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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

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

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[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

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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

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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

ERISA required de novo review of ERISA plan decisionmaking. The Court rested this decision on both doctrinal and functional grounds. Doctrinally, the Court regarded the preference for de novo review as a "settled principle[] of trust law . . . ."[47] 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'[48] . . . and 'to protect contractually defined benefits . . . .'"[49]

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 that standard, the Court treated the standard of review as a matter of default law that the employer or other plan sponsor was free to countermand by inserting self-serving language in the plan document requiring the reviewing court to grant deferential review. De novo review pertains, 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."[50] 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."[51]

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

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federal administrative law, see 2 RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE § 11.4, at 805–14 (4th ed. 2002).

[47] *Bruch*, 489 U.S. at 112. I have elsewhere criticized the Court's premise that de novo review of plan administration derives from trust law. *See* Langbein, *Trusts*, *supra* note 43, 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) (stating that the exercise of a trust power is discretionary unless restricted by the trust's terms or by a supervening rule of trust law). In ERISA fiduciary law, however, on account of the regulatory purposes of ERISA, I think the Court was indeed correct to prefer de novo review. *See infra* text at notes 133–59.

[48] *Bruch*, 489 U.S. at 113 (quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983)).

[49] *Bruch*, 489 U.S. at 113 (quoting Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985)).

[50] *Id.*

[51] *Id.*

such as the standard of review of benefit denials.[52] Accordingly, it is a mischaracterization to depict these parties as "agreeing"[53] to preclude impartial judicial review of self-serving plan decisionmaking. Second, as further explained in Part IV of this Essay, ERISA's protective purpose, that is, its regulatory mission, is to circumscribe the contractual autonomy of the parties to a pension or benefit plan.

ERISA plans are virtually always professionally drafted instruments, the work of specialist counsel or plan administration firms. Plan drafters routinely seize upon *Bruch*'s invitation to instruct the courts to defer to plan decisionmaking.[54] 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,"[55] or, in Judge Posner's revealingly dismissive formulation, "off the wall."[56]

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 operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.'"[57]

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[52] Judge Acker has remarked, "Although, in theory, the plan document is thought of as a contract between the employer (the plan sponsor) and the employee, it never is truly the product of arms-length negotiation . . . . The employee plays no part in fashioning the coverage or the claims procedure." Burroughs v. Bellsouth Telecommunications Inc., 446 F. Supp. 2d 1294, 1298 (N.D. Ala. 2006).

[53] *Bruch*, 489 U.S. at 103.

[54] 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. Entitled "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).

[55] 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 4, 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).

[56] Rud v. Liberty Life Assurance Co., 438 F.3d 772, 773 (7th Cir. 2006).

[57] *Bruch*, 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."

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 of review, because, as discussed next in Part III of this Essay, most ERISA plan benefit denials are the work of decisionmakers operating under serious conflicts of interest. The lower courts have not, however, taken much advantage of their license under the conflict proviso to resist plan-dictated deferential review in these 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."[58] This concern was an outgrowth of congressional investigations into labor union corruption, especially in the Teamsters Union, which uncovered evidence of looting, kickbacks, cronyism, and other serious maladministration in union-sponsored pension and benefit plans.[59]

In ERISA Congress responded to these dangers[60] by imposing fiduciary standards derived from private trust law[61] for the administration of all employee benefit plans. ERISA's rule of mandatory trusteeship requires that

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[58] Massachusetts v. Morash, 490 U.S. 107, 115 (1989).

[59] See Michael S. Gordon, Overview: Why Was ERISA Enacted?, *in* U.S. SEN. SPECIAL COMM. ON AGING, 98TH CONG., THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: THE FIRST DECADE 6, at 10–11 (1984); *see* also Langbein, *Trail*, *supra* note 22, at 1324 (discussing congressional investigations conducted in the 1950s and 1960s).

[60] 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 Essay are addressed to administrative (agency) risk, that is, to 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. The response in ERISA has been to impose actuarially based (but still not actuarially sound) funding requirements; and to establish a program of plan termination insurance administered by a government agency, the Pension Benefit Guarantee Corporation. *See* RICHARD A. IPPOLITO, THE ECONOMICS OF PENSION INSURANCE (1989); JAMES A. WOOTEN, THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974: A POLITICAL HISTORY 67–79, 94, 160–61 (2005).

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 4, at 133–67.

[61] *See* Bruch, 489 U.S. at 115; *supra* text accompanying notes 6–7.

"all assets of an employee benefit plan shall be held in trust . . . ."[62] Moreover, ERISA treats all persons who administer a plan, in the sense of exercising material discretion over plan affairs, as ERISA fiduciaries.[63] 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;[64] 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 . . . ."[65] ERISA's fiduciary law of plan administration governs claims administration[66] as well as the administration of plan assets.

Although "ERISA abounds with the language and terminology of trust law,"[67] ERISA fiduciary law differs markedly from conventional trust law in one crucial respect. 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, although the trust terms can make contrary provision.[68] 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).[69]

ERISA expressly authorizes the employer to use "an officer, employee, agent or other representative" as a fiduciary,[70] thereby inviting the conflicts

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[62] ERISA § 403(a), 29 U.S.C. § 1103 (2000). A proviso to the quoted language excuses a few types of plans that are regulated in other ways, such as those funded with insurance policies.

[63] *See* ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A) (2000). 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 4, at 515–27.

[64] *See* ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B) (2000).

[65] ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A)(i) (2000). 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 128 (Dan M. McGill ed., 1989); Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105 (1988). ERISA fiduciary law also contains a set of prohibited transaction rules, further proscribing self-dealing and kickbacks. *See* ERISA §§ 406–408, 29 U.S.C. §§ 1106–1108 (2000).

[66] Granting or denying claimed plan benefits entails the exercise of "discretionary authority" within the meaning of ERISA § 3(21)(A). *See* 29 U.S.C. § 1002(21)(A) (2000).

[67] *Bruch*, 489 U.S. at 110.

[68] *See* RESTATEMENT (SECOND) OF TRUSTS § 170(1) cmt. t (1959) (trust terms may authorize trustee self-dealing).

[69] 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) (2000). The plan sponsor, virtually always the employer, selects these persons. *See* ERISA § 402(a)(2), 29 U.S.C. § 1102(a)(2) (2000). The statute also requires that plan assets be held in trust by trustees selected under the plan or by a named fiduciary. *See* ERISA § 403, 29 U.S.C. § 1103 (2000).

[70] ERISA § 408(c)(3), 29 U.S.C. § 1108(c)(3) (2000). This provision expressly negatives liability under the prohibited transaction rule of ERISA § 406, 29 U.S.C. § 1106. See also ERISA §§ 3(16),

of interest that so trouble the law of benefit denials. This concession to employer interests, which departs notably from the trust tradition,[71] was motivated by the concern that without it employers would be less likely to sponsor benefit plans. Because pension and welfare benefit plans entail major expenditures,[72] the sponsor commonly prefers to have 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 [the employer's] pocket."[73] 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."[74] The reasoning in these opinions is deeply flawed.

1. Contrasting Gross Revenue.—Several of the Seventh Circuit cases belittle the danger of conflicts of interest by contrasting the gross revenue of the employer or the 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 out $240,000."[75] This reasoning improperly places wrongdoing beyond re-

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402(a), 29 U.S.C. §§ 1002(16), 1102(a) (2000), which make the employer the default plan administrator, and § 402(a)(1), 29 U.S.C. § 1102(a)(1) (2000), which makes plan administration a fiduciary function.

[71] For example, Bogert's formulation states that: "It is not possible for any person to act fairly in the same transaction on behalf of [him]self 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 still take actions to the disadvantage of employee beneficiaries, when they act as employers . . . ." Pegram v. Herdrich, 530 U.S. 211, 225 (2000) (citation omitted).

[72] 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 (2004).

[73] 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); *see supra* text accompanying note 6.

[74] Mers v. Marriott Int'l Group Accidental Death & Dismemb. Plan, 144 F.3d 1014, 1020 (7th Cir. 1998).

[75] Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995); *accord* Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. 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 (denying claimed $200,000 benefit as

proach so long as the benefit denied pales in comparison with the wrongdoer's gross revenue. Since virtually all plan benefit claims are "trivial"[76] 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."[77] 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.[78] To paraphrase Senator Dirksen (whose name adorns the Seventh Circuit's courthouse), $240,000 here, $240,000 there, pretty soon it's real money.[79]

2. Reputation.—Another tack in the Seventh Circuit cases has been the claim that reputational incentives 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."[80]

Reputational incentives may indeed constrain conflicted plan decisionmakers from abuse of authority,[81] but competing considerations weaken that incentive. The danger of unfair treatment in a matter as 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, if he or she has a choice of employers, undertakes to investigate the relative integrity of the benefit claims processes of those employers or their insurers. Because individual benefit denials are not publicized, and because many are quite justified on the merits, an underlying pattern of bias may be hard for the isolated employee to discern.[82]

"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).

[76] *Perlman*, 195 F.3d at 981.

[77] Shyman v. Unum Life Ins. Co., 427 F.3d 452, 455 (7th Cir. 2005).

[78] *See* About Us—UnumProvident, *supra* note 11.

[79] 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* Dirksen Congressional Center, A Billion Here, A Billion There . . . , http://www.dirksencenter.org/print_emd_billionhere.htm (last visited Feb. 26, 2006).

[80] *Perlman*, 195 F.3d at 981; *accord Mers*, 144 F.3d at 1021 ("[E]mployers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits.").

[81] I have emphasized this point elsewhere. *See* Langbein, *Trusts*, *supra* note 43, at 216; *accord* Fischel & Langbein, *supra* note 65, at 1132.

[82] *See* Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 388 (3d Cir. 2000).

Moreover, the greater the prospective gain from denying a benefit claim, the greater the inclination to subordinate the risk of reputational injury. For example, as Judge Posner remarked in a pension case in which $125 million turned on the plan fiduciaries' decision about what compensation was covered under a benefit accrual formula, "a loss of reputation might be a price worth paying to avoid $125 million in unanticipated expense."[83] Daniel Fischel and I have elsewhere pointed to the weakness of reputational incentives 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."[84] Considerations of this sort suggest that labor markets lack the capital markets' efficiency in disseminating reputational information.

In a prominent case decided in 1987, *Van Boxel v. Journal Co. Employees' Pension Trust*,[85] Judge Posner commented on the inadequacy of reputational incentives to prevent 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."[86]

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.*,[87] 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."[88] 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."[89]

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

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[83] Gallo v. Amoco Corp., 102 F.3d 918, 921 (7th Cir. 1996).

[84] Fischel & Langbein, *supra* note 65, at 1132.

[85] 836 F.2d 1048 (7th Cir. 1987).

[86] *Id.* at 1052.

[87] 438 F.3d 772 (7th Cir. 2006).

[88] *Id.* at 775.

[89] *Id.*

tion) 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 . . . ."[90] Judge Posner is, therefore, confusing a contract counterparty, who is allowed to act selfishly, with an ERISA fiduciary, who is forbidden to.[91]

Although Judge Posner recognizes that "ERISA is a paternalistic statute in a number of respects, notably in its vesting rules,"[92] 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,[93] and "full and fair" internal review of benefit denials,[94] we can be certain that Congress preferred these protective principles of ERISA fiduciary law over Judge Posner's concern about not making further "inroads into freedom of contract."[95] 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 . . . ."[96]

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, decided before the Unum/Provident scandal became public, he pointed out that large group insurance policies are "retrospectively-rated," meaning "that the employer agrees to reimburse the insurer" for benefit payments and expenses.[97] 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

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[90] ERISA § 404(a)(1)(A), 29 U.S.C. § 1104 (2000).

[91] Indeed, 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 Am. Chocolate Chip Cookie Co. v. River Valley Cookies, Ltd., 970 F.2d 273, 280 (7th Cir. 1992).

[92] *Rud*, 438 F.3d at 776.

[93] ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B) (2000).

[94] ERISA § 503(2), 29 U.S.C. § 1133(2) (2000). I explain below that ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) (2000), makes these provisions mandatory law, and hence not subject to alteration by plan terms. *See infra* text accompanying notes 138–52.

[95] *Rud*, 438 F.3d at 777.

[96] Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1052 (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 Insurers*, CHI. DAILY L. BULL., May 16, 2006, at 5.

[97] Perlman v. Swiss Bank Comprehensive Disability Prot. Plan, 195 F.3d 975, 981 (7th Cir. 1999).