massachusetts, Chief Judge Young collected citations to nearly twenty previous cases that he described as "reveal[ing] a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics."<sup>32</sup> He faulted Unum for behavior "entirely inconsistent with the company's public responsibilities and with its obligations under the [ERISA-covered disability] Policy" in the particular case.<sup>33</sup>

As complaints, litigation, and media accounts grew, several state insurance commission staffs began investigating Unum's claims denial practices. The Georgia commissioner concluded that Unum had been "looking for every technical legal way to

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<sup>27</sup>Moon v. UNUM Provident Corp., 405 F.3d 373, 381 (6th Cir. 2005).

<sup>28</sup>Lain v. UNUM Life Ins. Co., 279 F.3d 337, 347 (5th Cir. 2002).

<sup>29</sup>Stup v. UNUM Life Ins. Co., 390 F.3d 301, 310 (4th Cir. 2004).

<sup>30</sup>Dandurand v. UNUM Life Ins Co., 284 F.3d 331, 338 (1st Cir. 2002).

<sup>31</sup>Watson v. Unum/Provident Corp., 185 F. Supp. 2d 579, 585 (D.Md. 2002).

<sup>32</sup>Radford Trust v. First Unum Life Ins Co., 321 F.Supp. 2d 226, 247 n.20 (D. Mass. 2004).

<sup>33</sup>Id. at 247.

avoid paying a claim."<sup>34</sup> In 2003-04, the Maine, Massachusetts, and Tennessee insurance regulators, acting on behalf of most other states, conducted a coordinated investigation and filed a report that accused Unum of systematic irregularities in obtaining and evaluating medical evidence of disability. Unum agreed to pay a \$15 million fine, to reopen several years' worth of denied claims, and to make specified changes in its claims review procedures and its corporate governance.<sup>35</sup> In 2005 the California Department of Insurance settled separately with Unum, imposing an \$8 million civil penalty.<sup>36</sup> California regulators reported "violations of state law in nearly one-third of a random sample of about 1,000 claims handled by UnumProvident."<sup>37</sup> Barron's, the financial newspaper, reports that "[s]ince 1974, Unum has taken charge-offs of \$135 million," including the multi-state and California fines, as a result of the investigations.<sup>38</sup>

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<sup>34</sup>Mike Pare, \$1 Million Fine Hits Unum, *Chattanooga Times Free Press*, Mar. 19, 2003, at C1.

<sup>35</sup> Report of the Targeted Multistate Market Conduct Examination, available at [http://www.state.me.us/pfr/ins/Unum\\_Multistate\\_ExamReport.htm](http://www.state.me.us/pfr/ins/Unum_Multistate_ExamReport.htm) (Feb. 29, 2004).

<sup>36</sup>Diya Gullapalli, Unum Provident Is Set to Pay \$8 Million Penalty in California, *Wall St. J.*, Oct. 3, 2005, at C3. Unum also agreed to pay nearly \$600,000 to cover the costs of the California Department's investigation. Unum will review benefit denials as far back as 1997, under the oversight of an independent consultant assigned by the Department. *Id.* For the full text of the agreement, see *In re Certificates of Authority of Unum Life Ins. Co., etc.*, "Cal. Settlement Agreement," File Nos. DISP05045984-85, Oct., 2005, [SUPPLY WEB CITE] [hereinafter Cal. Settlement Agreement].

<sup>37</sup>Peter S. Gosselin, State Fines Insurer, Orders Reforms in Disability Cases, *Los Angeles Times*, Oct. 3, 2005, available at [www.latimes.com/business/la-fi-disability3oct03,0,6931969.story?coll=la-tot-promo](http://www.latimes.com/business/la-fi-disability3oct03,0,6931969.story?coll=la-tot-promo).

<sup>38</sup>Jonathan R. Laing, The \$675 Million Solution, *Barron's*, May 1, 2006, at 22. The Barron's story alleges that Unum has resorted to suspect accounting practices to protect its insurance-industry ratings.

In the course of discovery proceedings in the litigation against Unum, a remarkable internal memorandum<sup>39</sup> came to light, authored by a Unum executive, that exults in the "enormous"<sup>40</sup> advantages that ERISA, as now interpreted, bestows upon Unum in cases in which an insured challenges a benefit denial in court. "[S]tate law is preempted by federal law, there are no jury trials, there are no compensatory<sup>41</sup> or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review."<sup>42</sup> The memorandum recounts that another Unum executive "identified 12 claim situations where we settled for \$7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million."<sup>43</sup> We see in this document Unum's own understanding of how the deferential standard of review allowed under Bruch interacts with aspects of ERISA remedy law to facilitate aggressive claim denial practices.

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<sup>39</sup>"Provident Internal Memorandum," titled "Re: ERISA," from Jeff McCall to IDC Management Group & Glenn Felton, Oct. 2, 1995, Bates No. GSCONF 2893, available at <http://www.micethatroar.com/erisa-memo.pdf>, [hereafter Unum ERISA Memorandum], reprinted in Ray Bourhis, *supra* note \_\_\_, at 225.

<sup>40</sup>Id.

<sup>41</sup>In a series of 5-4 decisions, the Supreme Court has interpreted ERISA to permit recovery only of "benefits due," and to preclude both compensatory and punitive damages. I have elsewhere explained why the Court's refusal to allow compensatory "make whole" damages misreads the statute. See Langbein, Trail, *supra* note \_\_\_.

<sup>42</sup>Unum ERISA Memorandum, *supra* note \_\_\_

<sup>43</sup>Id. The document continues with a wink: "While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action." Id.

Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga lacks legal policy implications. On this view, a rogue insurance company behaved exceptionally badly; it got caught and sanctioned; and its fate should deter others. The other reading of these events is less sanguine: For reasons discussed below in Part III of this article, conflicted plan decisionmaking is a structural feature of ERISA plan administration. The danger pervades the ERISA-plan world that a self-interested plan decisionmaker will take advantage of its license under Bruch to line its own pockets by denying meritorious claims. Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect.

## II. Bruch

Because the Supreme Court's 1989 decision in Bruch<sup>44</sup> figures so centrally in the ERISA-plan cases in the Unum/Provident scandal, it is essential to understand what the Court decided in that case. I have elsewhere had occasion to discuss the opinion in considerable detail.<sup>45</sup> For present purposes, it suffices to identify the three distinct strands of the decision: First, the Court imposed de novo review as the default standard. Second, the Court allowed plan drafters to insert plan terms requiring a reviewing court

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<sup>44</sup>489 U.S. 101 (1989).

<sup>45</sup>John H. Langbein, *The Supreme Court Flunks Trusts*, [1990] *Sup. Ct. Rev.* 207 (1991) [hereinafter, Langbein, *Trusts*].

to defer to plan decisionmaking, hence defeating the de novo standard. Third, the Court cautioned about the need to adjust such deference in circumstances of conflict of interest.

#### A. Setting the Default Standard: De Novo Review

Although the text of ERISA as enacted in 1974 provided for judicial review of benefit denials,<sup>46</sup> the statute did not address the question of what standard of judicial review to apply in such cases.<sup>47</sup> The core choice is between deferential review, commonly called the "arbitrary and capricious" standard, which effectively presumes the correctness of the plan's decision to deny the claimed benefit; and nondeferential or "de novo" review, under which the reviewing court examines the merits afresh.

The Supreme Court in Bruch chose nondeferential review. Although the lower courts had mostly applied a deferential standard of review, on analogy to the standard that had developed for reviewing plan decisionmaking under the Taft-Hartley Act,<sup>48</sup> the Supreme Court held unanimously that ERISA required de novo review of ERISA plan

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<sup>46</sup>See ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 (authorizing suit "to recover benefits due").

<sup>47</sup>489 U.S. at 109 (ERISA neglected to "set out the appropriate standard of review" in such cases).

<sup>48</sup>Unlike other, so-called single employer benefit plans, the multi-employer plans instituted under the Taft-Hartley Act are required to be governed by a board comprised of equal numbers of employer- and union-selected trustees. Taft-Hartley Act § 302(c)(5), 29 U.S.C. § 186. There was, accordingly, greater justification for presuming the fairness of internal the claims review processes of multi-employer plans. Regarding the scope and application of the "arbitrary and capricious" standard in federal administrative law, see 2 Richard J. Pierce, Jr., *Administrative Law Treatise* § 11.4, at 805-14 (4th ed. 2002).

decisionmaking. The Court rested its decision that ERISA intended de novo review on both doctrinal and functional grounds. Doctrinally, the Court regarded the preference for de novo review as a "settled principle[] of trust law ...."<sup>49</sup> Functionally, the Court grounded its decision to prefer the more searching standard on ERISA's protective purposes. ERISA was "enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans'<sup>50</sup> ... and 'to protect contractually defined benefits ....'<sup>51</sup>

### B. Subordinating De Novo Review

Having explained the logic of nondeferential review, the Court then made its disastrous misstep in Bruch. In a brief aside, the Court assumed, and thus effectively decided, that the employer or other plan sponsor has the authority to defeat the de novo standard. Disregarding the protective purposes of ERISA that the Court had just invoked when choosing the de novo standard of review, the Court treated the standard of review as a matter of default law that the employer or other plan sponsor was free to

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<sup>49</sup>489 U.S. at 112. I have elsewhere criticized the Court's premise that de novo review of plan administration derives from trust law. Langbein, *Trusts*, supra note \_\_, at 217-19. De novo review is not the trust standard. In matters of trust administration, as opposed to the construction of trust instruments, courts routinely defer to trustee decisionmaking. See Restatement (Second) of Trusts § 187, cmt. a (1959) (exercise of a trust power is discretionary unless restricted by the trust terms or by a supervening rule of trust law). In ERISA fiduciary law, however, on account of the regulatory purposes of ERISA, discussed infra TAN \_\_\_\_, I think the Court was indeed correct to prefer de novo review.

<sup>50</sup>*Bruch*, 489 U.S. at 113, quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983).

<sup>51</sup>489 U.S. at 113, quoting *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985).

countermand by inserting language in the plan document requiring the reviewing court to grant deferential review. De novo review would pertain, said the Court, "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."<sup>52</sup> In such a case, "[n]either general principles of trust law nor a concern for impartial decisionmaking ... forecloses parties from agreeing upon a narrower standard of review."<sup>53</sup>

The Court's rationale for allowing plan terms to trump ERISA's "concern for impartial decisionmaking" appears to have been a notion of waiver or consent ("parties ... agreeing"). There are two difficulties with that reasoning. First, ERISA benefit plans are characteristic contracts of adhesion, offered on a take-the-plan-or-leave-the-job basis. As a practical matter, the employee has no opportunity to bargain with the employer about matters such as the standard of review of benefit denials. Accordingly, it is a mischaracterization to depict these "parties ... [as] agreeing"<sup>54</sup> to preclude impartial judicial review of self-serving plan decisionmaking. Second, as further explained in Part IV of this article, ERISA's regulatory mission circumscribes contractual autonomy, for protective purposes.

ERISA plans are virtually always professionally drafted instruments, the work of specialist counsel or plan administration firms, who now routinely seize upon Bruch's

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<sup>52</sup>Id.

<sup>53</sup>Id.

<sup>54</sup>Id.

invitation to instruct the courts to defer to plan decisionmaking.<sup>55</sup> In consequence, deferential review pervades the ERISA-plan world, despite the primary holding in Bruch that purports to establish the opposite. A program of bad faith benefit denial such as that unearthed in the Unum/Provident scandal is markedly easier to carry out under a deferential standard of review, which requires the court to sustain the denial unless the victim can adduce evidence that the denial was "whimsical, random or unreasoned,"<sup>56</sup> or in Judge Posner's revealingly dismissive formulation, "off the wall."<sup>57</sup>

### C. The Conflict Proviso

In the very passage in which the Court authorized plan drafters to defeat de novo review, the Court nevertheless tempered that grant of authority. In cases in which the plan requires deferential review, said the Court, if the "administrator or fiduciary ... is

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<sup>55</sup>In *Oliver v. Coca-Cola Co.*, 397 F.Supp. 2d 1318 (N.D. Ala. 2005), the court reproduces a typical example of such plan terms. Titled "Construction," the clause provides that a committee of employer personnel "will have the exclusive responsibility and complete and final discretionary authority to construe the Plan and to decide all questions arising under the Plan, ... and all actions or determinations of the Committee shall be final, conclusive and binding." *Id.* at 1323 (emphasis deleted).

<sup>56</sup>*Teskey v. M.P. Metal Products Inc.*, 795 F.2d 30, 32 (7th Cir. 1986). Regarding the lower courts' efforts to interpret and apply plan terms requiring deferential review, see Langbein, *Stabile & Wolk*, *supra* note \_\_, at 665-69, 674-84; Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 Okla. L. Rev. 637, 644-72 (2006); Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 Am. U.L. Rev. 1083, 1119-68 (2001).

<sup>57</sup>*Rud v. Liberty Life Assurance Co.*, 438 F.3d 772, 773 (7th Cir. 2006) (Posner, J).

operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.'"<sup>58</sup>

This concession to the danger of conflicted decisionmaking—which we may conveniently refer to as Bruch's conflict proviso—has in principle the potential to abate much of the mischief that has resulted from allowing plan drafters to dictate a lenient standard or review, because, as discussed next in Part III of this article, most ERISA plan benefit denials are the work of decisionmakers operating under serious conflicts of interest. The lower courts have not, however, taken full advantage of their license under the conflict proviso to resist plan-dictated deferential review in such cases.

### III. ERISA's Conflicted Decisionmakers

#### A. Plan Administration as Fiduciary Law

"In enacting ERISA," the Supreme Court has observed, "Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds."<sup>59</sup> This concern was an outgrowth of congressional investigations into labor union corruption, especially in the

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<sup>58</sup>489 U.S. at 115, quoting Restatement (Second) of Trusts § 187, cmt. d (1959). The Court has subsequently signaled its uneasiness with the conflict-tainted decisionmaking occurring under Bruch. Said Justice Souter in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n. 15 (2002): "It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest."

<sup>59</sup>*Massachusetts v. Morash*, 490 U.S. 107, 115 (1989).

Teamsters Union, uncovering evidence of looting, kickbacks, cronyism, and other forms of serious maladministration in union-sponsored pension and benefit plans (so-called multiemployer plans).<sup>60</sup>

Congress responded to these dangers<sup>61</sup> by imposing standards of fiduciary law, derived from the model of private trust law,<sup>62</sup> for the administration of all employee benefit plans. Under ERISA's rule of mandatory trusteeship, "all assets of an employee

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<sup>60</sup>See Michael S. Gordon, Overview: Why Was ERISA Enacted?, in *The Employee Retirement Income Security Act of 1974: The First Decade* 6, at 10-11 (U.S. Senate, Special Com. on Aging) (1984); see also Langbein, *Trail*, supra note \_\_, at 1324 (discussing congressional investigations conducted in the 1950s and 1960s).

<sup>61</sup>ERISA embodies three distinct programs of protection for plan participants and beneficiaries, responding to three distinct sorts of risk: administrative or agency risk, default risk, and forfeiture risk.

The fiduciary rules (and related disclosure requirements and remedial provisions) discussed in this article are addressed to administrative (agency) risk, that is, the danger that the persons who administer a plan and invest plan funds will misappropriate or mismanage the funds, or will misapply the standards for determining entitlement to plan benefits.

Default risk is the danger that a defined benefit pension plan will renege on promised benefits. ERISA imposes actuarially based (but still not actuarially sound) funding requirements; and by establishing a program of plan termination insurance administered by a new government agency, the Pension Benefit Guarantee Corporation. See James A. Wooten, *The Employee Retirement Security Act of 1974: A Political History* 67-79, 94, 160-61 (2005); Richard A. Ippolito, *The Economics of Pension Insurance* (1989).

Forfeiture risk arises from plan terms that cause promised benefits to be lost if the employee does not remain employed long enough or otherwise fails to fulfill plan-specified conditions. ERISA regulates forfeiture by means of vesting and related rules, see Langbein, *Stabile & Wolk*, supra note \_\_, at 133-67.

<sup>62</sup>Bruch, 489 U.S. at 115, noticed supra TAN \_\_.

benefit plan shall be held in trust ....<sup>63</sup> Moreover, ERISA treats all persons who administer the plan, in the sense of exercising material discretion over plan affairs, as ERISA fiduciaries.<sup>64</sup> ERISA subjects these persons to its version of the core substantive rules of trust fiduciary law: the care norm, that is, the duty of prudent administration;<sup>65</sup> and the loyalty rule, which requires plan fiduciaries to act "solely in the interest of the participants and beneficiaries and ... for the exclusive purpose of ... providing benefits to participants and their beneficiaries ...."<sup>66</sup> ERISA's fiduciary law of plan administration governs claims administration<sup>67</sup> as well as the administration of plan assets.

Although "ERISA abounds with the language and terminology of trust law,"<sup>68</sup> ERISA fiduciary law differs markedly from conventional trust law in one crucial respect.

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<sup>63</sup>ERISA § 403(a), 29 U.S.C. § 1103. A proviso to the quoted language excuses a few types of plan that are regulated in other ways, such as those funded with insurance policies.

<sup>64</sup>ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A). Regarding the case law and regulations applying this standard to the panoply of service providers who have contact with ERISA plans, see Langbein, Stabile & Wolk, *supra* note \_\_, at 515-27.

<sup>65</sup>ERISA § 404(a)(1)(B), § 29 U.S.C. 1104(a)(1)(B).

<sup>66</sup>ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A). Regarding the complexities inherent in transposing the loyalty norm from the model of the private trust to the pension plan, see John H. Langbein, *The Conundrum of Fiduciary Investing under ERISA*, in *Proxy Voting of Pension Plan Equity Securities* (Wharton School: Pension Research Council, D. McGill, ed.) (1989); Daniel Fischel & John H. Langbein *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. Chicago L. Rev. 1105 (1988). ERISA fiduciary law also contains a set of prohibited transaction rules, further sanctioning self-dealing and kickbacks. ERISA §§ 406-08, 29 U.S.C. §§ 1106-08.

<sup>67</sup>Because it entails the exercise of "discretionary authority" within the meaning of ERISA § 3(21)(A).

<sup>68</sup>Bruch, 489 U.S. at 110.

Trust law presupposes that the trustee who administers a trust will be disinterested, in the sense of having no personal stake in the trust assets,<sup>69</sup> although the trust terms can make contrary provision.<sup>70</sup> By contrast, ERISA fiduciaries are commonly aligned with the employer (or, in most plans that supply insurance benefits, with the insurance company to which the employer delegates administrative responsibilities for the particular plan).<sup>71</sup>

ERISA expressly authorizes the employer to use "an officer, employee, agent or other representative" as a fiduciary,<sup>72</sup> thereby inviting the conflicts-of-interest that so trouble the law of benefit denials. This concession to employer interests, which departs notably from the trust tradition,<sup>73</sup> was motivated by the concern that without it employers

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<sup>69</sup>"The trustee is under a duty to administer the trust solely in the interest of the beneficiaries." Restatement (Second) of Trusts § 170(1)(1959).

<sup>70</sup>See *id.* cmt. t.

<sup>71</sup>ERISA-covered plans must designate "one or more named fiduciaries" to manage the plan's affairs. ERISA §§ 402(a)(1), 29 U.S.C. § 1102(a)(1). The plan sponsor, virtually always the employer, selects these persons. ERISA § 402(a)(2), 29 U.S.C. § 1102(a)(2). The statute also requires that plan assets be held in trust by trustees selected under the plan or by a named fiduciary. ERISA § 403, 29 U.S.C. § 1103.

<sup>72</sup>ERISA § 408(c)(3), 29 U.S.C. § 1108(c)(3). This provision expressly negates liability under the prohibited transaction rule of ERISA § 406, 29 U.S.C. § 1106. See also ERISA §§ 3(16) and 402(a), 29 U.S.C. §§ 1102(16), 1102(a), which make the employer the default plan administrator; and § 402(a)(1), 29 U.S.C. § 1102(a)(1), which makes plan administration a fiduciary function.

<sup>73</sup>E.g., Bogert's formulation: "It is not possible for any person to act fairly in the same transaction on behalf of himself and in the interest of the trust beneficiary." George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 543, at 227 (rev. 2d ed., 1993). The Supreme Court has contrasted "the traditional trustee, [who] ... 'is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries,'" with the ERISA fiduciary, who "may have financial interests adverse to beneficiaries. Employers, for example, can be ERISA fiduciaries and

would be less likely to sponsor benefit plans. Because pension and welfare benefit plans entail major expenditures,<sup>74</sup> the sponsor mostly wants its own managers administering and monitoring plan operations for cost containment, a traditional management function.

## B. Denigrating the Conflict

The deferential standard of review allowed under Bruch heightens the dangers intrinsic to ERISA's authorization of conflicted plan decisionmakers. We recall the Third Circuit's observation in Bruch that "every dollar saved by the [plan] administrator on behalf of his employer is a dollar in Firestone's pocket."<sup>75</sup> Not all courts have been adequately sensitive to the danger of conflicted decisionmaking in ERISA benefit denial cases. In particular, a notable string of Seventh Circuit cases has attempted to "apply[] a law-and-economics rationale to establish that no conflict exists."<sup>76</sup> The reasoning in these opinions is deeply flawed.

1. Contrasting gross revenue. Several of the Seventh Circuit cases belittle the danger of conflict of interest by contrasting the gross revenue of the employer or the

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still take actions to the disadvantage of employee beneficiaries, when they act as employers ...." Pegram v. Herdrich, 530 U.S. 211, 225 (2000).

<sup>74</sup>Employer spending on benefits amounted to \$1 trillion in the year 2002. See Employee Benefit Research Institute (EBRI), Facts from EBRI: Employer Spending on Benefits, 2002, at 1 (May 2004).

<sup>75</sup>Bruch, 828 F.2d at 144, noted *supra* TAN \_\_\_.

<sup>76</sup>Mers v. Marriott International Group Accidental Death and Dismemberment Plan, 144 F.3d 1014, 1020 (7th Cir. 1998).

insurer with the amount of the disputed claim--asserting, for example, that "a corporation which generates revenues of nearly \$6 billion annually ... is ... not likely to flinch at paying \$240,000"<sup>77</sup> The trouble with this reasoning is that it places wrongdoing beyond reproach so long as the benefit being denied pales by comparison with the wrongdoer's gross revenue. Since virtually all plan benefit claims are "trivial"<sup>78</sup> when so measured, the Seventh Circuit's rationale would wholly preclude a reviewing court from considering the role of conflict of interest in plan decisionmaking.

In light of what is now known about the Unum/Provident scandal, it is beyond conjecture that Judge Easterbrook erred when he asserted as late as December 2005 that "Unum is much too large to be affected by its resolution of any one benefits claim."<sup>79</sup> However modest any one claim, if an insurer or other plan administrator denies enough claims, the aggregate savings can be quite significant. Unum reported paying \$4.2 billion in disability benefits in 2004.<sup>80</sup> To paraphrase Senator Dirksen (after whom the

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<sup>77</sup>Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995); accord, Perlman v. Swiss Bank Comprehensive Disability Protection Plan, 195 F.3d 975, 981 (7th Cir. 1999) ("When the administrator is a large corporation, the firm has a financial interest, but the award in any one case will have only a trivial effect on its operating results"); Mers, 144 F.3d at 1020-21 (7th Cir. 1998) (denying claimed \$200,000 benefit "minuscule compared to [insurer's] bottom line"); Chojnacki v. Georgia-Pacific Corp., 108 F.3d 810, 815 (7th Cir. 1997) (contrasting \$134,000 claim with employer's total revenue of \$12.3 billion).

<sup>78</sup>Perlman, 195 F.3d at 981.

<sup>79</sup>Shyman v. Unum Life Ins. Co., 427 F.3d 452, 455 (7th Cir. 2005).

<sup>80</sup>Supra note \_\_\_\_.

courthouse in which the Seventh Circuit sits is named), \$240,000 here, \$240,000 there, pretty soon it's real money.<sup>81</sup>

2. Reputation. Another tack in the Seventh Circuit cases has been the claim that reputational incentive will adequately deter conflicted decisionmakers from abuse. Judge Easterbrook has contended: "Large businesses ... want to maintain a reputation for fair dealing with their employees. They offer fringe benefits such as disability plans to attract good workers, which they will be unable to do if promised benefits are not paid."<sup>82</sup>

Reputational incentive does indeed constrain conflicted plan decisionmakers from abuse of authority,<sup>83</sup> but competing considerations weaken that incentive. The danger of unfair treatment in a matter so remote as the denial of a future disability or other benefit claim seldom weighs heavily in an employee's thinking when accepting employment. It is a rare prospective employee who, assuming he or she has a choice of employers, undertakes to investigate the relative integrity of the benefit claims processes of the respective employers or their insurers. Because individual benefit denials are not

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<sup>81</sup>The maxim, "A billion here, a billion there, and pretty soon you're talking real money," though commonly ascribed to the late Senator Everett M. Dirksen, has not been authoritatively traced to him. See [www.dirksencenter.org/print\\_emd\\_billionhere.htm](http://www.dirksencenter.org/print_emd_billionhere.htm).

<sup>82</sup>Perlman, 195 F.3d at 981. Accord, Mers, 144 F.3d at 1021 (employers "want to see their employees' claims granted because they want their employees satisfied with their fringe benefits").

<sup>83</sup>I have emphasized this point elsewhere. See Langbein, *Trusts*, supra note \_\_, at 216; Fischel & Langbein, supra note \_\_, at 1132.

publicized, and because many are quite justified on the merits, an underlying pattern of bias may be hard for the isolated employee to discern.<sup>84</sup>

Moreover, the greater the prospective gain from denying a benefit claim, the greater the inclination to subordinate the risk of reputational injury. For example, in a pension case in which \$125 million turned on the plan fiduciaries' decision about what compensation was covered under a benefit accrual formula, Judge Posner remarked that "a loss of reputation might be a price worth paying to avoid \$125 million in unanticipated expense."<sup>85</sup> Professor Fischel and I have elsewhere pointed to the weakness of reputational incentive in severance plan cases that arise from corporate downsizings: "[T]he employer's reputational interest [is] not likely to be effective when the long term relationship [is] dissolving .... In these cases, the gains from self-interested action by non-neutral fiduciaries may outweigh the usual inhibiting future costs."<sup>86</sup> Considerations of this sort suggest that labor markets lack the efficiency of the capital markets in disseminating reputational information.

In a prominent case decided in 1987, Van Boxel v. Journal Co. Employees' Pension Trust,<sup>87</sup> Judge Posner remarked on the inadequacy of reputational incentive as a

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<sup>84</sup>Noticed in *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000)

<sup>85</sup>*Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996).

<sup>86</sup>Fischel & Langbein, *supra* note \_\_\_, at 1132.

<sup>87</sup>836 F.2d 1048 (7th Cir. 1987).

safeguard against abusive plan administration. Speaking of a pension plan, he said that plan participants' "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, relying on the company's interest in its reputation to prevent it from acting on its bias."<sup>88</sup>

3. Confusing contract with fiduciary obligation. Judge Posner has recently gravitated toward his colleagues' apologetics for conflicted decisionmaking. In 2006 in Rud v. Liberty Life Assurance Co.,<sup>89</sup> he rejected the "argu[ment] that a conflict of interest exists because any money [that the insurer] pays to a claimant reduces its profits. The ubiquity of such a situation makes us hesitate to describe it as a conflict of interest."<sup>90</sup> Seeking to explain why ubiquity should excuse an otherwise manifest conflict, Judge Posner analogized the ERISA benefit denial cases to the contractual relations of commercial parties, who "have a conflict of interest in the same severely attenuated sense, because each party wants to get as much out of the contract as possible."<sup>91</sup>

In resorting to the language of contract to justify the self-serving behavior of an ERISA plan administrator who decides benefit claims, Judge Posner is overlooking a profoundly important difference: ERISA requires the administrator (or an insurer

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<sup>88</sup>Id. at 1052.

<sup>89</sup>438 F.3d 772 (7th Cir. 2006).

<sup>90</sup>Id. at 775.

<sup>91</sup>Id.

exercising delegated powers of plan administration) to act in a fiduciary capacity. Under ERISA's duty of loyalty, the decisionmaker must interpret and apply plan terms "solely in the interest of the participants and beneficiaries and ... for the exclusive purpose of ... providing benefits to participants and their beneficiaries ...."<sup>92</sup> Judge Posner is, therefore, confusing a contract counterparty, who is allowed to act selfishly, with an ERISA fiduciary, who is forbidden to.<sup>93</sup>

Although Judge Posner recognizes that "ERISA is a paternalistic statute in a number of respects, notably in its vesting rules,"<sup>94</sup> he fails to confront the reality that ERISA's fiduciary regime, which governs benefit denial cases, is also profoundly paternalistic. Precisely because ERISA subjects every employee benefit plan to ERISA's duties of loyalty, prudent administration,<sup>95</sup> and "full and fair" internal review of benefit denials,<sup>96</sup> we can be certain that Congress subordinated Judge Posner's concern about not making further "inroads into freedom of contract,"<sup>97</sup> in favor of the protective values

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<sup>92</sup>ERISA § 404(a)(1)(A), 29 U.S.C. § 1104, noted supra TAN \_\_\_\_.

<sup>93</sup>Judge Posner has elsewhere emphasized this distinction. "Contract law ... does not proceed on the philosophy that I am my brother's keeper. That philosophy may animate the law of fiduciary obligations but parties to a contract are not each other's fiduciaries." *Original Great American Chocolate Chip Cookie Co. v. River Valley Cookies, Ltd.*, 970 F.2d 273, 280 (7th Cir. 1992).

<sup>94</sup>438 F.3d at 776.

<sup>95</sup>ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B).

<sup>96</sup>ERISA § 503(2), 29 U.S.C. § 1153(2). I explain *infra*, TANs \_\_\_\_, that ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), makes these provisions mandatory law, hence not subject to alteration by plan terms.

<sup>97</sup>Rud, 772 F.3d at 777.

enshrined in ERISA fiduciary law. To refute Judge Posner's 2006 opinion in Rud that the employment contract impliedly authorizes self-serving decisionmaking about plan benefits, one need look no further than Judge Posner's 1987 opinion in Van Boxel, in which he emphasized that plan participants' "rights are too important these days for most employees to want to place them at the mercy of a biased tribunal ...."<sup>98</sup>

4. Experience rating. Judge Easterbrook has offered a pair of further rationalizations for deferring to conflicted decisionmaking. In a case involving denial of a benefit claim by Unum, but decided before the Unum/Provident scandal had become public, he pointed out that "[l]arge group insurance policies are 'retrospectively-rated,'" meaning "that the employer agrees to reimburse the insurer" for benefit payments and expenses.<sup>99</sup> He reasoned that in such circumstances, because the employer rather than the insurer would bear the ultimate costs of approving claims, "we have no reason to think that the actual decisionmakers at Unum approached their task any differently than do the decisionmakers at the Social Security Administration,"<sup>100</sup> to whose decisions the courts apply deferential review.

Judge Easterbrook's argument neglects a familiar commercial reality: Even when an insurance policy is experience-rated, the insurer still has a significant incentive to deny

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<sup>98</sup>Van Boxel, 836 F.2d 1048, 1053 (7th Cir. 1987). The discordance between the two Posner opinions is remarked in Mark D. DeBofsky, *Benefit Payment Decisions Should Not Be Left up to the Insurers*, Chicago Daily L. Bull., May 16, 2006, at 10005.

<sup>99</sup>Perlman, 195 F.3d at 981.

<sup>100</sup>Id.

claims, because the market for insurance services is intensely competitive. Low cost providers prevail over high cost providers. The better the job of cost containment that an insurer does under an experience-rated policy, the better that insurer's chance of retaining the account and getting others. In a Third Circuit case, Judge Becker pointed to this "active incentive to deny close claims in order to keep costs down" as "an economic consideration overlooked by the Seventh Circuit."<sup>101</sup>

5. Supposed difficulties of implementation. Judge Easterbrook has also asserted, in a case involving Unum, that plan sponsors or their hirelings would be unable to get claims processing employees to misbehave, because getting employees to identify with the interests of their employer "is a daunting challenge for any corporation."<sup>102</sup> There is indeed an economic literature, on which Judge Easterbrook drew,<sup>103</sup> regarding the challenges of incentivizing employees. That literature does not, however, claim that employees cannot be incentivized; rather, the point is that overcoming such characteristic agency problems requires counter incentives and more acute monitoring--just what Unum did in order to get its claims processing employees to engage for years in what Judge Young called a "pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics."<sup>104</sup> The events in the Unum/Provident

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<sup>101</sup>Pinto, 214 F.3d at 388.

<sup>102</sup>Perlman, 195 F.3d at 981 ("Getting employees to act as if shareholder's welfare were their own is a daunting challenge for any corporation").

<sup>103</sup>Id., citing Candice Prendergast, The Provision of Incentives in Firms, 37 J. Econ. Lit. 7 (1999).

<sup>104</sup>Radford, 321 F.Supp. 2d at 247 (D. Mass. 2004), supra TAN \_\_\_.

scandal demonstrate that the view advanced in the Seventh Circuit--that "applying a law-and-economics rationale ... establish[es] that no conflict exists"<sup>105</sup> in benefit denial cases involving conflicted decisionmakers--is bad law<sup>106</sup> and bad economics.

### C. Analogizing to Administrative Law

Judge Easterbrook's contention that courts have as much reason to be as deferential to the decisionmaking of Unum as to that of the Social Security Administration invokes another asserted strand of justification for deference to ERISA plan decisionmakers, drawn from administrative law. A thoughtful formulation of this analogy between ERISA plan decisionmakers and governmental agencies appeared in a pre-Bruch opinion by Judge Wilkinson in the Fourth Circuit. He observed that although deferential review "is perhaps more commonly associated with appellate court review of administrative findings, deference is likewise due when a district court reviews the action of a private plan trustee."<sup>107</sup> In both contexts, he reasoned, applying deferential review "ensure[s] that administrative responsibility rests with those whose experience is daily and continuous, not with judges whose exposure is episodic and occasional."<sup>108</sup>

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<sup>105</sup>Mers, 144 F.3d at 1020.

<sup>106</sup>The Seventh Circuit's claim contradicts the Supreme Court's recognition in Bruch that such conflicts should be weighed as "'factors in determining whether there is an abuse of discretion.'" Bruch, 489 U.S. at 115, quoting Restatement (Second) of Trusts § 187, cmt. d (1959).

<sup>107</sup>Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1006 (4th Cir. 1985).

<sup>108</sup>Id.

This analogy to the expertise of administrative agencies has been strongly resisted. In the Third Circuit opinion in Bruch, Judge Becker pointed out that a benefit denial case does not ordinarily "turn on information or experience which expertise as a claims administrator is likely to produce."<sup>109</sup> In many circumstances, such a case will "turn on a question of law or contract interpretation. Courts have no reason to defer to private parties to obtain answers to these kinds of questions."<sup>110</sup> He concluded that the "significant danger that the plan administrator will not be impartial [offsets] any remaining benefit which the administrator[']s expertise might be thought to produce."<sup>111</sup>

Other courts have drawn attention to the significance of institutional and procedural differences between the two reviewing functions. The Eleventh Circuit has emphasized that "the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies."<sup>112</sup> This important ground of distinction, underscored so starkly in the Unum/Provident scandal,<sup>113</sup> cuts strongly against Judge Easterbrook's contention that "[w]e have no reason to think that Unum's benefits staff is any more 'partial' against

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<sup>109</sup>Bruch, 828 F.2d at 144.

<sup>110</sup>Id.

<sup>111</sup>Id.

<sup>112</sup>Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556, 1564 (11th Cir. 1990).

<sup>113</sup>See supra TANs \_\_\_ for discussion of the pressures to deny meritorious claims that Unum brought to bear on its claims evaluation personnel.

applicants than are federal judges when deciding benefits claims."<sup>114</sup> The partiality of self-interested reviewers, long suspected in ERISA benefit denial practice, has now been documented in the Unum/Provident scandal.

Speaking of Social Security Administration (SSA) proceedings, which Judge Easterbrook equated with Unum's, Judge Posner has correctly observed that SSA "is a public agency that denies benefits only after giving the applicant an opportunity for a full and fair adjudicative hearing. The procedural safeguards thus accorded, designed to assure a full and fair hearing, are missing from determinations by plan administrators."<sup>115</sup>

#### D. Developing Bruch's Conflict Proviso

Bruch's conflict proviso, noticed above,<sup>116</sup> made a potentially important concession to the hazards of conflicted decisionmaking. Even in a case in which the plan documents require deferential review, said the Supreme Court, if the "administrator or fiduciary ... is operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.'"<sup>117</sup> That slender passage

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<sup>114</sup>Perlman, 195 F.3d at 981. Regarding the pressures that Unum brought to bear on its claims processing staff, see supra TANs \_\_\_\_.

<sup>115</sup>Herzberger v. Standard Ins. Co., 205 F.3d 327, 332 (7th Cir. 2000). This point is further developed in Mark D. DeBofsky, The Paradox of the Misuse of Administrative Law Claims in ERISA Benefit Claims, 37 J. Marshall L. Rev. 727, 738-43 (2004).

<sup>116</sup>Supra TANs \_\_\_\_, \_\_\_\_.

<sup>117</sup>Bruch, 489 U.S. at 115, quoting Restatement (Second) of Trusts § 187, cmt. d (1959).

has produced a large case law wrestling with the question of whether the plan decisionmaker is conflicted, and if so, how much the reviewing court should temper its deference.<sup>118</sup>

In an early post-Bruch decision, Brown v. Blue Cross & Blue Shield of Alabama,<sup>119</sup> the Eleventh Circuit held that "when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest."<sup>120</sup> The Eleventh Circuit has adhered to this burden-shifting rule in later cases.<sup>121</sup> Were that approach widely followed, it would materially narrow the scope of deference that courts must grant to plan-dictated standards of review.

The other circuits have not, however, agreed. Most circuits place upon the plaintiff the burden not only of showing that the decisionmaker was conflicted, but that the conflict resulted in improper decisionmaking. Thus, in the Ninth Circuit, a "showing of a conflict does not automatically eliminate the usual deference accorded to the plan administrator; rather, the plaintiff must show 'that the conflict may have influenced the

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<sup>118</sup>See Langbein, Stabile & Wolk, *supra* note \_\_, at 665-69; Kennedy, *supra* note \_\_, at 1046-62.

<sup>119</sup>898 F.2d 1556 (11th Cir. 1990).

<sup>120</sup>*Id.* at 1566.

<sup>121</sup>E.g., *Adams v. Thiokol Corp.*, 231 F.3d 837, 842 (11th Cir. 2000).

decision."<sup>122</sup> The claimant must adduce "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 duty to the [claimant]."<sup>123</sup> Similarly, the Second Circuit has held (in a benefit denial case involving Unum) that conflict "is alone insufficient as a matter of law to trigger stricter review."<sup>124</sup> The First Circuit leaves "the burden on the claimant to show that [the] decision was improperly motivated."<sup>125</sup> In the Eighth Circuit the claimant must present "probative evidence that [even a] palpable conflict of interest actually caused a serious breach of the plan administrator's fiduciary [duty]."<sup>126</sup> In a case involving an insurance company as plan decisionmaker, the Seventh Circuit said that although the company "acts as both administrator and insurer of the plan, that factor, standing alone, does not constitute a conflict of interest."<sup>127</sup> The contrary view voiced in Brown seems more candid: An insurance company's "fiduciary role lies in perpetual conflict with its profit-making role as a business."<sup>128</sup>

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<sup>122</sup>Alford v. DCH Foundation Group Long-Term Disability Plan, 311 F.3d 955, 957 (9th Cir. 2002).

<sup>123</sup>Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1323 (9th Cir. 1995).

<sup>124</sup>Pulvers v. First UNUM Life Ins. Co., 210 F.3d 89, 92 (2d Cir. 2000).

<sup>125</sup>Pari-Fasano v. ITT Hartford Life & Accident Ins. Co., 230 F.3d 415, 418 (1st Cir. 2000).

<sup>126</sup>Schatz v. Mutual of Omaha Ins. Co., 220 F.3d 944, 948 (8th Cir. 2000).

<sup>127</sup>Cozzie v. Metropolitan Life Ins. Co., 140 F.3d 1104, 1108 (7th Cir. 1998). The Seventh Circuit "presume[s] that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." Mers, 144 F.3d at 1020.

<sup>128</sup>898 F.2d at 1561–62.

The Supreme Court could, without confessing error in Bruch, materially reduce the scope of Bruch's mischief by resolving this conflict among the circuits in favor of the position of the Eleventh Circuit, insisting on de novo review despite contrary plan terms in cases involving conflicted decisionmaking.<sup>129</sup> That path is also open to any of the circuits that may find reason to reexamine the question. The suspicion is sometimes voiced in the ERISA plaintiffs' bar that part of what has motivated other circuits not to take advantage of their authority under Bruch's conflict proviso to resist plan-dictated deferential review clauses is the fear that caseloads would increase. Deciding a case on the merits is indeed more time-consuming than presuming the correctness of somebody else's self-serving decision. Because, however, Congress determined to subject ERISA-plan benefit denials to federal judicial review,<sup>130</sup> and because ERISA's draconian

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<sup>129</sup> Another potentially important limiting principle found in the case law is the suggestion, championed in the Fifth Circuit, that plan-dictated deferential review be limited to issues of fact rather than plan interpretation. See Pierre v. Connecticut General Life Ins. Co., 932 F.2d 1552 (5th Cir.), cert. denied, 502 U.S. 973 (1991). Pierre is "very much the minority view, and numerous circuits have declined to adopt it." Shaw v. Connecticut General Life Ins. Co., 353 F.3d 1276, 1285 (11th Cir. 2003) (citing cases). The Ninth Circuit has questioned the distinction, contending that "factual findings and plan interpretations are often intertwined. For example, determining eligibility for disability benefits almost always involves an interpretation of the plan's term 'disabled,' but it also involves the fact of whether the claimant is disabled." Walker v. American Home Shield Long Term Disability Plan, 180 F.3d 1065, 1070 (9th Cir. 1999). Bruch itself was an interpretation case, in which the Supreme Court remarked that "[a]s this case aptly demonstrates, the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue." 489 U.S. at 115. Accordingly, cases in the Seventh Circuit have taken the view the opinion in Bruch leaves no room for restricting de novo review to factual determinations. Petrilli v. Drechsel, 910 F.2d 1441, 1446 (7th Cir. 1990), reaffirmed in Ramsey v. Hercules, Inc., 77 F.3d 199, 204 (7th Cir. 1996).

<sup>130</sup> ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 authorizes suit "to recover benefits due ...." The statute also requires an ERISA plan to have internal review procedures that

preemption provision<sup>131</sup> suppresses the state law causes of action that existed for many such cases before ERISA,<sup>132</sup> the proper role of the federal courts is to decide these cases fairly, and not to slough them off onto biased decisionmakers.

The Unum/Provident scandal, showing just how serious the danger of conflicted plan decisionmaking really is, supplies cogent justification for the lower courts to tighten the standard of review in such cases.<sup>133</sup> For the Supreme Court, however, the better path would be to reconsider its misstep in Bruch.

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"afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." Section § 503(2), 29 U.S.C. § 1133(2).

<sup>131</sup>ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ...." ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). "The language of section 514(a) sweeps as broadly as the English language allows." Leon E. Irish & Harrison J. Cohen, ERISA Preemption: Judicial Flexibility and Statutory Rigidity, 19 U. Mich. J.L. Reform 109, 110–12 (1985).

<sup>132</sup>See, e.g., the discussion below, *infra* TANs \_\_-\_\_, regarding the protections in state insurance law against policy terms skewing the standard of review against the insured.

<sup>133</sup>Bogan and Fu argue in support of *de novo* review on different grounds. They would conclusively presume a breach of ERISA's duty of loyalty when a conflicted fiduciary denies a participant claim. Bogan & Fu, *supra* note \_\_, at 672-84. They analogize the ERISA cases to the no-further-inquiry rule of trust law, which conclusively presumes that trustee self-dealing entails breach of trust. I have criticized the no-further-inquiry rule in John H. Langbein, Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?, 114 Yale. L.J. 929 (2005). Quite apart from the merits of the trust law rule, I regard the position advanced by Bogan and Fu as having been foreclosed by the statutory text of ERISA. Because ERISA expressly permits employer personnel to serve as plan administrators, see *supra* TAN \_\_, it authorizes the very sort of conflicts of interest that the no-further-inquiry rule law rule attempts to deter in trust administration. In trust law, when the settlor authorizes the conflict, the no-further-inquiry rule does not apply. See Restatement (Second) of Trusts § 170(1), cmt. t (1959) (terms of the trust may authorize self-dealing).

#### IV. The Limits of Trust Law

It will be recalled that, apart from the conflict proviso just discussed, the decision in Bruch has two main branches. The Supreme Court held (1) that the standard of judicial review for ERISA plan decisionmaking is nondeferential or de novo, but (2) that the plan sponsor may by apt drafting of the plan documents defeat that standard and insist on deferential review. In justifying the first branch of the decision, the Court's opinion pointed to ERISA's protective policy as the reason for preferring de novo review.<sup>134</sup> The Court rested the second branch of the opinion on analogy to the "general principles of trust law," which permit the "parties" to the trust (the settlor and the trustee) to "agree[] upon a narrower standard of review."<sup>135</sup>

The "general principles of trust law" do support the Court's result, in the sense that trust law is indeed primarily a body of default law.<sup>136</sup> The settlor of a trust is allowed

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<sup>134</sup>ERISA "was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans' ... and 'to protect contractually defined benefits ....'" Bruch, 489 U.S. at 113, quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983), and Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985). The Court has subsequently observed with respect to its "lenient" practice of deferring to plan-dictated discretionary review clauses that "there is no ERISA provision directly providing a lenient standard for judicial review of benefit denials ...." Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 385 (2002).

<sup>135</sup>Bruch, 489 U.S. at 115.

<sup>136</sup>See Uniform Trust Code (UTC) § 105(a) (2000) identifying all trust law as default law except for those provisions identified in § 105(b). I have discussed the objectives and operation of the UTC provision in John H. Langbein, Mandatory Rules in the Law of Trusts, 98 Nw. U. L. Rev. 1105, 1106, 1119-28 (2004) [hereinafter Langbein, Mandatory Rules]

to relax the standard of judicial review of trustee decisionmaking.<sup>137</sup> The question is whether that principle of settlor autonomy should be transposed to ERISA fiduciary law.

#### A. Default or Mandatory Law?

When a legislature absorbs a private law regime such as trust law for regulatory purposes, as Congress did with ERISA,<sup>138</sup> the regulatory purposes should be understood to dominate, and where necessary, to alter the application of the borrowed principles. The reason that conventional private trust law is so strongly rooted in default law is that the primary purpose of the private trust is to implement the settlor's donative intent.<sup>139</sup> But as the Court remarked when explaining Bruch's preference for de novo review as the default standard, ERISA was enacted to protect plan participants and beneficiaries.<sup>140</sup>

What the Court neglected to consider in Bruch was whether ERISA's regulatory purpose would be better implemented by refusing to allow plan drafters to order

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<sup>137</sup>See Restatement (Second) of Trusts § 187 (1959).

<sup>138</sup>Speaking of ERISA's fiduciary duty of prudent administration, ERISA § 404(a)(1)(A), the Conference Committee Report said: "The conferees expect that the courts will interpret this prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purposes of employee benefit plans." H.R. Conference Report No. 1280, 93d (1974), reprinted in 1974 U.S. Code Cong. & Admin. News 5038, 5083.

<sup>139</sup>"The controlling consideration in determining the meaning of a donative document is the donor's intention." Restatement (Third) of Property: Wills and Other Donative Transfers § 10.1 (2003). Accord, Restatement (Third) of Trusts § 4 (2003).

<sup>140</sup>Supra note \_\_.

reviewing courts to defer to plan decisionmaking. The autonomy that the settlor of a private trust enjoys to shape the terms of the trust to his or her wishes is not appropriate in circumstances in which Congress' purpose in imposing trust principles was to restrict private autonomy.<sup>141</sup> As the Court remarked some years later in an unrelated ERISA case, "trust law does not tell the entire story. After all, ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection."<sup>142</sup>

## B. Textual Support

Although the Court in Bruch did not address the question of whether permitting a plan drafter to impose a self-serving standard of review intrudes upon ERISA's protective purpose, the text of ERISA in fact contains provisions that strongly support the view that a plan's standard of review should be treated as a matter of mandatory rather than default law, hence not open to contrary plan drafting.

1. "[C]onsistent with the provisions" of ERISA." ERISA requires plan instruments to be "consistent with the provisions of" ERISA.<sup>143</sup> The Supreme Court has interpreted

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<sup>141</sup>ERISA is not the only field in which trust law principles have been employed for regulatory purposes. A variety of regulatory compliance trusts, found in federal and state law, are discussed in John H. Langbein, *The Secret Life of the Trust: The Trust as an Instrument of Commerce*, 107 *Yale L.J.* 165, 174-77 (1997)

<sup>142</sup>*Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

<sup>143</sup>ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

this provision to mean "that trust documents cannot excuse trustees from their duties under ERISA, and that trust documents must generally be construed in light of ERISA's policies ...."<sup>144</sup> Especially because the opinion in Bruch invoked ERISA's protective purposes as the rationale for interpreting ERISA to require de novo review as the default standard, the question arises whether plan terms defeating de novo review are "consistent with the provisions of" ERISA.

Section 404(a)(1)(D) has been particularly significant in restraining plan autonomy in investment matters. For example, in the pension litigation arising from the collapse of Enron Corporation,<sup>145</sup> participants in plans funded in part with Enron stock contended that the plan fiduciaries had a duty to disregard plan terms requiring the fiduciaries to buy and retain the stock. In an amicus brief, the Department of Labor, which administers ERISA, emphasized the controlling importance, in its view, of section 404(a)(1)(D). The Department argued that section 404(a)(1)(D) places plan fiduciaries under a duty "to ignore the terms of the plan document where those terms require[] them to act imprudently in violation of [the duty of prudent administration found in] ERISA §

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<sup>144</sup>Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559, 568 (1985).

<sup>145</sup>See In re Enron Corp. Securities, Derivative & ERISA Litigation (Tittle v. Enron Corp.), 284 F.Supp. 2d 511 (S.D. Tex. 2003).

404(a)(1)(B)."<sup>146</sup> Thus, "[e]ven if the plan document requires an investment, the fiduciaries must override it if it violates ERISA."<sup>147</sup>

This theme that ERISA's core fiduciary regime is mandatory rather than default law has found favor in the case law. The Fifth Circuit has said: "In case of a conflict [between ERISA duties and plan terms], the provisions of the ERISA policies as set forth in the statute and regulations prevail over those of the [plan]."<sup>148</sup> In an employer stock plan case arising from the insolvency of Polaroid Corporation, the district court refused to treat as determinative a plan term that required the plan to invest in Polaroid stock. The court cited section 404(a)(1)(D) for the view that, "by force of statute, [the plan fiduciaries] had the fiduciary responsibility to disregard the Plan and eliminate Plan investments in Polaroid stock if the circumstances warranted."<sup>149</sup> Accordingly, "to the extent Polaroid stock was an imprudent investment, [the plan fiduciaries] possessed the authority as a matter of law to exclude Polaroid stock ... [as an] investment alternative, regardless of the Plan's dictates."<sup>150</sup>

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<sup>146</sup>Amended Brief of the Secretary of Labor as Amicus Curiae Opposing the Motions to Dismiss, *In re Enron Corp.*, Aug. 30, 2002, at 30-31.

<sup>147</sup>*Id.* at 32, citing, among other authority, long-standing Department opinion letters, No. 90-05A, 1990 WL 172964 at \*3 (Mar. 20, 1990); 83-6A 1983 WL 22495, at \*1-\*2 (Jan. 24, 1983).

<sup>148</sup>*Laborers' Nat'l Pension Fund v. Northern Trust Quantitative Advisors, Inc.*, 173 F.3d 313, 322 (5th Cir. 1999) (holding that investment manager must disregard plan terms if investing plan assets as required by plan would violate its duty of prudence).

<sup>149</sup>*In re Polaroid ERISA Litigation*, 362 F.Supp.2d 461, 474 (S.D.N.Y. 2005).

<sup>150</sup>*Id.* at 474-75. In another of the employer stock plan cases, concerning the Sears 401(k) plan, the district court sustained the plaintiff plan participants' claim that, under

Similar issues arose in the takeover battles of the 1980s, in circumstances in which plan terms required plan fiduciaries to vote plan-owned shares of employer stock in a manner that appeared to contravene their duty of loyalty to plan participants. In the celebrated takeover battle in 1982 involving Martin Marietta's offer for Bendix Corporation,<sup>151</sup> the Bendix plan contained a term prohibiting the trustee from tendering Bendix shares in a hostile tender offer. "When Martin Marietta announced its offer to purchase Bendix shares, however, [the trustee] decided that the risk of violating ERISA Section 404(a)(1)(D) by failing to tender the Bendix shares was so great that it had a duty to tender the shares in violation of the plan."<sup>152</sup> The courts sustained the trustee's position.<sup>153</sup> Department of Labor regulations now provide that when a plan investment manager (always a fiduciary under ERISA<sup>154</sup>) determines that complying with plan-dictated voting instructions would be "imprudent or not solely in the interest of plan

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ERISA section 404(a)(1)(D), "'blindly following' the Plan provisions requiring matching contributions to be made in Sears stock would be imprudent, in violation of ERISA fiduciary duties, when the Investment Committee knew or should have known the price of the stock was fraudulently inflated." *In re Sears Roebuck & Co. ERISA Litigation*, 32 E.B.C. 1699, 1705 (N.D. Ill. 2004).

<sup>151</sup>See generally Peter F. Hartz, *Merger: The Exclusive Inside Story of the Bendix-Martin Marietta Takeover War* (2000 ed.).

<sup>152</sup>See Edward A. Landry, *Fiduciary Responsibility under ERISA in a Takeover Situation*, 12 *Prob. Notes* 148, 151 (American College of Probate Counsel) (1986).

<sup>153</sup>*Id.*

<sup>154</sup>ERISA § 3(38), 29 U.S.C. § 1002(38); see also ERISA § 3(21)(A)(ii), 29 U.S.C. § 1002(21)(A)(ii).

participants, the investment manager would be required to ignore the voting policy that would violate ERISA § 404(a)(1)(D) in that instance."<sup>155</sup>

The message of these authorities is that ERISA fiduciary law as applied to investment matters is regulatory law, whose protective policy may not be defeated by self-serving plan terms. The view that I am advancing is that ERISA's regime of judicial review of fiduciary decisionmaking of benefit denials ought similarly to be understood as beyond the preserve of self-serving plan terms. Although the "general principles of trust law"<sup>156</sup> rightly inform much of ERISA, they must yield when in conflict with ERISA's regulatory purpose, which is "'to promote the interests of employees and their beneficiaries in employee benefit plans'... and 'to protect contractually defined benefits ....'"<sup>157</sup> ERISA's protective policy, buttressed through section 404(a)(1)(D), should prevail over plan terms that abridge ERISA's fiduciary duties of loyalty and prudence. Plan terms cannot authorize plan fiduciaries to loot the plan or waste its assets. For the same reason, plan fiduciaries ought not to be allowed to abridge ERISA's standard of judicial review of plan decisionmaking.

2. Forbidding exculpation clauses. Beyond section 404(a)(1)(D), other provisions of ERISA support the view that Congress meant to limit the autonomy of plan sponsors

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<sup>155</sup>Interpretive Bulletin 94–2, codified as 29 C.F.R. § 2509.94–2.

<sup>156</sup>Bruch, 489 U.S. at 115.

<sup>157</sup>Id. at 113, quoting Shaw, 463 U.S. at 90, and Russell, 473 U.S. at 148 (1985), noticed supra TAN \_\_\_\_.

to impose self-serving terms. Whereas private trust law allows the settlor to insert an exculpation clause,<sup>158</sup> ERISA forbids it. Section 410(a) provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under [ERISA fiduciary law]<sup>159</sup> shall be void as against public policy."<sup>160</sup> A plan term that defeats the otherwise applicable ERISA standard of nondeferential de novo review in favor of self-serving deferential review is in considerable tension with the prohibition on plan terms that relieve a fiduciary its responsibility under ERISA. There is scant practical difference between a conventional exculpation clause and the language that Judge Posner "drafted and commend[ed] to employers" for taking advantage of their license to skew the standard of review under Bruch: "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."<sup>161</sup>

3. "Full and fair review." Recall further that ERISA requires a plan to have internal review procedures that "afford a reasonable opportunity to any participant whose

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<sup>158</sup>Restatement (Second) of Trusts § 222 (1959), Uniform Trust Code § 1008 (2000), discussed in Langbein, Mandatory Rules, 98 Nw. U. L. Rev. at 1123-25.

<sup>159</sup>The statutory term replaced in the brackets is "this part," a reference to Title 1, Part 4, which contains ERISA's fiduciary provisions.

<sup>160</sup>ERISA § 410(a). 29 U.S.C. § 1110(a). The Solicitor General argued in an amicus brief in Bruch that on account of this provision, "language in a plan document purporting to give biased administrators unbounded discretion to decide what the terms of the plan mean ... would not be enforceable under ERISA." Brief for the United States as Amicus Curiae Supporting Respondents, Lexis 1987 U.S. Briefs 1054, at \*27. (I owe this reference to Donald Bogan.) The Court did not take notice of the point.

<sup>161</sup>Herzberger v. Standard Ins. Co., 205 F.3d 327, 331 (7th Cir. 2000)

claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."<sup>162</sup> Plan terms lowering the standard of judicial review undermine the effectiveness of ERISA's requirement of fairness in internal proceedings, by making it so much harder to challenge unfairness. An egregious example of the tension between ERISA's requirement of "full and fair" review and contrary plan terms appears in dictum in a Fourth Circuit case in which the court remarked that it would enforce a plan whose "language provided that pain could never support a finding of disability."<sup>163</sup> In a Seventh Circuit case, Judge Posner, taking as his premise that Bruch allows a plan to "specify the degree of deference due the plan administrator's benefit determination," asked rhetorically: "Why can't [the plan] equally specify the procedures and rules of evidence, including presumptions, that the plan's administrator shall use to evaluate claims?"<sup>164</sup> The answer is that ERISA's requirement of "full and fair" internal review should be understood as mandatory law, preventing contrary plan terms.

### C. Protective Principles from State Insurance Law

The Unum/Provident scandal has provoked a concerted movement among the state insurance commissioners to forbid terms in insurance policies that alter the standard

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<sup>162</sup>ERISA § 503(2), 29 U.S.C. § 1133(2).

<sup>163</sup>Smith v. Continental Casualty Co., 369 F.3d 412, 420 (4th Cir. 2004).

<sup>164</sup>Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 917 (7th Cir. 2003).

of judicial review.<sup>165</sup> The rationale for these interventions, in the words of the California provision, is that policy terms attempting to govern the standard of review deprive the insured of "the protections of California insurance law, including the covenant of good faith and fair dealing ...."<sup>166</sup> The influential National Association of Insurance Commissioners has been encouraging the states to take this position.<sup>167</sup> The Hawaii Commissioner ruled in 2004 that "[a] 'discretionary clause' granting to a plan administrator discretionary authority so as to deprive the insured of a de novo appeal is an unfair or deceptive act or practice in the business of insurance and may not be used in health insurance contracts or plans in Hawaii."<sup>168</sup> At that time such clauses were "prohibited by statute in Maine and Minnesota and by Insurance Commissioners in California, Illinois, Indiana, Montana, Nevada, New Jersey, Oregon, Texas and Utah."<sup>169</sup>

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<sup>165</sup>See Henry Quillen, State Prohibition of Discretionary Clauses in ERISA-Covered Benefit Plans, 32 J. Pension Planning & Compliance, Summer 2006, at 67. Bad faith claims denial is a longstanding subject of state insurance regulatory concern. The field has its own treatise, Stephen S. Ashley, *Bad Faith Actions: Liability and Damages* (2d ed. 1997 & Supp.).

<sup>166</sup>Gary M. Cohen, General Counsel, California Department of Insurance, to Teresa S. Renaker, Esq., "Letter Opinion per [California Insurance Code] § 12921.9: Discretionary Clauses," Feb. 26, 2004, noted in 11 ERISA Litigation Rptr. (Feb. 2004), at 10.

<sup>167</sup>Quillen recounts NAIC's deliberations and recommendations in Quillen, *supra* note \_\_\_, at 71-73. He reprints, *id.* at 83-85, the 2004 version of the NAIC's model act prohibiting discretionary clauses, together with a 2003 NAIC staff memorandum arguing that the act would escape ERISA preemption. *Id.* at 86-88. The NAIC's intervention is further discussed in Donald T. Bogan, ERISA: State Regulation of Insured Plans after Davila, 38 J. Marshall L. Rev. 693, 740 (2005).

<sup>168</sup>State of Hawaii, Insurance Div., Memorandum 2004-13H, Dec. 8, 2004, at 3, available at [www.naic.org/NBP/Basic.jsp](http://www.naic.org/NBP/Basic.jsp). (I owe this reference to Mary Ellen Signorelle.)

<sup>169</sup>*Id.* at 2.

In 2005, the Illinois regulations were further amended to forbid health or disability insurance contracts from "contain[ing] a provision purporting to reserve discretion to the [insurer] to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State."<sup>170</sup>

The question whether, as applied to ERISA plans, such regulations will survive ERISA's preemption clause (under its exception for state insurance regulation<sup>171</sup>) remains to be resolved. As part of Unum's October 2005 settlement with the California regulators, the company agreed to cease using discretionary review clauses in insurance policies sold in that state.<sup>172</sup>

The principle that underlies the state insurance commissioners' initiative bears importantly on the question whether ERISA should continue to facilitate plan-dictated standard-of-review clauses. The commissioners contend that allowing an insurance

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<sup>170</sup>50 Ill. Admin. Code § 2001.3.

<sup>171</sup>ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). The Supreme Court has "repeatedly held that state laws mandating insurance contract terms are saved from preemption under" ERISA's insurance saving clause. *Unum Life Ins. Co. v. Ward*, 526 U.S. 358, 375 (1999), citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 758 (1985); *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990). In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002), the Court sustained as appropriate state insurance regulation an Illinois statute that "undeniably eliminates whatever may have remained of a plan sponsor's option to minimize scrutiny of benefit denials ...." However, in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court held that Mississippi's state law cause of action for bad faith in claims processing sounded in tort or contract law rather than insurance and was not therefore protected from preemption under the exception for insurance regulation.

<sup>172</sup>Cal., Settlement Agreement, Oct. 2005, *supra* note \_\_\_, at \_\_\_, cited in Quillen, *supra* note \_\_\_.

policy to skew the standard of review against the insured interferes with the protective purpose of insurance regulatory law. Similarly, the view developed in this article is that allowing ERISA plan drafters to dictate the standard of judicial review of benefit denials undermines the regulatory purposes of ERISA. In the work of the insurance commissioners there is a further demonstration that when conscientious policymakers think carefully about the issue, rather than toss it off in a hasty aside as the Supreme Court did in Bruch, they conclude that the standard of review of benefit denials ought not to be subject to self-serving alteration.

## V. Conclusion

The Unum/Provident scandal, by underscoring the danger that inheres in allowing conflicted decisionmakers to deny claimed benefits, demonstrates that impartial judicial review of such denials is an essential safeguard against self-serving conduct. The Supreme Court in Bruch rightly interpreted ERISA to require nondeferential de novo review of plan decisionmaking, but an ill-considered aside allowed plan drafters to retake much of the ground that the court had just staked out for de novo review.

The analogy to trust law on which the Court rested this branch of its decision in Bruch is unsound. Although the drafter of a private trust may indeed insist on greater judicial deference to trustee decisionmaking, the courts grant that deference on the premise that the purpose of trust law is 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, to limit private autonomy. Accordingly, the analogy to "general principles of trust law," on which the Court based its decision to allow plan drafters to defeat the otherwise applicable ERISA standard of review, is a misapplication of trust law. When trust principles are transposed to regulatory purposes, as in ERISA, those purposes alter the normal trust law balance between default and mandatory law. Like ERISA's substantive fiduciary norms of loyalty and prudence, ERISA's provision for judicial review of plan decisionmaking has an essentially protective purpose. Congress did not allow employers and other plan sponsors the option to decline to be subject to ERISA fiduciary law. For much the same reason, the Supreme Court was wrong to assume that ERISA allows plan drafters to dictate reduced scrutiny for conflicted plan fiduciaries in contested benefit denial cases. The Court (or Congress<sup>173</sup>) ought to learn from the Unum/Provident scandal and correct the mistake in Bruch before more ERISA plan participants and beneficiaries are victimized by more bad faith benefit denials.

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<sup>173</sup>Judge Becker suggested that Congress "consider amending ERISA to require more stringent review where an employer acts as its own plan administrator." *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40, 45 n. 5 (3d Cir.1993). Former Senator Robert Dole (R. Kansas) proposed such a measure shortly after the decision in Bruch. See S. Bill 3267, 101st Cong., 2d Sess. (1990). The bill would have amended ERISA to provide that in any civil action under § 502(a)(1)(B), "if the action involves a matter previously decided by a named fiduciary who has a significant interest which would be adversely affected by a decision in favor of the participant or beneficiary, the court shall review the decision of the fiduciary without according any deference to any findings or conclusions of such fiduciary."