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Essay

TRUST LAW AS REGULATORY LAW: THE UNUM/PROVIDENT SCANDAL AND JUDICIAL REVIEW OF BENEFIT DENIALS UNDER ERISA

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INTRODUCTION 1315
I. THE UNUM/PROVIDENT SCANDAL 1317
II. *BRUCH* 1322
  A. Setting the Default Standard: De Novo Review 1322
  B. Subordinating De Novo Review 1323
  C. The Conflict Proviso 1324
III. ERISA'S CONFLICTED DECISIONMAKERS 1325
  A. Plan Administration As Fiduciary Law 1325
  B. Denigrating the Conflict 1327
  C. Analogizing to Administrative Law 1331
  D. Developing Bruch*'s Conflict Proviso* 1333
IV. THE LIMITS OF TRUST LAW 1335
  A. Default or Mandatory Law? 1336
  B. Textual Support 1336
  C. Protective Principles from State Insurance Law 1340
CONCLUSION 1342

INTRODUCTION

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 Essay reviews what is known of this episode.

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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").[1] Most disability insurance in the United States (apart from the Social Security program) is employer-provided,[2] and hence ERISA-governed.[3] 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*,[4] 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 Essay 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. ERISA places the plan administrator under a fiduciary duty to act "solely in the interest of the participants and beneficiaries,"[5] yet, as the 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."[6] This Essay 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

[1] Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001–1461 (2000).

[2] In 2003, employers provided short-term disability insurance for 39% of the workforce, and long-term disability insurance for 30%. AMERICAN COUNCIL OF LIFE INSURERS, LIFE INSURERS FACT BOOK 101 (2005). ERISA-covered plans also provide most of the nation's health insurance. Presently, 91% 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 exempt from ERISA. *See* ERISA § 4(b), 29 U.S.C. § 1003(b) (2000). ERISA plans also supply much of the nation's life insurance. By the end of 2004, there was $7.6 trillion of group life insurance in force, virtually all employer-provided, compared to $9.7 trillion of individually purchased coverage. AMERICAN COUNCIL OF LIFE INSURERS, *supra*, at 88, 92.

[3] ERISA covers all employee benefit plans as defined in ERISA § 3(3), 29 U.S.C. § 1002(3) (2000). *See* ERISA, § 4(a), 29 U.S.C. § 1003(a) (2000). This is true except for those excluded under ERISA § 4(b), 29 U.S.C. § 1003(b), most notably the plans of federal, state, and local government employers. *See* ERISA § 4(b)(1), 29 U.S.C. § 1003(b) (2000) (referencing ERISA § 3(32), 29 U.S.C. § 1002(32)).

[4] 489 U.S. 101, 115 (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).

[5] ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (2000) (discussed *infra* text accompanying notes 66–74).

[6] Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144 (3d Cir. 1987), *aff'd in part, rev'd in part*, 489 U.S. 101 (1989).

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 there rested its decision on analogy to "general principles of trust law."[7] 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,"[8] trust law exhibits great deference to the wishes of the transferor. In ERISA, by contrast, Congress imposed trust law concepts for regulatory purposes, to restrict rather than to promote the autonomy of the employer over its 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 weaken the standards under which its benefit denial decisions (or those of a hireling) are to be reviewed.

I. THE UNUM/PROVIDENT SCANDAL[9]

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

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[7] *Bruch*, 489 U.S. at 115.

[8] Bernard Rudden, *Book Review*, 44 MOD. L. REV. 610, 610 (1981) (reviewing JOHN P. DAWSON, GIFTS AND PROMISES (1980)).

[9] Portions of this account draw upon sources collected in LANGBEIN, STABILE & WOLK, *supra* note 4, at 669–74.

[10] 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. *See* Steven Lipin & Leslie Scism, *Provident Reaches Accord with Textron to Buy Paul Revere Unit for $1.2 Billion*, WALL ST. J., Apr. 29, 1996, at A3; *see also* Leslie Scism and Steven Lipin, *Provident's Purchase of Paul Revere Signals Recovery*, WALL ST. J., Apr. 30, 1996, at B4. "Unum" is sometimes rendered in upper case, but not in this Essay.

[11] *See* Dean Foust, *Disability Claim Denied!*, BUSINESS WEEK, Dec. 22, 2003, at 62, 63. 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 disability insurance to more than 11 million American workers." UnumProvident.com, About Us—UnumProvident, http://www.unumprovident.com/aboutus (last visited Feb. 26, 2006) [hereinafter About Us—UnumProvident]. The larger figure

Although most benefit claims arising under policies of disability insurance are processed routinely,[12] 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.[13] A reviewing court will not often find close guidance on such factual 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.[14] Moral hazard dangers are more acute with 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.[15]

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. Pressures 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.[16] Word of these practices began to emerge in lawsuits brought by former Unum claims-processing employees, and in investigative reports broadcast in 2002 by

mentioned in the text includes individual and other non-employer-provided policies, reflecting the decline in Unum's business that has resulted from publicity about the investigations and proceedings against the company.

[12] Unum advertises that it processed 450,000 new disability claims in 2004 and paid $2.4 billion in disability benefits. About Us—UnumProvident, *supra* note 11.

[13] The reported case law is surveyed in STEVEN PLITT ET AL., COUCH ON INSURANCE chs. 147–48 (3d ed. 1995 & Supps.).

[14] *See, e.g.*, Shyman v. Unum Life Ins. Co., 427 F.3d 452, 456 (7th Cir. 2005) (discussing 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 was observed coaching basketball and baseball, exercising on a treadmill, and driving his children to and from school). 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 benefits to claimants who are not entitled to receive them." Davis v. Unum Life Ins. Co., 444 F.3d 569, 575 (7th Cir. 2006).

[15] Disability insurers commonly limit an insured's disability coverage to a sum well short of his or her full salary. *See* Hall v. Life Ins. Co. of N. Am., 317 F.3d 773, 775 (7th Cir. 2003) ("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 . . . ."). 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).

[16] *See* Foust, *supra* note 11, at 64.

NBC's *Dateline*[17] and CBS's *60 Minutes*[18] 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."[19] The *Dateline* story pointed to an internal company email cautioning a group of claims staff that they had one week remaining to "close," that is, deny, eighteen more claims in order to meet desired targets.[20]

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 it had dismissed the dissidents 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 suggest additional medical tests"; and that he was "not supposed to help a claimant perfect a claim for disability insurance benefits."[21]

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,[22] large punitive damage awards have been made against Unum/Provident companies for bad faith claim denials in several non-ERISA cases.[23] In one such case, a federal judge sustained a $5 million 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."[24]

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17 *Dateline: Benefit of the Doubt* (NBC television broadcast, Oct. 13, 2002) (transcript on file with author).

18 *60 Minutes: Did Insurer Cheat Disabled Clients?* (CBS television broadcast, Nov. 17, 2002) (transcript on file with author).

19 *Id.*

20 *See Dateline*, *supra* note 17.

21 McSharry v. UnumProvident Corp., 237 F. Supp. 2d 875, 877 (E.D. Tenn. 2002).

22 *See* 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*].

23 *See* Foust, *supra* note 11, at 63.

24 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 his experiences in the case. *See* RAY BOURHIS, INSULT TO INJURY: INSURANCE, FRAUD, AND THE BIG BUSINESS OF BAD FAITH (2005).

Many federal courts have now commented on Unum's aggressive claims denial practices. Published opinions speak of "selective review of the administrative record,"[25] "lack of objectivity and an abuse of discretion by UNUM,"[26] misuse of "ambiguous test results,"[27] and claims evaluation practices that "defie[d] common sense"[28] and "bordered on outright fraud."[29] 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."[30] 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.[31]

As complaints, litigation, and media accounts multiplied, several state insurance commission staffs began investigating Unum's claims denial practices. In the view of the Georgia commissioner, Unum had been "looking for every technical legal way to avoid paying a claim."[32] In 2003 and 2004, 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 reviewing procedures and its corporate governance.[33] In 2005 the California Department of Insurance settled separately with Unum, imposing an $8 million civil penalty.[34] California regulators reported "violations of state law in nearly one-third of a random sample of about 1,000 claims handled by UnumProvident."[35] *Barron's*, the financial newspaper, reports that "[s]ince 2004, Unum has taken charge-offs

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[25] Moon v. UNUM Provident Corp., 405 F.3d 373, 381 (6th Cir. 2005).

[26] Lain v. UNUM Life Ins. Co., 279 F.3d 337, 347 (5th Cir. 2002).

[27] Stup v. UNUM Life Ins. Co. of Am., 390 F.3d 301, 310 (4th Cir. 2004).

[28] Dandurand v. UNUM Life Ins. Co. of Am., 284 F.3d 331, 338 (1st Cir. 2002).

[29] Watson v. UnumProvident Corp., 185 F. Supp. 2d 579, 585 (D. Md. 2002).

[30] Radford Trust v. First Unum Life Ins. Co., 321 F. Supp. 2d 226, 247 (D. Mass. 2004).

[31] *Id.*

[32] Mike Pare, *$1 Million Fine Hits Unum*, CHATTANOOGA TIMES FREE PRESS, Mar. 19, 2003, at C1.

[33] *See* Maine Bureau of Insurance, Report of the Targeted Multistate Market Conduct Examination, http://www.maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (last visited Mar. 7, 2007).

[34] *See* Diya Gullapalli, *UnumProvident 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 "Cal. Settlement Agreement," *In re* Certificates of Authority of Unum Life Insurance Co., etc., Nos. DISP05045984–85 (Oct. 2005) [hereinafter Cal. Settlement Agreement] (copy on file with author).

[35] Peter G. Gosselin, *State Fines Insurer, Orders Reforms in Disability Cases*, L.A. TIMES, Oct. 3, 2005, at A1, A12.

of $135 million," including the multi-state and California fines, as a result of the investigations.[36]

In the course of discovery proceedings in the lawsuits against Unum, there came to light a remarkable internal memorandum written in 1995 by a Unum executive.[37] In it, he exults in the "enormous"[38] advantages that ERISA, as interpreted by the courts, bestowed upon Unum in cases in which an insured sought judicial review of a benefit denial. "[S]tate law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review."[39] 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."[40] We see in this document Unum's keen understanding of how the deferential standard of review allowed under *Bruch* interacts with aspects of ERISA remedy law to facilitate aggressive claim denial practices.

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 was sanctioned, and its fate should deter others. The other reading of these events is less sanguine: For reasons discussed below in Part III, 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. Cases of abusive benefit denials involving other disability insurers abound.[41] Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect.

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[36] Jonathan R. Laing, *The $675 Million Solution*, BARRON'S, May 1, 2006, at 22.

[37] Memorandum from Jeff McCall to IDC Management Group & Glenn Felton, Provident Internal Memorandum, Re: ERISA (Oct. 2, 1995) [hereinafter Unum ERISA Memorandum], *reprinted in* BOURHIS, *supra* note 24, at 225.

[38] *Id.*

[39] *Id.* 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. Great-West Life Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Mertens v. Hewitt Assocs., 508 U.S. 248 (1993); Mass. Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (unanimous decision but with dicta regarding remedy that provoked opposing concurrence, dividing the Court 5–4). I have elsewhere explained why the Court's refusal to allow compensatory "make whole" damages misreads the statute. *See* Langbein, *Trail*, *supra* note 22.

[40] Unum ERISA Memorandum, *supra* note 37. 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.*

[41] *See, e.g.*, Zanny v. Kellogg Co., No. 4:05-CV-74, 2006 WL 1851236, at *9 (W.D. Mich. 2006) ("In this case, [Metropolitan Life Insurance Co.] regularly reviewed the client's file with an open inten-

II. *BRUCH*

Because the Supreme Court's 1989 decision in *Bruch*[42] figures so centrally in the ERISA-plan cases in the Unum/Provident scandal, understanding what the Court decided in that case is essential. I have elsewhere had occasion to discuss the opinion in considerable detail.[43] 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, meaning that in the absence of contrary plan terms, a reviewing court should decide a contested benefit denial case afresh, according no presumption of correctness to the plan administrator's decision to deny the claim. Second, however, the Supreme Court allowed the ERISA plan drafter to insert a term requiring the reviewing court to defer to the plan administrator's decision, effectively defeating the de novo standard. Third, the Court cautioned that in such cases of plan-dictated deferential review, the reviewing court might need to temper its deference in circumstances in which the decisionmaker acted under a 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,[44] the statute did not address the question of what standard of judicial review to apply in such cases.[45] 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,[46] the Supreme Court held unanimously that

tion to deny benefits despite the profound and compelling evidence of serious and prolonged mental illness."); Loucks v. Liberty Life Assurance Co., 337 F. Supp. 2d 990, 995 (W.D. Mich. 2004) (characterizing the evaluation of disability claims as "unprincipled, bias[ed] and craven[,] . . . grossly negligent and driven by financial motives"); Wible v. Aetna Life Ins. Co., 375 F. Supp. 2d 956, 969 (C.D. Cal. 2005) ("[T]he record reflects unrebutted material, probative evidence tending to show that Aetna's self-interest caused a breach of its fiduciary obligations to" the disability claimant.).

[42] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).

[43] *See* John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207 [hereinafter, Langbein, *Trusts*].

[44] *See* ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 (2000) (authorizing suits "to recover benefits due").

[45] *See, e.g., Bruch*, 489 U.S. at 109 (noting that ERISA neglected to "set out the appropriate standard of review" in such cases).

[46] 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. *See* Taft-Hartley Act § 302(c)(5), 29 U.S.C. § 186 (2000). There was, accordingly, greater justification for presuming the fairness of the internal claims review processes of multi-employer plans. Regarding the scope and application of the "arbitrary and capricious" standard in