Post-Firestone Skirmishes: "Obama Care", Discretionary Clauses and Judicial Review of ERISA Plan Administrator Decisions

Maria Hylton, Boston University

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Post-*Firestone* Skirmishes: “Obama Care”, Discretionary Clauses and Judicial Review of

ERISA Plan Administrator Decisions

María O’Brien Hylton*

- Professor of Law, Boston University School of Law. Thanks to Colleen Medill for helpful comments and to Mia Midenjak, Chris Ferns, and Erica Cadez for research assistance.
I. Introduction

Ever since the Supreme Court’s decision in *Firestone Tire & Rubber Co. v. Bruch*[^1^], ERISA plan administrators have largely been insulated from *de novo* review in denial of benefits cases. This is because *Firestone*, while acknowledging that Congress did not specify a standard of review in civil actions to recover benefits, concluded that “a denial of benefits … is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”[^2^] The now-standard language in most health and disability plans that grants broad discretion to the plan administrator is commonly known as a discretionary clause and ensures that a reviewing court will use the highly deferential “arbitrary and capricious” standard in evaluating a denial of benefits.[^3^] While *de novo* review is still technically available—for example, in cases where the plan drafters failed to include a discretionary clause[^4^]—as a practical matter, plaintiffs in benefits denial cases are at a huge disadvantage.[^5^] Since

[^2^]: 489 U.S. at 115. Italics added.
[^3^]: “After *Firestone*, insurers commonly inserted discretionary clauses into ERISA-regulated policies. These clauses limit a federal court’s review of an insurer’s decision to deny benefits in ERISA cases. That is, under ERISA, if an insurer is granted discretion to determine a person’s eligibility for benefits, a court may only overturn that decision if the decision is arbitrary and capricious.” D. Andrew Portinga, “OFIS Bans Discretionary Clauses in Insurance Policies,” 1 J. Ins. & Indem. L. 11 (2008).
[^4^]: See Besser v. Prudential Ins. Co. of Am., No. 07-00437, 2008 U.S. Dist. LEXIS 116869, at *2 (D. Haw. Sept. 30, 2008) (applying *de novo* review because the insurer failed to demonstrate that the ERISA plan documents unambiguously gave the insurer discretion to interpret the insurance policy); McCoy v. Fed. Ins. Co., 7 F. Supp. 2d 1134, 1141 (E.D. Wash. 1998) (applying *de novo* review because the plan did not clearly give the administrator discretion to determine benefit eligibility and interpret the plan terms); Davidson v. St. Francis Reg’l Med. Ctr. Employee Group Health Plan, 715 F. Supp. 1038, 1039 (D. Kan. 1989) (applying *de novo* review because the plan gave the administrator no discretion to determine benefit eligibility and construe the plan terms); see also Hug v. Union Cent. Life Ins. Co., No. 98-5047 (DRD), 2006 U.S. Dist. LEXIS 19942, at *21 (D.N.J. Apr. 10, 2006) (applying *de novo* review to a benefit denial because a “vague and ambiguous” reference in the plan to the claim approval process could not be construed as a grant of discretionary authority); Sorel v. CIGNA, No. 94-089-JD, 1995 U.S. Dist. LEXIS 8886, at *6 (D.N.H. June 15, 1995) (refusing to apply arbitrary and capricious review to the denial of benefits because the plan’s discretionary clause limited the administrator’s authority to determining only when benefits start and not when benefits terminate).
[^5^]: The AARP’s Mary Ellen Signorille, a well-respected ERISA litigator notes: “For some participants this [the existence of a discretionary clause] literally could be the difference between life and death in the health context or economic devastation in the disability and pension context.” “States Beef Up Bans on ‘Discretionary Clauses’ as
Firestone, many judges and other commentators have bemoaned the enormous difficulty faced by plaintiffs who seem to have a strong claim to promised benefits, only to find themselves unable to meet the very high bar required for a finding of arbitrary and capricious behavior.\(^6\)

In the years following Firestone plans in all 50 states quickly inserted discretionary clauses into governing plan documents and many state insurance commissioners followed by attempting to limit or ban the use of these clauses.\(^7\) And, as with so many other contested areas of ERISA, these state efforts to inject a degree of procedural fairness into the benefits denial review process have been met with preemption challenges.\(^8\) In this respect, ongoing litigation

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\(^6\) See John Langbein, “Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA,” 101 Nw. U. L. Rev. 1315, 1324 (2007) (arguing that the deferential standard of review made it easier to deny benefits in bad faith because courts must sustain a benefit denial unless the victim can produce evidence that the plan’s decision was unreasonable); Brigham v. Sun Life of Can., 317 F.3d 72, 85 (1st Cir. 2003) (holding that Sun Life’s denial of long-term disability benefits to a paraplegic plaintiff suffering from muscle strain, pain, and limited bodily function was not arbitrary and capricious because Sun-Life made a reasonable determination and acknowledging the difficulty faced by the plaintiff in attempting to prove he was totally disabled).

\(^7\) At present, 22 states have or are in the process of limiting or banning outright the use of discretionary clauses.

\(^8\) ERISA § 514(a) preempts all state laws that relate to an ERISA-governed employee benefit plan. 29 U.S.C. § 1141(a) (2010). Section 514(b)(2)(A), known as the savings clause, exempts state laws regulating insurance, banking, or securities from ERISA’s preemption. 29 U.S.C. § 1144(b)(2)(A) (2010). However, § 514(b)(2)(B), known as the deemer clause, provides that no employee benefit plan shall be deemed to be an insurance company within the meaning of the savings clause for the purpose of avoiding ERISA preemption. 29 U.S.C. § 1144(b)(2)(B) (2010). See Hancock v. Metro. Life Ins. Co., 590 F.3d 1141, 1146 (10th Cir. 2009) (“The question is whether the [discretionary] clause is valid. Ms. Hancock contends that it is invalid because it fails to comply with Utah's insurance Rule 590-218; therefore, she reasons, MetLife lacks discretionary authority and its decision must be reviewed de novo. MetLife counters, however, that ERISA expressly preempts the application of the rule in this case.”); Standard Ins. Co. v. Morrison, 584 F.3d 837, 841 (9th Cir. 2009), cert. denied, 78 U.S.L.W. 3667 (U.S. May 17, 2010) (No. 09-885) (“Standard Insurance Company ("Standard") duly applied to [Montana’s insurance commissioner] Morrison for approval of its proposed disability insurance forms which contained discretionary clauses; Morrison denied the request. Standard responded by suing in district court, arguing that the subject is preempted by ERISA. The district court granted the Commissioner summary judgment, and Standard timely appeals.”); Am. Council of Life Insurers v. Ross, 558 F.3d 600, 603 (6th Cir. 2009) (“Following discovery, both parties moved for summary judgment, with the Insurance Industry arguing, inter alia, that (1) the rules are preempted by ERISA because they interfere with that statute’s objectives, and (2) the rules do not fall within the ambit of ERISA’s savings clause, 29 U.S.C. § 1144(b)(2)(A). The district court rejected each of these arguments, granting summary judgment in favor of the Commissioner. We review the district court’s grant of summary judgment on the issue of ERISA preemption de novo.”).
about the ability of state insurance authorities to ban discretionary clauses is similar to other
ERISA battles: the state attempts to regulate under the guise of the savings clause and in a way
that it believes will rectify ERISA’s bias in favor of plan autonomy and the plan community
and insurers respond with a preemption challenge. Readers familiar with any of the many
ttempts by state authorities to regulate ERISA employee benefits in other contexts will
recognize a familiar pattern.9

In March of 2010 President Obama signed into law the Patient Protection and Affordable
Care Act (“PPACA”).10 This statute, sometimes referred to colloquially as “Obama Care”,
together with the Health Care and Education Reconciliation Act which the President signed

9 See Aetna Health v. Davila, 542 U.S. 200, 204 (2004) (holding that ERISA preempted a Texas state law which
allowed claimants to recover damages when an HMO failed to exercise ordinary care in making health care
treatment decisions); Dist. of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 126 (1992) (holding that
ERISA preempted a section of a D.C. law which required an employer who provides health coverage to an
employee to provide the same level of health coverage to an injured employee who is eligible for worker’s
compensation benefits); FMC Corp. v. Holliday, 498 U.S. 52, 64-65 (1990) (holding that ERISA preempted a
Pennsylvania antisubrogation law from applying to self-funded ERISA plans); Shaw v. Delta Air Lines, 463 U.S.
85, 108 (1983) (holding that ERISA preempted New York’s Human Rights Law to the extent that the law
prohibited employment practices that were then lawful under federal law, such as discrimination on the basis of
that ERISA preempted a New Jersey state law which prohibited offsets of pension benefits by the amount of
workers’ compensation awards); Hancock v. Metro. Life Ins. Co., 590 F.3d 1141, 1151-52 (10th Cir. 2010)
(holding that ERISA preempted a Utah state rule which governed discretionary clauses in ERISA-governed
employee benefit plans); Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007) (holding that
ERISA preempted Maryland’s Fair Share Health Care Fund Act which required employers with 10,000 or more
employees to spend at least 8% of their payroll on employees’ health insurance or pay the amount of their
shortfall to the State of Maryland); Minn. Chapter of Associated Builders & Contractors. v. Minn. Dep’t of Pub.
Safety, 267 F.3d 807, (8th Cir. 2001) (holding that ERISA preempted parts of the Minnesota Sprinkler Fitter
Licensing Law and rules which mandated the standards for an approved apprenticeship training program because
they had a sufficient connection to ERISA-governed plans); Am. Med. Sec. v. Bartlett, 111 F.3d 358, 360 (4th
Cir. 1997) (holding that ERISA preempted a Maryland insurance regulation which required self-funded ERISA
plans to provide state-mandated health benefits when they purchase certain types of stop-loss insurance);
Plumbing Indus. Bd. v. E.W. Howell Co., 126 F.3d 61, 69 (2d Cir. 1997) (holding that ERISA preempted a New
York lien law which required a general contractor to assume responsibility for a sub-contractor-employer’s failure
to cover his benefit obligations and thus impermissibly added to the exclusive list of parties responsible for an
employer’s benefit obligations under ERISA); Air Transp. Ass’n of Am. V. City & County of San Francisco, 992
F. Supp. 1149, 1155 (N.D. Cal. 1998) (holding that ERISA preempted a San Francisco city ordinance which
prohibited the city from contracting with companies whose employee benefit plans discriminated between
employees with spouses and employees with domestic partners); Fixx v. United Mine Workers, 645 F. Supp. 352,
355 (S.D. W. Va. 1986) (holding that ERISA preempted a section of a West Virginia law which prohibited
employers who provided any type of medical insurance from reducing or canceling such benefits while an
employee was on temporary total disability).
into law one week later amended certain provisions of part A of title XXVII of the Public Health Service Act that relate to group health plans and health insurance issuers of group and individual coverage. The Departments of the Treasury, Labor and Health and Human Services issued interim final regulations in May, June and July of 2010 which effectively implement new requirements for group health plans and health insurers in the group and individual markets. The PPACA also added section 715(a)(1) to ERISA and section 9815(a)(1) to the Internal Revenue Code (the “IRC”) in order to incorporate part A of title XXVII of the Public Health Service Act into ERISA and the IRC. The addition of these sections was intended to make the statutes applicable to group health plans and health insurance providers who provide coverage relate to group health plans; however, section 1251 of the PPACA provides that certain plans or health insurance coverage existing as of the statute’s date of enactment in March 2010—these are known as grandfathered plans—are subject to only some of the PPACA’s provisions. As we shall see, a plan can take affirmative steps which will cause it to lose its grandfathered status or fail to act which will also trigger a loss of status. Most important, all plans are now subject to new, complex external review

13 Id; Interim Final Rules on Coverage of Preventive Services Under the PPACA, 75 Fed. Reg. 41,727 (July 19, 2010); Interim Final rules on Preexisting Condition Exclusions, Lifetime and Annual Limits, rescissions and Patient Protections Under the PPACA, 75 Fed. Reg. 37,188 (June 28, 2010); Interim Final Rules on Grandfathered Health Plan Status Under the PPACA, 75 Fed. Reg. 34,538 (June 17, 2010); Interim Final Rules on Dependent Coverage of Children to Age 26 Under the PPACA, 75 Fed. Reg. 27,122 (May 13, 2010).
14 Interim Final Rules on Grandfathered Health Plan Status Under the PPACA, 75 Fed. Reg. 34,539 (June 17, 2010).
15 Id. At 34,539; Patient Protection and Affordable Care Act of 2010 section 1251.
16 Grandfathered health plan coverage applies to coverage provided by group health plans or health insurance issuers in which an individual was enrolled as of the PPACA’s enactment on March 23, 2010. The regulations provide that a plan cannot lose grandfathered status as long as it has covered someone continuously since March 23, 2010, even if all the other individuals who were enrolled in the plan on that date cease to be covered. However, if an employer or employee organization has a collectively bargained plan and enters into a new policy after March 23, 2010, then the new policy is not a grandfathered health plan with regard to the individuals who participle in the group health plan.
requirements that depend on whether they are insured, self insured and/or grandfathered.\textsuperscript{17}

The prototype benefits claim litigation involves an employee/participant in an ERISA regulated welfare plan who seeks payment for a medical condition (which may or may not be disabling). The plan administrator, operating subject to plan terms that grant broad discretion, determines that the participant’s claim is not payable under the terms of the plan and denies the claim. This denial triggers a flurry of specialists’ reports, independent physician evaluations and other documents which the plan administrator considers during the ERISA mandated\textsuperscript{18} internal review process. Should the internal review result in a second denial, as of March 2010, the participant can now request an independent external review subject to the applicable state insurance rule\textsuperscript{19} and the governing plan’s status. If no appropriate state process is

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The regulations prescribe detailed rules on how to maintain grandfathered status. Health plans are required to disclose their grandfathered status to plan participants and beneficiaries in a written statement or risk losing such status. Additionally, health plans must retain records which state the plan terms and any other documents that are necessary to verify their status as grandfathered plans. Failure to comply with the recordkeeping requirements outlined in the interim final regulations causes plans to lose their grandfathered status. Next, a plan ceases to be a grandfathered health plan if the purpose of a merger or acquisition is to cover new individuals under the plan. Furthermore, a plan loses its grandfathered status if employees are transferred into the plan or health insurance from a plan that they were covered under on March 23, 2010; if the transferee plan were treated as an amendment of the transferor plan; and if there was no “bona fide employment-based reason” to transfer the employees into the transferee plan.

Collectively bargained plans are also subject to the requirements outlined in the interim final regulations regarding the maintenance of grandfather status. Such plans remain grandfathered at least until the date when the last collective bargaining agreement, which was in effect on March 23, 2010, terminates. Moreover, group plans or health insurance coverage cease to be grandfathered if they eliminate all or substantially all benefits which are required to diagnose or treat a condition; if there is an increase in percentage cost-sharing requirements, such as coinsurance; if there is an increase in fixed-amount cost-sharing requirements other than a co-payment, such as a deductible, which exceeds the maximum percentage increases as defined in the regulations; and finally, if there is an increase in the fixed-amount co-payment which is equal to $5 increased by medical inflation or exceeds the maximum percentage increase. A grandfathered plan also loses its status if the employer or employee organization decreases its contribution rate by more than 5 percentage points below the contribution rate for the period that covered March 23, 2010, whether the reduction is based on cost of coverage or a formula employed by the plan. Patient Protection and Affordable Care Act of 2010 § 1251 at 34,562-64.
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\textsuperscript{17} Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the PPACA, 75 Fed. Reg. 43,356 (July 23, 2010).
\textsuperscript{18} See, e.g., the detailed description of the pre-litigation record in Holmstrom v. Met. Life Ins. Co., 2010 U.S. App. Lexis 16123, at *1 (7\textsuperscript{th} Cir. 2010).
\textsuperscript{19} See discussion of Rush v. Moran infra at .
available the participant may resort to the federal external review process.

Prior to the PPACA a claimant whose plan was self insured typically had no choice but to pursue a claim in federal court to recover the disputed benefit under ERISA section 502(a)(1)(B). Some insured plans were subject to Rush type external review requirements depending upon applicable state insurance regulations. Participants in insured plans could, of course, sue to recover promised benefits as well.

This article examines the development of discretionary clauses and contrasts the Supreme Court’s consistent support for these clauses with the (thus far) unanimous support by the Courts of Appeal for the position that states can limit or ban such clauses without running afoul of ERISA’s broad preemption language. It also considers the PPACA’s requirement of universal independent external review and suggests that, at least in the short run, the contested terrain of discretionary clauses will not change much.

Although there is at present no conflict among the circuits (which would normally increase the likelihood that the Supreme Court would take up a discretionary clause/preemption case)20 it seems likely that the high court will soon have occasion to consider whether ERISA preempts efforts to regulate discretionary clauses; in addition, the PPACA’s new rules creating a right to external review which depends on the kind of plan a participant has, are certain to complicate matters both for plans and for claimants. Should the Court continue to favor the use of discretionary clauses, the states will once again find themselves in the familiar position of

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trying to employ devices to regulate ERISA insurance plans that are immune from attack on preemption grounds, yet consistent with the requirements of the PPACA.

This paper argues that an independent external review process which would either correct and/or avoid altogether the kinds of defects that Firestone deference has engendered would be superior to the current regime that promises a high degree of deference to plan administrators at the expense—sometimes—of fairness for claimants. It remains to be seen, however, whether the kind of external review that the new PPACA interim final regulations mandate will provide both the operational simplicity that plans need and the substantive fairness that claimants hope for.

II. The ERISA Framework and Judicial Review Since Firestone

A. ERISA and benefits claim litigation

Under § 3(1), ERISA regulates welfare benefit plans that provide “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death, or unemployment” through the purchase of insurance. Congress enacted ERISA to protect the “interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts.” ERISA § 502(a)(1)(B) allows plan participants and beneficiaries to bring a civil action in federal court to recover their benefits, enforce their rights, or clarify their rights to future benefits under the terms of the plan. Congress ensured that employee benefit

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regulation would be “exclusively a federal concern” by enacting “expansive pre-emption provisions” under ERISA § 514.\textsuperscript{24} Section 514(a) states that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”\textsuperscript{25} However, Congress retained an exception to § 514(a) by providing in § 514(b)(2)(A) that “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”\textsuperscript{26} Section 514(b)(2)(A), commonly known as the savings clause,\textsuperscript{27} protects state laws regulating insurance, banking, or securities from ERISA’s pre-emption scheme. Congress qualified this statutory exception in § 514(b)(2)(B), also known as the deemer clause, stating that “Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies.”\textsuperscript{28} Specifically, § 514(b)(2)(B) preempts state insurance laws from regulating self-funded ERISA plans on the ground that such plans are not insured and may not be deemed to be insurance companies within the meaning of the savings clause.\textsuperscript{29} Therefore, the deemer clause limits the reach of the savings clause and fortifies ERISA’s preemption provisions.

Although ERISA establishes a broad pre-emption scheme under § 514 and sets out civil enforcement provisions in § 502, the statute does not specify what standard of review applies to benefit determinations by plan fiduciaries under § 502(a)(1)(B). ERISA merely states in § 503(2) that an employee benefit plan shall provide a full and fair review by the appropriate

\textsuperscript{25} 29 U.S.C. § 1144(a) (2010).
It is not surprising that plan drafters have taken advantage of ERISA’s ambiguity regarding what standard of review applies to benefit denials by inserting discretionary clauses into plan terms that instruct judges to defer to the plan administrator’s decisions. Recent cases have raised the question whether state regulations banning discretionary clauses are a valid exercise of the state power to regulate insurance, and whether courts must apply a deferential standard of review or evaluate benefit denials de novo. The following section summarizes the relevant Supreme Court decisions on discretionary clauses.

**B. The Supreme Court Lays the Groundwork for Discretionary Clauses**

Commentators who have discussed the proliferation of discretionary clauses in ERISA-regulated plans have generally taken the Supreme Court’s 1989 decision in *Firestone Tire & Rubber Co. v. Bruch* as their starting point. John Langbein argued in “Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA” that *Firestone* “all but invited [bad faith benefit denials by allowing plan sponsors] to impose self-serving terms that severely restrict the ability of a reviewing court to correct a wrongful benefit denial.”

In *Firestone*, several former Firestone Tire employees sought severance benefits under

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a termination pay plan after Firestone sold the plants where they worked to Occidental Petroleum Company. Firestone, acting as the plan administrator and fiduciary, denied the employees’ severance benefits because Occidental rehired them for the same positions without reduction in work or pay. Under the terms of the termination pay plan, a reduction in work was a requirement for severance benefit eligibility. As the case turned on an assessment of Firestone’s benefit denial, the Supreme Court sought to clarify the “appropriate standard of judicial review of benefit determinations by fiduciaries or plan administrators under ERISA.”

Looking to principles of trust law, the Supreme Court held that *de novo* is the appropriate standard of review of benefit denials challenged under 29 U.S.C. § 1132(a)(1)(B), “unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” Discretionary clauses require courts to review benefit denials under an abuse of discretion standard. The Court emphasized that *de novo* is the default standard of review “regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest,” such as an insurance company that acts as payor of benefits and evaluator of benefit claims. If, however, a plan grants discretionary authority to an administrator or fiduciary who is operating under a conflict of interest, the courts must weigh that conflict “as a factor in determining whether there is an abuse of discretion.”

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35 *Id.*
36 *Id.*
37 *Id.*
38 *Id.* at 115.
39 *Id.*
40 *Id.*
41 Langbein, supra note 23, at 1326.
42 Bruch, 489 U.S. at 115.
Langbein and others have criticized *Firestone* as making it easier for plan administrators to deny claims because of the availability of deferential review in the courts.\(^{43}\) Mark DeBofsky has also argued that *Bruch* changed the relationship between insurer and insured by permitting insurers to include favorable terms in their insurance policies which deprive benefit claimants of plenary review in the courts.\(^{44}\) DeBofsky concluded that *Firestone* ultimately undermined claimants’ rights under employee benefit plans by making those rights depend on “the degree of discretion lodged in the administrator.”\(^{45}\)

The Supreme Court appeared to shift away from *Firestone* in *Rush Prudential HMO, Inc. v. Moran*. In *Rush*, Moran sought reimbursement for a surgery as “medically necessary” under Illinois’s HMO Act.\(^{46}\) Through her husband, Moran was the beneficiary of an employer-sponsored and ERISA-governed welfare benefit plan.\(^{47}\) The plan contracted with Rush to provide medical services to plan participants and their beneficiaries.\(^{48}\) The plan also granted Rush the “broadest possible discretion” to determine if a medical service is covered under the plan as “medically necessary.”\(^{49}\)

By contrast, the Illinois HMO Act sought to regulate HMOs’ decision making.\(^{50}\) The

\(^{43}\) Langbein, *supra* note 23, at 1324; Beverly Cohen, “Divided Loyalties: How the Metlife v. Glenn Standard Discounts ERISA Fiduciaries’ Conflict of Interest,” 2009 Utah L. Rev. 955, 960 (2009) (arguing that the Supreme Court’s decision in *Firestone* allowed plan fiduciaries to determine claims “in a way that better controlled the costs of their employee benefit plans, as they could construe plan terms to promote cost efficiency and would be subject to reversal by a court only if their interpretations were arbitrary and capricious”); John Langbein, “The Supreme Court Flunks Trusts,” 1990 Sup. Ct. Rev. 207,222 (1990) (criticizing *Firestone* on the grounds that “If the purpose of ERISA fiduciary law is to protect plan participants from abusive management by the plan fiduciary, it seems transparently counterproductive to allow the employer to bootstrap around the safe-guards of the statute by inserting boilerplates in the plans ordering the courts not to pay much attention to the misbehavior of an employer-dominated fiduciary”).


\(^{45}\) *Id.* (quoting Herzberger v. Standard Ins. Co., 205 F.2d 327, 331 (7th Cir. 2000).


\(^{47}\) *Id.*

\(^{48}\) *Id.* at 359.

\(^{49}\) *Id.* at 359-360.

\(^{50}\) *Id.*
Illinois statute required HMOs to provide an independent medical review if a plan participant or beneficiary’s primary care physician and the HMO disagreed on the medical necessity of a procedure. The Act stated that the HMO “shall provide the covered service” if the independent reviewer determines it to be medically necessary. Additionally, the Act stated that “when a plan purchases medical services and insurance from an HMO, benefit denials are subject to [] de novo review.”

Moran’s primary care physician recommended she undergo surgery, but Rush refused to pay for the procedure on the grounds that it was not medically necessary. Rush continued to deny Moran’s claim even after an independent reviewer concluded that the surgery was medically necessary. Moran consequently had the surgery at her own expense and sued Rush in state court under the Illinois HMO Act. Rush removed the case to federal court, arguing that Moran’s claim for benefits was “completely preempted by ERISA’s civil enforcement provisions.” The relevant legal question was whether the Illinois HMO Act contravenes ERISA’s enforcement scheme, as well as Firestone deference, by requiring that an independent physician review the benefit denial de novo.

The Supreme Court held in Rush that the Illinois HMO Act “does not implicate ERISA’s enforcement scheme at all, and is no different from the types of substantive plan regulation of insurance contracts we have in the past permitted to survive preemption.” The Court reasoned that although the Illinois statute precludes deferential review, “this effect of

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51 Id. at 361.
52 Id.
53 Id. at 384.
54 Id. at 360.
55 Id. at 362-363.
56 Id.
57 Id. at 363.
58 Id. at 386.
eliminating an insurer’s autonomy to guarantee terms congenial to its own interests is the stuff of garden variety insurance regulation through the imposition of standard policy terms.”

The Court found that the Illinois statute survives under ERISA’s savings clause because it is “hard to imagine a reservation of state power to regulate insurance that would not be meant to cover restrictions of the insurer’s advantage in this kind of way.”

The Rush Court weakened discretionary clauses by explicitly taking the view that state insurance regulation “is not preempted merely because it conflicts with substantive plan terms.” The Court noted there were clear limits on the enforceability of discretionary clauses since nothing in ERISA permits insurers to “displace any state regulation simply by inserting a contrary term in plan documents. This interpretation would virtually read the saving clause out of ERISA.” The Court emphasized that “the independent reviewer’s de novo examination of the benefit claim mirrors the general or default rule we have ourselves recognized [in Firestone].”

Notably, the Rush Court declined to clarify “the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review.” The Court found instead that Rush did not require an answer to this question. Instead, Rush emphasized, “We have read [ERISA] to require a uniform judicial regime of categories of relief and standards of conduct, not a uniformly lenient regime of reviewing benefit

59 Id. at 387.
60 Id.
61 Id. at 385, n. 16.
62 Id.
63 Id. at 386-387.
64 Rush Prudential, 536 U.S. at 384, n. 15.
65 Id.
determinations.” While the Court noted that discretionary clauses are “simply a matter of plan design or the drafting of an HMO contract” and not required by ERISA, it was silent about the extent of judicial deference when a court reviews a discretionary decision of a conflicted plan administrator.

The Supreme Court finally addressed the conflicted plan administrator in *Metropolitan Life Ins. Co. v. Glenn* in 2008. *Glenn* involved a challenge to an adverse benefit determination where the decision maker acted as both plan administrator and insurer. Respondent Wanda Glenn was employed by Sears and was diagnosed with a heart condition whose symptoms include fatigue and shortness of breath. Glenn also participated in an ERISA-governed long-term disability insurance plan through Sears. Petitioner MetLife served as the plan administrator and insurer. The plan granted MetLife discretion to determine eligibility for benefits and pay valid benefit claims.

Glenn applied for disability benefits in 2000 and MetLife approved the claim for an initial 24-month period because Glenn could not perform her job duties. MetLife also directed Glenn to a law firm that would help her apply for Social Security benefits. In 2002, an administrative law judge found that Glenn’s disability prevented her from performing any

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66 Id. at 385.
67 Id. at 386.
68 The consequence of not clarifying the scope of judicial deference in cases where the administrator is conflicted and enjoys *Firestone* deference, was a lack of subsequent split among the Courts of Appeals. See Post v. Hartford Ins. Co., 501 F.3d 154 (3d Cir. 2007) (applying a sliding scale approach whereby the existence of a conflict of interest mandates a heightened form of arbitrary and capricious review); Rud v. Liberty Life Assurance Co. of Boston, 438 F.3d 772 (7th Cir. 2006) (finding no conflict of interest despite the insurer’s role as plan administrator and payor of benefits, and applying the arbitrary and capricious standard of review);
70 Id. at 2346.
71 Id.
72 Id.
73 Id.
74 Id.
75 Id.
jobs for which she could qualify and which exist in significant numbers in the national economy.\textsuperscript{76} As a result, the Social Security Administration granted Glenn permanent disability benefits retroactive to 2000.\textsuperscript{77} Glenn, however, kept none of the retroactive benefits because three-quarters went to MetLife to offset the more generous plan benefits and the rest went to Glenn’s lawyers.\textsuperscript{78}

In order to receive plan disability benefits beyond the 24-month period, Glenn had to show that her disability prevented her from performing her job and “‘the material duties of any gainful occupation for which’ she was ‘reasonably qualified.’”\textsuperscript{79} MetLife refused to extend Glenn’s disability benefits because it found that she could perform full-time sedentary work.\textsuperscript{80} Glenn subsequently filed a federal lawsuit challenging MetLife’s denial of benefits.\textsuperscript{81} The District Court denied relief and Glenn appealed to the Sixth Circuit Court of Appeals.\textsuperscript{82} The Sixth Circuit applied \textit{Firestone} deference in its review because the plan explicitly granted MetLife discretion to determine eligibility for benefits.\textsuperscript{83} The Court of Appeals also treated MetLife’s conflict of interest as a relevant factor.\textsuperscript{84}

The Sixth Circuit set aside MetLife’s denial of benefits because of the conflict of

\textsuperscript{76} Id.  
\textsuperscript{77} Id. at 2347.  
\textsuperscript{78} Id.  
\textsuperscript{79} Id.  
\textsuperscript{80} Petition for Writ of Certiorari at 31a, Metro. Life Ins. Co. v. Glenn, No. 06-923 (U.S. Jan. 3, 2007) (“MetLife then reevaluated plaintiff’s claim and concluded that benefits were not payable after September 16, 2002. Plaintiff was advised of this decision in a four-page letter dated August 28, 2002. AR 66-69. In this letter, MetLife noted that Dr. Patel previously found that plaintiff was able to work; that plaintiff’s medical records supported the conclusion that plaintiff’s condition was stable and plaintiff was able to perform fulltime sedentary work . . . .”).  
\textsuperscript{81} Glenn, 128 S. Ct. at 2347.  
\textsuperscript{82} Id.  
\textsuperscript{83} Glenn v. MetLife, 461 F.3d 660,666 (6th Cir. 2006), aff’d 554 U.S. 105 (2008) (“In this case, the district court appropriately reviewed the record under the "arbitrary and capricious" standard, because the plan at issue granted the plan administrator discretionary authority to interpret the terms of the plan and to determine benefits. . . . Indeed, the plaintiff conceded that review for arbitrariness was the correct standard of review here”).  
\textsuperscript{84} Glenn, 128 S. Ct. at 2347.
interest and other issues. MetLife sought review before the Supreme Court on the question of whether a plan administrator who evaluates and pays benefit claims operates under conflict of interest. The Solicitor General suggested that the Supreme Court also consider how conflicts of interest are to be taken into account in reviewing discretionary benefit determinations. The Court granted certiorari on both questions.

The case turned on the interpretation of the *Firestone* principle that a fiduciary’s conflict of interest must be weighed as a factor in determining whether there is an abuse of discretion. The first question the Court addressed was whether a plan administrator who evaluates and pays benefit claims operates under the kind of conflict of interest to which the Court referred to in *Firestone*. The Court determined that the plan administrator was indeed conflicted. The Court acknowledged that a conflict of interest clearly exists in the case of an employer who both funds the plan and evaluates benefit claims. Not surprisingly then, the Court held that judges must consider an employer’s conflict of interest in reviewing

85 Glenn v. MetLife, 461 F.3d at 674 (“[W]e conclude that MetLife's decision to deny long-term benefits in this case was not the product of a principled and deliberative reasoning process. MetLife acted under a conflict of interest and also in unacknowledged conflict with the determination of disability by the Social Security Administration. In denying benefits, it offered no explanation for crediting a brief form filled out by Dr. Patel while overlooking his detailed reports. This inappropriately selective consideration of Glenn's medical record was compounded by the fact that the occupational skills analyst and the independent medical consultant were apparently not provided with full information from Dr. Patel on which to base their conclusions. Moreover, there was no adequate basis for the plan administrator's decision not to factor in one of the major considerations in Glenn's pathology, that of the role that stress played in aggravating her condition and, in the language of the MetLife policy, in preventing her return to 'gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earning.' Taken together, these factors reflect a decision by MetLife that can only be described as arbitrary and capricious”).

86 Brief for the United States as Amicus Curiae Supporting Respondent at 1, Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008) (No. 06-923) (“If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination”).

87 Glenn, 128 S. Ct. at 2347.

88 Id. at 2347.

89 Id. at 2348.

90 Id.

91 Id.

92 Id.
discretionary benefit determinations.\textsuperscript{93}

MetLife argued that an employer who funds and administers a plan has implicitly approved the resulting conflict of interest.\textsuperscript{94} The Supreme Court rejected this argument based on principles of trust law.\textsuperscript{95} The \textit{Glenn} Court noted that nothing in trust law requires a judge to forgo careful scrutiny even if the settlor has approved a trustee’s conflict of interest.\textsuperscript{96} In response, MetLife pointed out that the Supreme Court need not follow principles of trust law where trust law conflicts with ERISA’s language, structure, and purpose.\textsuperscript{97} Specifically, MetLife argued that to find a conflict of interest frustrates Congressional efforts to avoid complex review procedures and encourage employers to create benefit plans.\textsuperscript{98} MetLife also claimed that to find a conflict of interest violates 29 U.S.C. § 1108(c)(3) permitting employers

\textsuperscript{93} Id. (“[W]here it is the employer that both funds the plan and evaluates the claims . . . [t]he employer’s fiduciary interest may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary. Thus, the employer has an ‘interest . . . conflicting with that of the beneficiaries,’ the type of conflict that judges must take into account when they review the discretionary acts of a trustee of a common-law trust”).

\textsuperscript{94} Transcript of Oral Argument at 52, Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008) (No. 06-923) (“The dual-role conflict that everybody knows exists . . . was absolutely intended on’’); Initial Brief of Appellant-Petitioner at 23, Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008) (No. 06-923) (“Under traditional trust-law principles, trustees may serve in settings where their decisions could potentially further their own interests, as long as that arrangement is contemplated in the trust documents”).

\textsuperscript{95} Glenn, 128 S. Ct. at 2348.

\textsuperscript{96} Id. at 2349.

\textsuperscript{97} Reply-Brief of Appellant-Petitioner at 3, Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008) (No. 06-923) (“ERISA's text, structure, and purpose establish that entities that both evaluate and pay benefit claims do not, without more, operate under a conflict of interest that must be weighed on judicial review. In an effort to circumvent the clear implications of these interpretive guideposts, respondent and the United States marginalize ERISA's statutory text, invoke irrelevant trust-law principles that post-date ERISA's enactment, and adopt a restrictive view of ERISA's statutory objectives’’).

\textsuperscript{98} Initial Brief of Appellant-Petitioner at 28-29, Metro. Life Ins. Co. v. Glenn, 554 U.S. 105 (2008) (No. 06-923) (“ERISA reflects Congress's ‘desire not to create a system that is so complex that . . . litigation expenses[] unduly discourage employers from offering welfare benefit plans.’ . . . Indeed, ERISA seeks to facilitate cost-effective dispute resolution through internal administrative review rather than litigation. See 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h)(1). Increasing the litigation burdens on ERISA plans will drain their limited financial resources and discourage employers from establishing benefit plans-to the substantial detriment of existing and prospective plan participants and beneficiaries. This Court should not lightly rewrite the deferential standard that the plan settlor envisioned when it delegated discretionary authority to the claim fiduciary, solely on the basis of a potential conflict that was also contemplated by the plan, and thus invite wasteful litigation that can only diminish the assets that are ultimately available to provide and fund benefits’’).
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to administer their own plans.\textsuperscript{99} The Court again rejected MetLife’s arguments and concluded that “taken together, we believe them outweighed by ‘Congress’ desire to offer employees enhanced protection for their benefits.”\textsuperscript{100}

The Court next considered whether a conflict of interest exists where an insurance company acts as the plan administrator and has discretionary authority to evaluate and pay benefit claims.\textsuperscript{101} Once again, the Court found three reasons for a conflict of interest.\textsuperscript{102} First, an employer choosing a plan administrator would prefer typically an insurance company with low rates to one with accurate claims processing;\textsuperscript{103} second, ERISA imposes clear duties of care and loyalty on insurers to act in the best interests of plan participants and beneficiaries;\textsuperscript{104} and third, “a legal rule that treats insurance company administrators and employers alike with respect to the existence of a conflict of interest can nonetheless take account of circumstances” that diminish the conflict.\textsuperscript{105} Noting that insurers have a strong incentive to provide accurate claims processing because the marketplace punishes companies that offer sub par insurance products.\textsuperscript{106} The Court suggested this market pressure might reduce “the significance or severity of the conflict in individual cases.”\textsuperscript{107}

\textsuperscript{99} Glenn, 128 S. Ct. at 2349 (“MetLife adds that to find a conflict here is inconsistent . . . with an ERISA provision specifically allowing employers to administer their own plans, see 29 U.S.C. § 1108(c)(3)”).

\textsuperscript{100} Id.

\textsuperscript{101} Id.

\textsuperscript{102} Id. at 2349-2350.

\textsuperscript{103} Id. at 2350 (The Supreme Court noted that “the employer’s own conflict may extend to its selection of an insurance company to administer its plan. An employer choosing an administrator in effect buys insurance for others and consequently (when compared to the marketplace customer who buys for himself) may be more interested in an insurance company with low rates than in one with accurate claims processing.” The Court correctly observed that a conflict of interest may be no less obvious in the case of an employer who uses a third-party administrator than in the case of a self-insuring employer.)

\textsuperscript{104} Id.

\textsuperscript{105} Id. (The Supreme Court elaborated that a legal rule which requires courts to consider a conflict of interest as a factor in their analysis of a benefit denial also permits them to take account of the full range of facts and circumstances that diminish “the significance or severity of the conflict in individual cases.”)

\textsuperscript{106} Id.

\textsuperscript{107} Id.
The Supreme Court next examined how judges should account for a conflict of interest in reviewing discretionary benefit determinations. The Court reiterated its holding in Firestone that courts must weigh a conflict of interest as a factor in determining whether there is an abuse of discretion. The Court also clarified that the mere presence of a conflict of interest implies no change in the standard of review from deferential to de novo review. Instead, judges must continue to apply a deferential standard where conflicted trustees make discretionary decisions. At the same time, judges must also consider a trustee’s conflict of interest in determining if there has been an abuse of discretion.

The Court refused to overturn Firestone “by adopting a rule that in practice could bring about near universal review by judges de novo--i.e., without deference--of the lion’s share of ERISA plan claims denials.” The Court declined to take such an action without more explicit guidance from Congress. The Court also refused to create special burden-of-proof rules in cases where there is a conflict of interest. Instead, the Court held that conflicts of interest are “but one factor among many that a reviewing judge must take into account.”

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108 Glenn, 128 S. Ct. at 2350.
109 Id. ("[W]e elucidate what this Court set forth in Firestone, namely, that a conflict should ‘be weighed as a ‘factor in determining whether there is an abuse of discretion.’")
110 Id.
111 Id.
112 Id.
113 Id. ("Had Congress intended such a system of review, we believe it would not have left to the courts the development of review standards but would have said more on the subject.”). The PPACA is now, arguably, the expression of explicit Congressional intent or guidance the Court has been waiting for.
114 Id. at 2351; The Supreme Court’s decision in Glenn effectively overturned the Third Circuit’s sliding scale approach requiring courts to apply a heightened arbitrary and capricious standard when plan administrators operate under a conflict of interest. See Goletz v. Prudential Ins. Co. of Am., 2010 U.S. App. LEXIS 11501, at *8 (3d Cir. June 7, 2010) (“We had previously applied a heightened form of arbitrary and capricious review for those cases in which an administrator acts under a conflict of interest, using a "sliding scale" approach to address how much deference should properly be afforded to a conflicted administrator's determination. See Post v. Hartford Ins. Co., 501 F.3d 154, 161 (3d Cir. 2007). However, in the wake of Metropolitan Life Insurance Co. v. Glenn, 554 U.S. 105, 128 S.Ct. 2343, 171 L. Ed. 2d 299 (2008) ("Met Life"), our sliding scale approach is no longer tenable.”)
115 Id.
116 Id.
Finally, the Court acknowledged that in some instances a conflict of interest could prove more important because circumstances suggest a higher likelihood that the conflict affected a benefit decision. In other instances, a conflict of interest could prove less important because the administrator “has taken active steps to reduce bias and promote accuracy,” such as imposing penalties for inaccurate decision-making. The Supreme Court ultimately affirmed the judgment of the Sixth Circuit Court of Appeals.

Following Glenn, the high court once again took up discretionary clauses in Conkright v. Frommert in 2010. In Conkright, respondents left Xerox’s employ in the 1980s, received lump sum distributions of their retirement benefits, and later returned to work at Xerox. To calculate respondents’ current benefits and avoid paying the same benefits twice, the administrator interpreted Xerox’s pension plan to require an approach known as the “phantom account” method. The method calculated the hypothetical growth of respondents’ past distributions if the money had remained in Xerox’s investment funds, and reduced respondents’ current benefits accordingly. The administrator had general authority under the plan to construe the plan terms.

117 Id. (“We believe that Firestone means what the world ‘factor’ implies, namely, that when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one. . . . In such instances, any one factor will act as a tie-breaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor’s inherent or case-specific importance. The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.”)
118 Id.
119 Id. (The Supreme Court’s opinion was accompanied by concurrences from Chief Justice Roberts and Justice Kennedy and a dissenting opinion from Justice Scalia with whom Justice Thomas joined.)
120 Conkright v. Frommert, 130 S. Ct. 1640, 176 L. Ed. 2d 469 (2010).
121 Id. at 473.
122 Id.
123 Id. at 474.
124 Id. at 476.
Respondents challenged the phantom account method in administrative proceedings. After the administrator denied the challenge, respondents sued in federal court under ERISA. The District Court applied a deferential standard of review to the administrator’s interpretation of the plan terms and granted summary judgment for the plan. The Second Circuit Court of Appeals vacated and remanded the District Court’s decision, holding that the “Plan Administrator's interpretation was unreasonable and that respondents had not been adequately notified that the phantom account method would be used to calculate their benefits.”

On remand, the plan administrator proposed a different approach to calculate the present value of past distributions using an interest rate “that was fixed at the time of the distribution.” Unlike the phantom account method, which “calculated the present value of a past distribution based on events that occurred after the distribution was made,” the new approach calculated the “current value of the distribution based on information that was known at the time of the distribution.” The District Court did not apply a deferential standard of review to the new approach and rejected the plan administrator’s interpretation of the plan. Instead, the District Court found that the plan was ambiguous and adopted the respondents’ approach. This approach did not account for the time value of money and reduced

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125 Id. at 474.
126 Id.
127 Id.
128 Id; Frommert v. Conkright, 433 F.3d 254, 265-266 (2d Cir. 2006), rev’d, 176 L. Ed. 2d 469 (2010) (“Since the terms of the phantom account were neither included in the 1989 Restatement nor included in the Plan’s SPDs up through 1994, we disagree that the Plan has always contained the phantom account or that its existence was adequately disclosed. It is clear, under either an arbitrary or capricious standard or as a matter of law, that the Plan administrator’s conclusion that the Plan always included the phantom account is unreasonable.”)
129 Id.
130 Id.
131 Id.
132 Frommert v. Conkright, 472 F. Supp. 2d 452, 456-458 (W.D. N.Y. 2007) (“The Second Circuit held that the Plan's use of a so-called phantom account in determining present benefits violated the Employee Retirement
respondents’ present benefits “only by the nominal amount of their past distributions--thereby
treating a dollar distributed to respondents in the 1980's as equal in value to a dollar distributed

Income Security Act ("ERISA"), 29 U.S.C. § 1101 et seq., in several respects. First, the Plan's formula constituted a "retroactive cut-back" of benefits, 433 F.3d at 268, contrary to § 204(g) of ERISA. In addition, the court found that employees were not given proper notice in the Summary Plan Description ("SPD") of the nature and scope of the phantom account, at least prior to 1998, when the SPD was amended to include the phantom account and describe the offset procedure. Id. at 263, 269, . . . Although the Circuit clearly precluded use of the phantom account in determining how to treat prior distributions, it did little to elucidate what formula should be adopted, except to suggest using an "appropriate pre-amendment calculation" guided by equitable principles in determining the appropriate remedy for affected employees. The problem is that if one removes the phantom account mechanism, there is little else remaining. The Circuit expressly recognized this by noting the "difficulty" confronting the district court "because of the ambiguous manner in which the pre-amendment terms of the Plan described how prior distributions were to be treated." Id. at 268. Describing the procedures to be utilized prior to the 1998 amendments as "ambiguous" is generous. In fact, virtually nothing is set forth in either the Plan or the SPD as to the precise mechanism for taking into account a prior distribution in calculating an employee's present benefits after a rehire. Some testimony at the hearing before me focused on the appropriate economic, financial and actuarial methods for treating prior distributions. But this Court is not charged with writing a sound retirement plan. Rather, I must interpret the Plan as written and consider what a reasonable employee would have understood to be the case concerning the effect of prior distributions. If the employee had no notice of the "phantom account," he also had no notice of some of the other mechanisms suggested by witnesses at the remand hearing before me. What is "best" from a financial or actuarial point of view is not what the Court has been charged with determining. The Court's task, as directed by the Court of Appeals, is simply to determine, based on the language of the Plan and the SPD, what benefits are now due this group of rehired employees. To the extent that there is some ambiguity as to the precise manner by which prior distributions are to be offset from present benefits, it is Xerox, not the employees, who should suffer. See Burke v. Kodak Ret. Income Plan, 336 F.3d 103, 113 (2d Cir. 2003) ("The consequences of an inaccurate SPD must be placed on the employer"). It was defendants' obligation to provide a clear description, in the SPD and in the Plan itself, as to how those prior distributions would be treated. To the extent that the Plan was constituted, at Xerox's doing, to consider all prior years of service, defendants had the burden of elucidating precisely how that would be accomplished. . . . As the Court of Appeals noted, there was no description whatsoever as to the mechanics of this so-called phantom account. 433 F.3d at 258. For that reason, the Second Circuit and other courts rejected the administrator's utilization of such a mechanism in calculating benefits. The SPD provides even less guidance than the Plan in this regard. As the Court of Appeals noted, the only notice in the SPD concerning non-duplication of benefits was the proviso that "the amount you receive may also be reduced if you had previously left the company and received a distribution at that time." Id. at 265 (citing Layaou, 238 F.3d at 210). The Court of Appeals in both Frommert and Layaou determined that this bare-bones notice failed to adequately apprise employees as to the phantom account mechanism. . . . The question, then, is what, in light of these vague provisions in the Plan and SPD, this Court should do to remedy the violation of ERISA. I believe that the best course is to do what I did previously in Layaou involving a similar remand from the Court of Appeals. Layaou v. Xerox Corporation, 330 F.Supp.2d 297 (W.D.N.Y. 2004). In Layaou, I directed the administrator "to recalculate plaintiff's retirement benefit, . . . and to pay plaintiff a lump sum in the amount of the difference between the amount of benefits that plaintiff has received, and the amount of the recalculated benefit, without any consideration of a 'phantom account.'" Id. at 305 (footnote omitted). I added that "[i]t would not be unreasonable . . . for the administrator to subtract out the amount of the prior distribution," in order to avoid giving the plaintiff a windfall, but left it to the Plan administrator to perform the actual calculation of the plaintiff's benefits in the first instance, stating that "[i]f plaintiff believes that the administrator's calculation is erroneous, and the matter cannot be resolved between the parties, he can seek further relief in this Court." Id. at 304. The same process should apply here. This process is straightforward; it adequately prevents employees from receiving a windfall, and I believe it most clearly reflects what a reasonable employee would have anticipated based on the not-very-clear language in the Plan and SPD. Again, if there is some doubt or ambiguity as to this formula, it must be resolved in favor of the employee."
today.” The Second Circuit Court of Appeals affirmed in part, holding that the District Court did not err in refusing to apply a deferential standard of review and did not abuse discretion.

The Supreme Court agreed to consider two questions: first, whether the District Court owed deference to the administrator’s interpretation of the plan on remand, and second, whether the Court of Appeals properly deferred to the District Court on the merits. However, the Supreme Court found it necessary to address only the first question. The Court first considered the Second Circuit’s rule that a court can forfeit deferential review if it previously found that an administrator’s interpretation of plan terms violated ERISA. The Court rejected the Second Circuit’s rule as having no basis in Firestone or in the terms of the plan. Firestone, the Court noted, established a broad standard of deference “without any suggestion that the standard was susceptible to ad hoc exceptions like the one adopted by the Court of Appeals.” Moreover, the Court had recently refused in Glenn to create exceptions

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133 Conkright v. Frommert, 176 L. Ed. 2d at 474.
134 Id.
135 Id.
136 Id. at 475 (“The Court of Appeals erred in holding that the District Court could refuse to defer to the Plan Administrator’s interpretation of the Plan on remand, simply because the Court of Appeals had found a previous related interpretation by the Administrator to be invalid. Because we reverse on that ground, we do not reach the question whether the Court of Appeals also erred in applying a deferential standard of review to the decision of the District Court on the merits”). The Supreme Court never reached the second question on which it granted certiorari—whether the Court of Appeals properly deferred to the District Court—because it determined that the District Court erroneously refused to defer to the plan administrator’s interpretation of the plan on remand. The Supreme Court’s answer to the first question on which it granted certiorari precluded answering the second one.
137 Id.
138 Id. (“It is undisputed that, under Firestone and the terms of the Plan, the Plan Administrator here would normally be entitled to deference when interpreting the Plan. See 328 F. Supp. 2d, at 430-431 (observing that the Plan grants the Plan Administrator "broad discretion in making decisions relative to the Plan"). The Court of Appeals, however, crafted an exception to Firestone deference. Specifically, the Second Circuit held that a court need not apply a deferential standard "where the administrator ha[s] previously construed the same [plan] terms and we found such a construction to have violated ERISA." 535 F.3d at 119. Under that view, the District Court here was entitled to reject a reasonable interpretation of the Plan offered by the Plan Administrator, solely because the Court of Appeals had overturned a previous interpretation by the Administrator. . . . We reject this "one-strike-and-you're-out" approach. Brief for Petitioners 51. As an initial matter, it has no basis in the Court's holding in Firestone . . .”).
139 Id.
to the *Firestone* standard, holding that even a systemic conflict of interest does not strip the plan administrator of deference.140 In light of *Glenn*, the *Conkright* Court declined to say that an administrator’s “single honest mistake” in choosing the method of calculating benefits “would require a different result.”141

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140 Id. at 476 (“*Firestone* set out a broad standard of deference without any suggestion that the standard was susceptible to ad hoc exceptions like the one adopted by the Court of Appeals. . . . Indeed, we refused to create such an exception to *Firestone* deference in *Glenn*, recognizing that ERISA law was already complicated enough without adding "special procedural or evidentiary rules" to the mix. . . . If, as we held in *Glenn*, a systemic conflict of interest does not strip a plan administrator of deference, . . . it is difficult to see why a single honest mistake would require a different result”). The Supreme Court’s conclusion was a response to the Court of Appeals’ reasoning in *Frommert v. Conkright*. The Court of Appeals stated, “Defendants-Appellants argue that the District Court erred in failing to adopt the plan administrator’s proposed approach, or at least consider it under a deferential standard of review. . . . However, the District Court here had no decision to review because the plan administrator never rendered any decision other than the original benefit determinations, all of which were premised on the now-impermissible "phantom account" offset mechanism. See id. ("[W]e may give deferential review only to actual exercises of discretion."). Defendants-Appellants have identified no authority in support of the proposition that a district court must afford deference to the mere opinion of the plan administrator in a case, such as this, where the administrator had previously construed the same terms and we found such a construction to have violated ERISA.” *Frommert v. Conkright*, 535 F.3d 111, 119 (2d Cir. 2008). The Supreme Court interpreted the Court of Appeals’ reasoning in *Frommert v. Conkright* as indicating that the District Court could withhold deference on remand if it previously determined that the plan administrator’s interpretation of the plan violated ERISA. The Supreme Court found that this interpretation conflicted with the Court’s ruling in *Firestone*, where the Court established a deferential standard of review for a plan administrator’s discretionary determinations. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). More importantly, the Supreme Court did not elaborate any exceptions to the deferential standard in *Firestone* of the type that the Court of Appeals found permissible. Id. This construction of *Firestone* formed the basis for the Supreme Court’s rejection of the Second Circuit’s approach.

141 Id. The Court’s majority view in *Conkright v. Frommert*, that a plan administrator’s mistake in interpreting the plan is insufficient to strip the administrator of deferential review in the District Court on remand, faced strong criticism from Justice Breyer, who dissented from the Court’s opinion and was joined by Justices Stevens and Ginsburg. Justice Breyer stated, “[N]othing in the present case suggest[s] that the District Court abused its remedial authority. . . . The Second Circuit stated that the interpretive problem on remand was in essence a remedial problem. See 433 F.3d at 268. It added that the remedial problem was ‘difficult’ and that ‘the district court . . . may wish to employ equitable principles when determining the appropriate calculation and fashioning the appropriate remedy.’ *Ibid.* The Administrator had previously abused his discretionary power. Id., at 265-268. And the District Court found that the Administrator’s primary remedial suggestion on remand -- adjusting respondents’ previous benefits distributions by adding interest -- probably would have violated ERISA’s notice provisions. 472 F. Supp. 2d, at 457. Under these circumstances, the District Court reasonably could have found a need to use its own remedial judgment, rather than rely on the Administrator’s -- which is just what the Second Circuit said. 535 F.3d at 119. . . . In any event, it is far from clear that the Court's legal rule reflects an appropriate analysis of ERISA-based policy. To the contrary, the majority's absolute 'one free honest mistake' rule is impractical, for it requires courts to determine what is 'honest,' encourages appeals on the point, and threatens to delay further proceedings that already take too long. . . . It also ignores what we previously have pointed out -- namely, that abuses of discretion 'arise in too many contexts' and 'concern too many circumstances' for this Court 'to come up with a one-size-fits-all procedural [approach] that is likely to promote fair and accurate' benefits determinations. *Ibid.* And, finally, the majority's approach creates incentives for administrators to take 'one free shot' at employer-favorable plan interpretations and to draft ambiguous retirement plans in the first instance with the expectation that they will have repeated opportunities to interpret (and possibly reinterpret) the ambiguous
The Conkright Court also looked to principles of trust law, but determined that trust law “is unclear on the narrow question before us.” Instead, the Supreme Court found that the guiding principles underlying ERISA resolve the issue in the case. According to the Court, Firestone deference protects important Congressional interests relating to employee benefit plans. Deference preserves the balance in ERISA between ensuring enforcement of plan rights and encouraging plan creation. Additionally, deference “promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation.” Finally, deference protects interests in predictability and uniformity by “helping to avoid a patchwork of different interpretation of a plan, like the one here.” In other words, nothing in Glenn or Conkright suggests that the Court is losing its enthusiasm for Firestone deference.

Justice Breyer dissented in Conkright and was joined by Stevens and Ginsburg.

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terms. I thus fail to see how the majority’s ‘one free honest mistake’ approach furthers ERISA’s core purpose of ‘promot[ing] the interests of employees and their beneficiaries in employee benefit plans.’” Conkright v. Frommert, 176 L. Ed. 2d 469, 488-489 (Breyer, J., dissenting).

142 Id.

143 Id. at 478 (“Here trust law does not resolve the specific issue before us, but the guiding principles we have identified underlying ERISA do. Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place. Lockheed Corp. v. Spink, 517 U.S. 882, 887, 116 S. Ct. 1783, 135 L. Ed. 2d 153 (1996). We have therefore recognized that ERISA represents a ‘careful balancing’ between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.’ Aetna Health Inc. v. Davila, 542 U.S. 200, 215, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004) (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54, 107 S. Ct. 1549, 95 L. Ed. 2d 375 (1987)). Congress sought ‘to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.’ Varity Corp., supra, at 497, 116 S. Ct. 1065, 134 L. Ed. 2d 130. ERISA “induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.” Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379, 122 S. Ct. 2151, 153 L. Ed. 2d 375 (2002).

144 Id.

145 Id.

146 Id.

147 Id. (“Firestone deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions -- a result that ‘would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them’”).

148 Id. at 481 (Breyer, J., dissenting).
Breyer identified “three significant mistakes involved in this case.”

The first concerned the 1989 amendment to Xerox Corporation’s pension plan, which provided that the benefits of returning employees would be offset by an amount attributable to the lump-sum distributions the employees received when they first left Xerox. The 1989 amendments to the plan, however, said nothing about how the plan would calculate the offset amount or that it would use the “phantom account” method. The Court of Appeals found the plan’s omission and continued use of the “phantom account” method to be arbitrary and capricious and determined that the plan administrator’s interpretation of the plan violated ERISA.

Next, he noted that a second error was committed by the District Court when it accepted the plan administrator’s argument that the 1989 amendments to Xerox’s pension plan incorporated the “phantom account” method and rejected the participant-petitioners’ claim that

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149 Id.
150 Id. at 481-483 (“The first mistake is that of Xerox Corporation’s pension plan (Plan) and its administrators (collectively, Plan Administrator), petitioners here. . . . [The case] concerns the way in which the Plan Administrator calculates that adjustment [of employees’ prior lump-sum distributions] so as to reflect the fact that a retiring leaving-and-returning employee has already received a distribution when she initially left Xerox. Before 1989, the Plan Administrator calculated the adjusted amount by taking the benefits distribution previously received (say, $ 100,000) and adjusting it to equal the amount that would have existed in the investment account had no distribution been made. . . . Thus, if an employee had not left Xerox, and if the $ 100,000 had been left in her investment account for, say, 20 years, that amount would likely have increased dramatically -- perhaps doubling, tripling, or quadrupling in amount, depending upon how well the Plan's investments performed. It is this hypothetical sum -- termed the "phantom account," . . . -- that is at issue in this case. Xerox's pre-1989 Plan assumed that a rehired employee had this hypothetical sum on hand at the time of her final retirement from the company, and in effect subtracted the amount from the employee's benefits upon her departure. . . . Depending on how the Plan's investments did over time, the Administrator's use of this "phantom account" could have a substantial impact on a rehired employee's benefits. . . . When the Plan Administrator amended Xerox's Employee Retirement Income Security Act of 1974 (ERISA) Plan in 1989, however, it made what it tells us was an "inadvertent" omission. . . . In a section of the 1989 Plan applicable to the roughly 100 leaving-and-returning employees who are plaintiffs here, the Plan said that it would "offset" the retiring employees' 'accrued benefit' (as ordinarily calculated) 'by the accrued benefit attributable' to the prior lump-sum 'distribution' those employees received when they initially left Xerox”).
151 Id. at 483 (“But the Plan said nothing about how it would calculate this ‘offset.’ In other words, the Plan said nothing about the Administrator's use of the 'phantom account').
152 Id. (“Despite the Plan's failure to include language explaining how the Administrator would take into account an employee's prior distribution, the Plan Administrator continued to employ the "phantom account" methodology. In essence, the Administrator read the 1989 Plan to include the language that had been omitted -- an interpretation that, . . . the Court of Appeals found to be arbitrary and capricious and in violation of ERISA”).
153 Id.
neither the 1989 plan nor the 1989 Summary Plan Description said anything about the “phantom account” method.\textsuperscript{154} Breyer argued that the District Court’s ruling in favor of the plan administrator was the second mistake in the case.\textsuperscript{155} The Second Circuit Court of Appeals subsequently vacated the District Court’s decision on this issue and held that the plan administrator’s interpretation of the 1989 plan as incorporating the “phantom account” method, while in fact the plan said nothing about it, was arbitrary and capricious.\textsuperscript{156} The Court of Appeals instructed the District Court to “employ equitable principles when determining the appropriate [benefit] calculation and fashioning the appropriate remedy.”\textsuperscript{157} On remand, the District Court determined that the appropriate remedy was to subtract out the amount of

\textsuperscript{154} Id. at 483-484 (“The District Court committed the second mistake in this case. In 1999, the respondents, nearly 100 employees who left and were later rehired by Xerox, brought this lawsuit. \textit{Ante}, at 2; Brief for Petitioners ii-iii, 12. They pointed out that the 1989 Plan said that it would decrease their retirement benefits to reflect the fact that they had already received a lump-sum benefits distribution when they initially left Xerox. But, they added, neither the 1989 Plan, nor the 1989 Plan’s Summary Plan Description, said anything about whether (or how) the Administrator would adjust their previous benefits distribution to take into account that they had received the distribution well before their retirement. They thus claimed that the Plan Administrator could not use the "phantom account" methodology to adjust their previous distributions. See Brief for United States as \textit{Amicus Curiae} 4-5. The District Court, however, rejected respondents' claims. 328 F. Supp. 2d 420 (WDNY 2004). The court accepted the Administrator's argument that the 1989 Plan implicitly incorporated the "phantom account" approach that had previously been part of Xerox's retirement plan. Id., at 433-434”).

\textsuperscript{155} Id. at 484 (“[T]he court thus held in favor of petitioners -- thereby committing the second mistake in this case”).

\textsuperscript{156} Id. (“On appeal, the Second Circuit disagreed with the District Court and vacated the District Court's decision in relevant part. 433 F.3d 254 (2006). The Court of Appeals concluded that, because the 1989 Plan said nothing about how the Administrator would adjust the previous benefits distributions, it was "arbitrary and capricious" for the Administrator to interpret the 1989 Plan as if it still incorporated the "phantom account." Id., at 265-266, and n. 11. And the Court of Appeals thus held that the language of the Plan and the Summary Plan Description, at the least, violated ERISA by failing to provide respondents with fair notice that the Administrator was going to use the "phantom account" approach. See id., at 265 (discussing 29 U.S.C. § 1022); see also 433 F.3d at 263, 267-268 (holding that the Administrator's attempt to apply the "phantom account" to respondents violated two other ERISA provisions: 29 U.S.C. § 1054(h)'s notice requirement and § 1054(g)'s prohibition on retroactive benefit cutbacks). Rather, the court noted, respondents "likely believed" -- based on the language of the Plan -- "that their past distributions would only be factored into their [current] benefits calculations by taking into account the amounts they had actually received." 433 F.3d at 267”).

\textsuperscript{157} Id. ("[T]he Court of Appeals recognized the need to devise a remedy for the Administrator's abuse of discretion and ERISA violations -- a remedy that took into account the previous benefits distributions respondents had received in a manner consistent with the 1989 Plan. The court therefore remanded the case to the District Court, with the following instructions: ‘On remand, the remedy crafted by the district court for those employees [in the respondents' situation] should utilize an appropriate [pre-1989 Plan] calculation to determine their benefits. We recognize the difficulty that this task poses . . . . As guidance for the district court, we suggest that it may wish to employ equitable principles when determining the appropriate calculation and fashioning the appropriate remedy." Id., at 268").
participant-petitioners’ lump-sum distributions from their recalculated total benefit. The Court of Appeals affirmed the District Court’s ruling.

Justice Breyer further insisted that the Supreme Court committed the third mistake in Conkright. Citing Firestone, the Court stated that trust law governs the standard of review of in ERISA cases and requires courts to defer to a plan administrator’s discretion to interpret a plan. However, the Court also determined that trust law was unclear on the issue of whether courts must defer to an administrator’s second interpretation of a plan if the first interpretation was arbitrary and capricious. Justice Breyer criticized the Court’s conclusion that trust law requires absolute deference to a plan administrator’s every interpretation of a plan and argued that “trust law imposes no such rigid and inflexible requirement.”

Justice Breyer reasoned instead that “the fact that trust law grants courts discretion does not mean that

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158 Frommert v. Conkright, 472 F. Supp. 2d 452, 458 (W.D.N.Y. 2007) (“I believe that the best course is to do what I did previously in Layaou involving a similar remand from the Court of Appeals. Layaou v. Xerox Corporation, 330 F.Supp.2d 297 (W.D.N.Y. 2004). In Layaou, I directed the administrator "to recalculate plaintiff's retirement benefit, … and to pay plaintiff a lump sum in the amount of the difference between the amount of benefits that plaintiff has received, and the amount of the recalculated benefit, without any consideration of a 'phantom account.'” Id. at 305(footnote omitted). I added that "[i]t would not be unreasonable … for the administrator to subtract out the amount of the prior distribution," in order to avoid giving the plaintiff a windfall, but left it to the Plan administrator to perform the actual calculation of the plaintiff's benefits in the first instance, stating that "[i]f plaintiff believes that the administrator's calculation is erroneous, and the matter cannot be resolved between the parties, he can seek further relief in this Court.” Id. at 304. The same process should apply here. This process is straightforward; it adequately prevents employees from receiving a windfall, and I believe it most clearly reflects what a reasonable employee would have anticipated based on the not-very-clear language in the Plan and SPD”).

159 Conkright v. Frommert, 176 L. Ed. 2d 469, 485 (2010) (“[T]he Court of Appeals, finding that the District Court did not abuse its discretion in crafting a remedy, affirmed”).

160 Id.
161 Id. at 477.
162 Id. at 485 (“As the majority recognizes . . . ‘principles of trust law’ guide this Court in 'determining the appropriate standard' by which to review the actions of an ERISA plan administrator. . . . And, as the majority also recognizes . . . where an ERISA plan grants an administrator the discretionary authority to interpret plan terms, trust law requires a court to defer to the plan administrator's interpretation of plan terms”).
163 Id. (“[T]he majority further concludes that trust law ‘does not resolve the specific issue before’ the Court in this case -- i.e., whether a court is required to defer to an administrator's second attempt at interpreting plan documents, even after the court has already determined that the administrator's first attempt amounted to an abuse of discretion”).
164 Id.
they will exercise that discretion in all instances.”\textsuperscript{165} While trust law grants the courts authority to defer to the trustee’s discretion, it also permits them to craft a separate remedy when a trustee acts unreasonably.\textsuperscript{166} Accordingly, Justice Breyer argued that the District Court acted reasonably by exercising its remedial authority to determine the method of calculating the participant-respondents’ benefits.\textsuperscript{167} The District Court initially found that the plan administrator abused his discretion by using the “phantom account” method to adjust the participant-respondents’ benefits.\textsuperscript{168} On remand, the District Court rejected the plan administrator’s other calculation method because it found that the method would violate ERISA’s notice provisions.\textsuperscript{169} Justice Breyer concluded that the District Court reasonably could have found it necessary to rely on its own remedial authority under the circumstances.\textsuperscript{170}

Unlike the majority in \textit{Conkright}, Justice Breyer would have relied on the principles of trust

\textsuperscript{165} \textit{Id.} at 486 (“Of course, the fact that trust law grants courts discretion does not mean that they will exercise that discretion in all instances. The majority refers to the 2007 edition of Scott on Trusts . . . which says that, if there is ‘no reason’ to doubt that a trustee ‘will . . . fairly exercise’ his ‘discretion,’ then courts ‘ordinarily will not fix the amount’ of a payment ‘but will instead direct the trustee to make reasonable provision for the beneficiary’s support,’ 3 A. Scott, W. Fratcher, & M. Ascher, Scott and Ascher on Trusts § 18.2.1, pp. 1348-1349 (5th ed. 2007) (emphasis added). As this passage demonstrates, there are situations in which a court will typically defer to a trustee’s remedial suggestion. The word “ordinarily” confirms, however, that the Scott treatise writers recognize that there are instances in which courts will not defer. And other treatises indicate that black letter trust law gives the district courts authority to decide which instances are which. See Bogert & Bogert § 560, at 222-223 (when there is an abuse of discretion, a court ‘may set aside the transaction,’ ‘award damages to the beneficiary,’ or ‘order a new decision to be made in the light of rules expounded by the court’); 2 Third Restatement § 50, and Comment b, at 261 (discussing similar remedial options); 1 Second Restatement § 187, and Comment b, at 402 (same); see also 3 Third Restatement § 87, and Comment c, at 244-245 (noting that “judicial intervention on the ground of abuse” is allowed when a “good-faith,” yet “unreasonable,” decision is made by a trustee); \textit{Rubion, supra}, at 54-55, 308 S. W. 2d, at 11 (discussing a court’s remedial options”).

\textsuperscript{166} \textit{Id.} at 488 (“I thus do not find trust law ‘unclear’ on this matter. . . . When a trustee abuses its discretion, trust law grants courts the authority either to defer anew to the trustee’s discretion or to craft a remedy. See, e.g., 3 A. Scott & W. Fratcher, Scott on Trusts § 187, pp. 14-15 (4th ed. 1988) (“This ordinarily means that so long as [the trustee] acts not only in good faith and from proper motives, but also within the bounds of reasonable judgment, the court will not interfere; but the court will interfere when he acts outside the bounds of a reasonable judgment”).

\textsuperscript{167} \textit{Id.} (“Nor does anything in the present case suggest that the District Court abused its remedial authority. The Second Circuit stated that the interpretive problem on remand was in essence a remedial problem. See 433 F.3d at 268. It added that the remedial problem was ‘difficult[t]’ and that ‘the district court . . . may wish to employ equitable principles when determining the appropriate calculation and fashioning the appropriate remedy’”).

\textsuperscript{168} \textit{Id.}

\textsuperscript{169} \textit{Id.}

\textsuperscript{170} \textit{Id.} at 489.
law to answer the question of whether the District Court was required to the defer to the plan administrator’s alternative interpretation of the plan terms.\textsuperscript{171}

Besides disagreeing with the \textit{Conkright} majority on whether trust law provided the appropriate framework for analysis, Justice Breyer also dissented from the Court’s reliance on ERISA-based policies to resolve the issue of whether the District Court was required to defer to the plan administrator’s interpretation on remand.\textsuperscript{172} Justice Breyer noted that the policies which motivated the majority opinion, such as predictability, uniformity, and plan creation, are in fact offset by the Court’s “one free honest mistake rule” which encourages employers to draft ambiguous plans with the continued expectation of judicial deference to their interpretations of the plan terms.\textsuperscript{173} Trust law, Justice Breyer argued, provides a better guiding principle in ERISA cases and also leaves room for the supervising courts to decide “how much

\textsuperscript{171} \textit{Id.}
\textsuperscript{172} \textit{Id.}
\textsuperscript{173} \textit{Id.} at 489-490 (“[I]t is far from clear that the Court’s legal rule reflects an appropriate analysis of ERISA-based policy. To the contrary, the majority’s absolute ‘one free honest mistake’ rule is impractical, for it requires courts to determine what is ‘honest,’ encourages appeals on the point, and threatens to delay further proceedings that already take too long. (Respondents initially filed this retirement benefits case in 1999.) See \textit{Glenn}, supra, at ___.

128 S. Ct. 2343, 2351, 171 L. Ed. 2d 299, 310. It also ignores what we previously have pointed out -- namely, that abuses of discretion ‘arise in too many contexts’ and ‘concern too many circumstances’ for this Court ‘to come up with a one-size-fits-all procedural [approach] that is likely to promote fair and accurate’ benefits determinations. \textit{Ibid.} And, finally, the majority’s approach creates incentives for administrators to take ‘one free shot’ at employer-favorable plan interpretations and to draft ambiguous retirement plans in the first instance with the expectation that they will have repeated opportunities to interpret (and possibly reinterpret) the ambiguous terms. I thus fail to see how the majority’s ‘one free honest mistake’ approach furthers ERISA’s core purpose of ‘promot[ing] the interests of employees and their beneficiaries in employee benefit plans.’ \textit{Shaw v. Delta Air Lines, Inc.}, 463 U.S. 85, 90, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983); see also, \textit{e.g.}, 29 U.S.C. § 1001(b) (noting that ERISA was enacted “to protect . . . employee benefit plans and their beneficiaries”); \textit{Curtiss-Wright Corp. v. Schoonejongen}, 514 U.S. 73, 83, 115 S. Ct. 1223, 131 L. Ed. 2d 94 (1995) (discussing ERISA’s central ‘goal[I]’ of ‘enab[ing] plan beneficiaries to learn their rights and obligations at any time’); \textit{Massachusetts Mut. Life Ins. Co. v. Russell}, 473 U.S. 134, 148, 105 S. Ct. 3085, 87 L. Ed. 2d 96 (1985) (ERISA was enacted ‘to protect contractually defined benefits’). The majority does identify ERISA-related factors -- \textit{e.g.}, promoting predictability and uniformity, encouraging employers to adopt strong plans -- that it believes favor giving more power to plan administrators. See \textit{ante}, at 9-13. But, in my view, these factors are, at the least, offset by the factors discussed above -- \textit{e.g.}, discouraging administrators from writing opaque plans and interpreting them aggressively -- that argue to the contrary”\textsuperscript{17}).
weight to give to a plan administrator’s remedial opinion” on review.\footnote{Id. at 490.}

Finally, Breyer stated that he would have answered the second question on which the Supreme Court granted certiorari—whether the Court of Appeals properly deferred to the District Court on the merits.\footnote{Id.} He reasoned that answering this question would depend on how one characterizes the Court of Appeals’ decision.\footnote{Id.} First, if the Court of Appeals deferred to the District Court’s interpretation of the plan terms in order to determine the appropriate benefit calculation method, then the appropriate standard of review under \textit{Firestone} is \textit{de novo}.\footnote{Id.} If, however, the Court of Appeals deferred to the District Court’s creation of a remedy based on equitable principles, then the correct standard of review is abuse of discretion.\footnote{Id.} The District Court and the Court of Appeals’ opinions contained language that supported either interpretation, although Justice Breyer viewed the Court of Appeals’ decision as directed primarily to the District Court’s creation of a remedy.\footnote{Id. at 491.} As such, Justice Breyer stated, it was appropriate for the Court of Appeals to review the District Court’s decision for abuse of discretion.\footnote{Id. at 491.}

\footnote{Id. (“Since the District Court was not required to defer to the Administrator's fallback position, I should consider the second question presented, namely, whether the Court of Appeals properly reviewed the District Court's decision under an "abuse of discretion" standard. \textit{Ante}, at 4 (acknowledging, but not reaching, this issue). The answer to this question depends upon how one characterizes the Court of Appeals' decision. If the court deferred to the District Court's interpretation of Plan terms, then the Court of Appeals most likely should have reviewed the decision \textit{de novo}. See \textit{Firestone}, supra, at 112, 109 S. Ct. 948, 103 L. Ed. 2d 80; cf. \textit{Davila}, supra, at 210, 124 S. Ct. 2488, 159 L. Ed. 2d 312 ("Any dispute over the precise terms of the plan is resolved by a court under a \textit{de novo} review standard").")}
The plan administrator insisted that the Court of Appeals would have been prohibited from treating the District Court’s remedy as anything other than an application of the plan terms because the participant-respondents sought relief under 29 U.S.C. § 1132(a)(1)(B), which permits plaintiffs only to enforce their rights under the terms of the plan. Breyer rejected this argument on the grounds that seeking relief under § 1132(a)(1)(B) does not restrict a court’s remedial authority or prohibit a court from fashioning relief based on equitable principles. It may be especially appropriate for a court to rely on equitable principles in cases where the plan administrator fails to adequately notify employees of the plan terms. Justice Breyer concluded that he would have affirmed the Court of Appeals’ decision.

Thus, the current rule on discretionary clauses is that plans may give their fiduciaries discretionary authority to evaluate claims and pay benefits. This grant of discretion will trigger deferential review in the event a claimant objects to a denial. In cases of conflict this standard of review is not automatically altered from deferential to de novo. Rather, it is but one factor that courts must consider in determining if there has been an abuse of discretion by the fiduciary. Since Firestone, and in the absence of explicit guidance from Congress, the Supreme Court has consistently upheld the validity of discretionary clauses and of the deferential standard of review in examining benefit decisions, even in cases of conflict. The PPACA unquestionably represents new guidance from Congress in this area although it indirectly addresses the problem of Firestone deference by creating independent external

\[\text{\textsuperscript{181} Id.}\]
\[\text{\textsuperscript{182} Id.}\]
\[\text{\textsuperscript{183} Id.}\]
\[\text{\textsuperscript{184} Id.}\]
review for all plan participants. The new statute does tackle the problem of conflicted decision making directly by insisting on impartial, outside reviewers in benefits denial cases. Whether the post PPACA reviews will in fact be independent and beyond the scope of insurer influence remains to be seen.

III. Implicit Support for De Novo Review

A. An Emerging Consensus in the Circuit Courts of Appeals

Henry Quillen has argued that the Supreme Court’s decision in Rush “catalyzed an organized response to discretionary clauses by state insurance regulators.”\textsuperscript{185} The response in many cases was to ban the clauses for insured (but not for self-insured\textsuperscript{186}) plans. This response to the near-universal use of discretionary clauses has, predictably, led to several challenges in the Courts of Appeals.

In \textit{American Council of Life Insurers v. Ross}, the Sixth Circuit Court of Appeals upheld Michigan’s ban on discretionary clauses in insurance contracts and policies.\textsuperscript{187} The insurance industry argued that the rules are preempted by § 514(a) of ERISA and do not fall “within the ambit of ERISA’s savings clause.”\textsuperscript{188} The Sixth Circuit rejected both arguments and held that Michigan’s rules avoid federal preemption because they are state laws regulating insurance and consequently fall “within the ambit of ERISA’s savings clause.”\textsuperscript{189}

\textsuperscript{185} Quillen, \textit{supra} note 22, at 71.
\textsuperscript{186} \textit{Id.} Unlike an insured ERISA plan, a “self-funded [ERISA] plan does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.” FMC Corp. v. Holliday, 498 U.S. 52, 54 (1990). Consequently, state laws regulating insurance “do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.” \textit{Id.} at 61.
\textsuperscript{187} Am. Council of Life Insurers v. Ross, 558 F.3d 600, 602 (6th Cir. 2009).
\textsuperscript{188} \textit{Id.} at 603.
\textsuperscript{189} \textit{Id.} at 602.
The Sixth Circuit first considered whether Michigan’s rules barring discretionary clauses are, in fact, state laws that regulate insurance within the meaning of ERISA’s savings clause.\(^{190}\) The Sixth Circuit applied the Supreme Court’s test in *Kentucky Ass’n of Health Plans, Inc. v. Miller*\(^{191}\) to determine whether Michigan’s rules regulate insurance under ERISA’s savings clause.\(^{192}\) In *Miller*, the Supreme Court held that state laws must be specifically directed toward the insurance industry and substantially affect the risk-pooling arrangement between insurers and insureds to fall within the savings clause.\(^{193}\) State laws are directed toward the insurance industry if they regulate “*insurers* with respect to their *insurance* practices.”\(^{194}\) The appellate court determined that Michigan’s rules are specifically directed toward the insurance industry because they regulate only the rights of insurers “to engage in the business of insurance in Michigan.”\(^{195}\) In addition, Michigan’s rules substantially affect the risk-pooling arrangement because they change the terms of enforceable contracts and alter “the scope of permissible bargains between insurers and insureds.”\(^{196}\)

\(^{190}\) Id. at 605.


\(^{192}\) Ross, 558 F.3d at 605.

\(^{193}\) Id. (quoting Ky. Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329, 341 (2003) (“In *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329, 123 S. Ct. 1471, 155 L. Ed. 2d 468 (2003) (hereinafter ‘Miller’), the Supreme Court clarified the appropriate test to determine whether a state law regulates insurance under the ERISA savings clause. There, the Court held that, first, ‘the state law must be specifically directed toward entities engaged in insurance,’ and, second, ‘the state law must substantially affect the risk-pooling arrangement between the insurer and the insured[s],’ *Id.* at 341”).

\(^{194}\) Id.

\(^{195}\) Ross, 558 F.3d at 605.

\(^{196}\) Id. at 606-607 (“First, the rules directly control the terms of insurance contracts by prohibiting insurers and insureds from entering into contracts that include discretionary clauses and prohibiting enforcement of such clauses. By changing the terms of enforceable insurance contracts, the Commissioner has ‘alter[ed] the scope of permissible bargains between insurers and insureds.’ *See Ward*, 526 U.S. at 374-75 (explaining that the state notice-prejudice rule changed the bargain between insured and insurer because it effectively created a mandatory contract term that required the insurer to prove prejudice before enforcing a timeliness-of-claim provision); *see also Benefit Recovery Inc. v. Donelon*, 521 F.3d 326, 331 (5th Cir. 2008) (holding that the state insurance commissioner’s directive prohibiting insurers from enforcing subrogation rights until insureds are fully compensated for their injuries alters the permissible bargains between insureds and insurers by telling them what bargains are acceptable). Second, under the rules, insurers can no longer invest the plan administrator with unfettered discretionary authority to determine benefit eligibility or to construe ambiguous terms of a plan. Prohibiting plan administrators from exercising discretionary authority in this manner ‘dictates to the insurance...
The insurance industry then argued that ERISA’s civil enforcement scheme under § 502 preempts Michigan’s rules banning discretionary clauses even if the rules fall under the savings clause. The industry asserted that ERISA preempts state laws that provide a cause of action for plan benefits “outside of, or in addition to, ERISA’s remedial scheme.” The court rejected this argument, finding that Michigan’s rules do not conflict with ERISA’s civil enforcement provisions because the rules “do not authorize any form of relief in state courts” and “at most may affect the standard of judicial review.”

The insurance industry also challenged Michigan’s rules on the ground that they conflict with “ERISA’s policy of ensuring a set of uniform rules for adjudicating cases.” This argument was rejected as well since ERISA could not preempt a state law requiring de novo review as “the de novo standard of
review is already the default standard in ERISA cases” after *Firestone.*

Finally, the Sixth Circuit noted that the Supreme Court’s decision in *Glenn* supported the holding in *Ross* that ERISA does not preempt Michigan’s law. The *Glenn* Court held that a conflict of interest arising from an entity’s dual role as plan administrator and payor of plan benefits is “but one factor among many” that judges must consider in reviewing a discretionary benefit determination. In light of *Glenn’s* holding, the Sixth Circuit found it “difficult to understand why a State should not be allowed to eliminate the potential for such a

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201 Id. (“[C]iting the rules’ proscription of a deferential standard of judicial review, the Insurance Industry argues that the rules are preempted because they squarely conflict with ERISA’s policy of ensuring a set of uniform rules for adjudicating cases under ERISA. The rules, according to the Insurance Industry, have no purpose or effect other than to control ERISA litigation. Here, too, we find their argument unavailing. First, the plain language of ERISA provides nothing about the standard of review in cases brought under the statute’s civil enforcement provisions. See *Rush Prudential*, 536 U.S. at 385 (‘ERISA itself provides nothing about the standard’ of review). It is worth noting that the de novo standard of review is already the default standard in ERISA cases, so it is difficult to imagine how a state law requiring that level of review would conflict with the statute. See *Firestone Tire & Rubber Co.*, 489 U.S. at 115 (holding that ‘a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard regardless of whether the plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan’); see also *Rush Prudential*, 536 U.S. at 355 (‘[A] general or default rule of de novo review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion[,]’); *Calvert v. Firstar Fin., Inc.*, 409 F.3d 286, 291 (6th Cir. 2005) (‘This Court reviews de novo an ERISA plan administrator's denial of benefits where the administrator has no discretion to determine benefits eligibility.’). More importantly, we are guided by the Supreme Court's rejection of a similar argument in *Rush Prudential*. There, the Supreme Court held that a state statute mandating that benefit denials are subject to de novo review did not conflict with ERISA. 536 U.S. at 384. In reaching this decision, the Supreme Court first explained that ERISA does not mandate a particular standard of review for reviewing benefit denials. Id. at 385. The Court then held that ERISA requires only that: (1) the plan grant a 'beneficiary some mechanism for internal review of a benefit denial;' (2) the plan 'provide a right to a subsequent judicial forum for a claim to recover benefits;' and (3) that the standard of judicial review not conflict with anything in the text of ERISA, which the Court read to require 'a uniform judicial regime of categories for relief and standard of primary conduct, not a uniformly lenient regime of reviewing benefit determinations.' Id. ‘Nor is there any conflict in the removal of fiduciary 'discretion':... ERISA does not require that such decisions be discretionary, and insurance regulation is not preempted merely because it conflicts with substantive plan terms.’ *Id.* at n.16 (citing *Ward*, 526 U.S. at 376).

In *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), the Supreme Court reaffirmed these principles, noting that a plan administrator's decision denying plan benefits challenged under ERISA, 29 U.S.C. §1132(a)(1)(B), is reviewed de novo unless the plan provides to the contrary. *See id.* at 2347 (applying trust principles to review of plan administrator's decision following *Firestone*). According to *Glenn*, where the plan provides otherwise by giving the administrator discretionary authority to determine eligibility for benefits, trust principles make a deferential standard of review appropriate. *Id.* Given *Glenn's* positive citations of principles announced in *Firestone* and *Rush Prudential*, and its decision in *Rush Prudential*, we conclude that the rules do not conflict with ERISA’s civil enforcement provisions or its policy favoring a uniform set of rules.”).

202 Id. at 609.

203 Glenn, 128 S. Ct. at 2351.
conflict of interest by prohibiting discretionary clauses in the first place.”

In *Standard Ins. Co. v. Morrison*, the Ninth Circuit Court of Appeals followed the Sixth Circuit’s decision in *Ross* to uphold Michigan’s ban on discretionary clauses. The facts in *Morrison* closely resembled those in *Ross*. Montana law required its insurance commissioner to disapprove any insurance form that contains “inconsistent, ambiguous, or misleading clauses . . . which deceptively affect the risk purported to be assumed in the general coverage of the contract.” Montana’s Commissioner of Insurance, John Morrison, interpreted the statute as requiring him to disapprove any insurance contract that contains a discretionary clause.

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204 Ross, 558 F.3d at 609 (“If, as Glenn reaffirms, there is a conflict of interest when the same plan administrator decides the merits of a benefits plan and pays that claim, and if, as Glenn also holds, it is consistent with ERISA to account for that conflict of interest in reviewing a plan administrator’s decision, it is difficult to understand why a State should not be allowed to eliminate the potential for such a conflict of interest by prohibiting discretionary clauses in the first place. Nor is it necessarily the case, as the Insurance Industry suggests, that, if Michigan can remove discretionary clauses, it will be allowed to dictate the standard of review for all ERISA benefits claims. All that today’s case does is allow a State to remove a potential conflict of interest. And while Michigan’s law may well establish that the courts will give *de novo* review to lawsuits dealing with the meaning of an ERISA plan, it does not follow that they will do so in reviewing the application of a settled term in the plan to a given benefit request”.


206 *Id.* at 840.

207 *Id.* (“Montana requires its commissioner of insurance to ‘disapprove any [insurance] form . . . if the form . . . contains . . . any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract . . . .’ Mont. Code Ann. § 33-1-502. John Morrison, who is commissioner by virtue of being state auditor, has announced that this statute requires him to disapprove any insurance contract containing a so-called ‘discretionary clause.’ He has consistently disapproved such policy forms”); Initial Brief for Appellee-Respondent at 2-4, *Standard Ins. Co. v. Morrison*, No. 08-35246 (6th Cir. Aug. 27, 2008) (“[T]he Commissioner was mandated to disapprove discretionary clauses because they violate Montana law... The Commissioner believes the material undisputed facts are: 1. The Commissioner is the Montana State Auditor, ex officio Commissioner of Insurance. As such, he is responsible for regulating the business of insurance in the State of Montana. Mont. Code Ann. §§ 2-15-1902, -1903, 33-1-311. 2. The Commissioner reviews and approves or disapproves insurance policy forms pursuant to Mont. Code Ann. § 33-1-502, including insured employee benefit plans. 3. The Commissioner has been disapproving any insurance policy forms that contain a discretionary clause. 4. A discretionary clause grants the plan administrator (who is often, as here, the insurance company that issues the plan) authority to interpret the plan and to resolve all questions arising under it, such as whether a plan beneficiary is entitled to benefits. Discretionary clauses vest extraordinary power in the plan administrator to resolve disagreements with a plan participant. These types of clauses matter, among other reasons, because judicial review of an administrative decision in the ERISA context is governed by the abuse of discretion standard of review when a plan contains a discretionary clause. 5. If there is no discretionary clause in the plan, the *de novo* standard of review applies. A discretionary clause means a more deferential standard of judicial review when an administrator’s decision to deny benefits is challenged on
Accordingly, Morrison denied Standard Insurance Company’s request for approval of proposed
disability insurance forms that contained discretionary clauses. Standard sued in district
court and challenged Morrison’s practice as preemption by ERISA. The district court
granted summary judgment to Morrison and Standard appealed.

The legal issue on appeal was simply whether ERISA preemption Commissioner
Morrison’s practice of denying insurance forms with discretionary clauses. Because
Morrison’s practice related to ERISA-governed employee benefit plans, the Ninth Circuit
reasoned that the practice is preemption unless it falls under the savings clause pursuant to 29
U.S.C. § 1144(b)(2). The Ninth Circuit applied the two-prong Miller test to determine if
Morrison’s disapproval of discretionary clauses came within the reach of the savings clause.
The Ninth Circuit found that Morrison’s practice satisfied both requirements and survives
ERISA preemption. In reaching this conclusion, the Ninth Circuit rejected each of five
arguments raised by Standard.

Standard first argued that Morrison’s practice of banning discretionary clauses is not
specifically directed toward the insurance industry because it targets ERISA plans and
procedures. The Ninth Circuit rejected this argument, finding instead that ERISA plans are

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208 Morrison, 584 F.3d at 841.
209 Id.
210 Id.
211 Id.
212 Id. at 842.
213 Id. (Under Miller, a state law regulates insurance if it is specifically directed toward the insurance industry and
substantially affects the risk pooling arrangement between insurer and insured.)
214 Id. at 849.
215 Id. at 842.
also a form of insurance and that Morrison’s practice regulates insurance by limiting the terms that insurance companies can include in their policies. 216 In its holding, the Ninth Circuit expressly agreed with the Sixth Circuit in Ross that rules which impose conditions on an insurer’s right to engage in the business of insurance within a particular state are directed toward the insurance industry. 217

Standard suggested that Commissioner Morrison’s practice was still not specifically directed toward the insurance industry because it “merely applies ‘laws of general application that have some bearing on insurers.’” 218 The Ninth Circuit found this argument unpersuasive as well. The Court observed that Morrison’s practice of disapproving insurance forms that contain discretionary clauses is specific to the insurance industry. 219 Moreover, Montana does not require approval of most contracts, but instead has “‘special solicitude for insurance customers’” because it requires that the Commissioner approve insurance forms in particular. 220 Montana’s prohibition on discretionary clauses “addresses an insurance-specific problem, because discretionary clauses generally do not exist outside of insurance plans.” 221 The Ninth Circuit found Morrison’s practice of requiring all insurers to exclude discretionary clauses

216 Id.
217 Id. (“We agree with the Sixth Circuit’s decision in American Council of Life Insurers v. Ross, 558 F.3d 600 (6th Cir. 2009). In that case, the Sixth Circuit confronted a Michigan prohibition on discretionary clauses. It concluded, as we do, that ‘[g]iven that the rules impose conditions only on an insurer’s right to engage in the business of insurance in [the state,] . . . the rules are directed toward entities engaged in the business of insurance.’ Id. at 605’); Am. Council of Life Insurers v. Ross, 558 F.3d 600, 605 (6th Cir. 2009) (“[S]tate laws are ‘directed toward entities engaged in insurance’ if insurers are regulated with respect to their insurance practices. Id. Here, there can be no serious dispute that the rules meet the first prong of the Miller test because they regulate insurers with respect to their insurance practices. . . . Given that the rules impose conditions only on an insurer’s right to engage in the business of insurance in Michigan, we conclude that the rules are directed towards entities engaged in the business of insurance. See Miller, 538 U.S. at 337 (‘[T]he laws] regulate [] insurance by imposing conditions on the right to engage in the business of insurance.’)”.
218 Id.
219 Id.
220 Id. at 843.
221 Id.
from their policies to be “‘an application of a special order’” as opposed to a general rule.\textsuperscript{222}

Finally, the Ninth Circuit held that Morrison’s disapproval of discretionary clauses is directed toward the insurance industry and satisfies the first prong of the \textit{Miller} test.\textsuperscript{223}

Turning to the second prong of the \textit{Miller} test, Standard argued that disapproval of discretionary clauses does not substantially affect the risk pooling arrangement between insurers and insureds.\textsuperscript{224} Standard asserted that risk pooling occurs when an insurance contract is made instead of when a claim is made.\textsuperscript{225} Consistent with this definition, risk pooling, claim investigations, the appeals process, and litigation fall outside the risk pooling arrangement.\textsuperscript{226}

The Ninth Circuit rejected Standard’s argument in favor of a broader notion of risk pooling.\textsuperscript{227} Specifically, the Ninth Circuit found that Morrison’s practice changes the scope of permissible bargains between insurers and insureds because insureds “may no longer agree to a

\textsuperscript{222} \textit{Id.} at 844.
\textsuperscript{223} \textit{Id.} at 842-844 (‘Standard next argues that the practice is not specifically directed at insurers because it merely applies ‘laws of general application that have some bearing on insurers.’ \textit{Kentucky Ass’n}, 538 U.S. at 334. To Standard, the practice is nothing more than an attempt to apply the common-law rule that contracts are interpreted against their drafter. . . . Morrison’s practice is grounded in policy concerns specific to the insurance industry, such as ensuring fair treatment of claims by insurers with potential conflicts of interest. It is indeed directed at insurance companies”).
\textsuperscript{224} \textit{Id.} at 844.
\textsuperscript{225} \textit{Id.} (“Insurance companies’ core function is to accept a number of risks from policyholders in exchange for premiums. Some of the risks accepted will result in actual losses. Risk pooling involves spreading losses ‘over all the risks so as to enable the insurer to accept each risk.’ \textit{Union Labor Life Ins. Co. v. Pireno}, 458 U.S. 119, 127-28, 102 S. Ct. 3002, 73 L. Ed. 2d 647 & n.7 (1982). By receiving a large number of relatively small premiums, the insurer can afford to compensate the few insureds who suffer losses. In this way, the insured no longer bears more than a small amount of his own risk--it has been transferred into a common pool into which all members of the pool contribute by paying premiums. The requirement that insurance regulations substantially affect risk pooling ensures that the regulations are targeted at insurance practices, not merely at insurance companies. \textit{See Kentucky Ass’n}, 538 U.S. at 338 (noting that, absent the risk pooling requirement, ‘any state law aimed at insurance companies could be deemed a law that regulates insurance’ (internal quotation marks omitted)). For instance, a state law requiring insurers to pay their janitors twice the minimum wage would not regulate insurance because it would have no effect on the risk-pooling relationship between insurers and the insured. \textit{Id.} Standard argues for a definition of risk pooling that it claims is used in the insurance industry. According to such definition, risk is pooled at the time the insurance contract is made, not at the time a claim is made”).
\textsuperscript{226} \textit{Id.} (Standard argued that “[a]dministrative factors” such as ‘claim investigations, the appeals process, and litigation’ can ‘affect amounts paid to insureds under [a] policy,’ but are outside of the risk pooling arrangement”). Standard’s goal in presenting this argument was to persuade the Ninth Circuit Court of Appeals that Montana’s ban on discretionary clauses, by failing to satisfy the second prong of the \textit{Miller} test, does not fall under the savings clause and is therefore preempted by ERISA. In short, Standard sought to prevent Commissioner Morrison’s ban on discretionary clauses from being enforced.
\textsuperscript{227} \textit{Id.}
discretionary clause in exchange for a more affordable premium.”\textsuperscript{228} The Court noted that Montana’s policy of barring discretionary clauses and “removing the benefit of a deferential standard of review from insurers” will result in more claim payouts because insurers will be forced to explain their claim decisions.\textsuperscript{229} The Court also found that Morrison’s practice affects the risk pooling arrangement because it alters the terms “by which the presence or absence of the insured contingency is determined.”\textsuperscript{230} The Court finally held that Commissioner Morrison’s practice of disapproving discretionary clauses falls under the savings clause and survives ERISA preemption.\textsuperscript{231}

Standard also claimed that Morrison’s practice interferes with ERISA’s exclusive remedial scheme pursuant to 29 U.S.C. § 1132(a).\textsuperscript{232} ERISA preempts “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy.”\textsuperscript{233} The Ninth Circuit, like the Sixth Circuit in Ross, rejected this argument and held that Morrison’s practice created no additional remedy outside of ERISA’s civil enforcement scheme.\textsuperscript{234} The Court acknowledged that this practice will likely lead to \textit{de novo} review in the federal courts, but found no conflict with ERISA because \textit{de novo} has been the default standard of review since the Supreme Court’s decision in \textit{Firestone}.\textsuperscript{235} The Court thus distinguished Morrison’s disapproval of discretionary clauses from “cases in which a state attempts to meld a

\begin{footnotes}
\footnotetext[228]{Id. at 844-845 (“Montana insureds may no longer agree to a discretionary clause in exchange for a more affordable premium. The scope of permissible bargains between insurers and insureds has thus narrowed”).}
\footnotetext[229]{Id. at 845.}
\footnotetext[230]{Id.}
\footnotetext[231]{Id.}
\footnotetext[232]{Id. at 846.}
\footnotetext[233]{Id. (quoting Aetna Health v. Davila, 542 U.S. 200, 209 (2004) (holding that ERISA preempts a Texas state law which allows claimants to recover damages when an HMO fails to exercise ordinary care in making health care treatment decisions)).}
\footnotetext[234]{Id.}
\footnotetext[235]{Id.}
\end{footnotes}
new remedy to the ERISA framework.”

Finally, Standard asserted that Montana’s bar on discretionary clauses contravenes the purpose and policy behind ERISA of balancing employees’ right to benefits and incentivizing employers to create benefit plans. Standard relied on the Supreme Court’s opinion in *Glenn*, where the Court retained the *Firestone* standard of deference instead of requiring *de novo* review and held that courts must treat a fiduciary’s conflict of interest as just one factor in deciding whether there is abuse of discretion. The gist of Standard’s argument was that the Ninth Circuit likewise ought to refrain from “‘adopting a rule that in practice could bring about near universal review by judges *de novo*-i.e. without deference-of a lion’s share of ERISA plan claims denials.’”

The Ninth Circuit found that the appropriate test was to balance ERISA’s preemption scheme against the state insurance regulation. The Court noted that the Supreme Court’s refusal to mandate *de novo* review does not necessarily preclude states from issuing insurance regulations that have such effect. Additionally, while the Supreme Court in *Firestone* and

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236 *Id.* (“[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted.’ *Aetna Health*, 542 U.S. at 209. . . . Here, however, there is no additional remedy. Insureds may only recover the value of the denied claim from their insurers. The practice neither ‘authorize[s] any form of relief in state courts’ nor ‘serve[s] as an alternate enforcement mechanism[ ] outside of ERISA’s civil enforcement provisions.’ *Am. Council of Life Ins.,* 558 F.3d at 607; see also *Aetna Health*, 542 U.S. at 218 (‘[E]ven a state law . . . regulating insurance will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme.’ (internal quotation marks omitted)). . . . Since it adds nothing the ERISA scheme does not already contemplate, the practice is distinguishable from cases in which a state attempts to meld a new remedy to the ERISA framework”). If Commissioner Morrison’s ban on discretionary clauses created a new remedy outside of or in addition to the exclusive list of remedies under ERISA Section 502 (29 U.S.C. § 1132), ERISA would preempt Commissioner Morrison’s practice pursuant to § 514 (29 U.S.C. § 1144).

237 *Id.* at 847.

238 *Id.*

239 *Id.* (quoting *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350 (2008)).


241 *Id.* (“*Glenn* involved an exercise of the Court’s power to make federal common law, as evidenced by its frequent reference to trust law and the absence of any applicable state insurance regulation. The Court’s refusal to
Glenn endorsed the abuse of discretion standard, the Supreme Court’s acceptance of de novo review as the default nonetheless “indicates that highly deferential review is not a cornerstone of the ERISA system.” Recalling the Supreme Court’s opinion in Rush, where the Court explicitly stated that it was permissible for states to eliminate a plan administrator’s discretion and ability to minimize scrutiny of benefit denials, the Ninth Circuit concluded that Morrison’s practice likewise prohibits insurers from inserting terms into policies that advantage the insurer. The Ninth Circuit held there was no conflict with ERISA and expressly declined to limit the reach of the savings clause. Nonetheless, the Court acknowledged the tension

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242 Id. at 847-848.
243 Id. at 848 (“[T]he Court stated that it was perfectly appropriate for the state to "eliminate[ ] whatever may have remained of a plan sponsor's option to minimize scrutiny of benefit denials." Id. at 387. In Rush Prudential, the state had ‘eliminat[ed] an insurer’s autonomy to guarantee terms congenial to its own interests’ by requiring an independent medical review when the patient's doctor and the HMO disagreed about medical necessity. Id. That, however, was merely 'the stuff of garden variety insurance regulation through the imposition of standard policy terms.' Id. And ensuring a level playing field for claims is at the heart of the state’s power to regulate insurance: ‘[i]t is . . . hard to imagine,’ said the Court, ‘a reservation of state power to regulate insurance that would not be meant to cover restrictions of the insurer's advantage in this kind of way.’ Id. Here, the Commissioner has likewise forbidden insurers from inserting terms which tip the balance in their favor. Although this creates disuniformities in the regime of rights and remedies under ERISA, ‘[s]uch disuniformities . . . are the inevitable result of the congressional decision to save local insurance regulation. Although we have recognized a limited exception from the saving clause for alternative causes of action and alternative remedies . . ., we have never indicated that there might be additional justifications for qualifying the clause’s application. . . . [F]urther limits on insurance regulation pre-served by ERISA are unlikely to deserve recognition.’ Id. at 381 (emphasis added) (internal citation omitted)); Initial Brief for Appellee-Respondent at 15-16, Standard Ins. Co. v. Morrison, No. 08-35246 (6th Cir. Aug. 27, 2008) (“For at least 80 years, Montana courts have consistently and uniformly maintained a balance between insurers and insureds, placing insureds on an even playing field with insurers. Thus, Montana courts have implicitly rejected discretionary authority that favors insurance companies by resolving ambiguities in favor of insureds. See e.g., Farmers Alliance Mut. Ins. Co. v. Holeman, 1998 MT 155, P25, 289 Mont. 312, 961 P.2d 114; and Park Saddle Horse Co. v. Royal Indem. Co., (1927) 81 Mont. 99. This is a settled and indisputable principle of Montana insurance law. It is also consistent with Montana statutory insurance law which requires the Commissioner to disapprove any insurance policy provisions that are ‘inconsistent, ambiguous, or misleading ... which deceptively affect the risk purported to be assumed in the general coverage of the contract.’ Mont. Code Ann. § 33-1-502 (2007). Thus, the Commissioner was mandated to disapprove discretionary clauses because they transfer undue power to insurers in a manner that is inherently inconsistent, ambiguous, and misleading and because they violate 80 years of settled Montana insurance law. The Commissioner spoke out against these insurance provisions because they violate Montana law. If the Commissioner did not believe discretionary clauses violated Montana law, he would approve their inclusion in policies he reviews pursuant to Mont. Code Ann. § 33-1-502”).
244 Id. at 848-849.
between Commissioner Morrison’s practice and the federal common law regarding the appropriate standard of review in benefit denial cases.\textsuperscript{245}

Finally, the Tenth Circuit Court of Appeals recently cited with approval the decisions in \textit{Ross} and \textit{Morrison}.\textsuperscript{246} in \textit{Hancock v. Metro. Life Ins. Co.}. That court distinguished \textit{Ross} and \textit{Morrison} as inapplicable to the facts at hand but agreed with their reasoning.\textsuperscript{247}

Verla Hancock participated in an employer-sponsored ERISA-covered plan that offered life insurance and accidental death and dismemberment (AD & D) benefits.\textsuperscript{248} The plan paid AD & D benefits for loss of life if the participant was injured in an accident covered under the plan, if the accident was the sole cause of the injury, and if death occurred within one year of the accident.\textsuperscript{249} However, the plan did not cover injuries resulting from physical or mental illness.\textsuperscript{250} MetLife was the plan’s insurer and claim fiduciary, responsible for resolving benefit claims and reviewing appeals.\textsuperscript{251} The plan granted MetLife discretion to interpret the plan terms and to determine eligibility for benefits.\textsuperscript{252} In 2003, Utah’s insurance commissioner issued Rule 590-218 which prohibited discretionary clauses in insurance forms relating to an ERISA-covered benefit plan unless “their language is ‘substantially similar’ to the safe-harbor language set forth in the regulation.”\textsuperscript{253} Additionally, Rule 590-219 altogether prohibited

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\item \textsuperscript{245} \textit{Id.} at 849 (“Although we acknowledge the tension between the Commissioner’s practice and federal common law concerning the standard of review, we see nothing that would justify taking the extraordinary step of creating a new exclusion under the savings clause. Accordingly, we agree with the district court that the Commissioner’s practice of disapproving discretionary clauses is not preempted by ERISA’s exclusive remedial scheme”).
\item \textsuperscript{246} \textit{Id.} at 1149.
\item \textsuperscript{247} \textit{Id.} at 1144.
\item \textsuperscript{248} \textit{Id.}
\item \textsuperscript{249} \textit{Id.}
\item \textsuperscript{250} \textit{Id.}
\item \textsuperscript{251} \textit{Id.}
\item \textsuperscript{252} \textit{Id.} (“[T]he Plan granted MetLife ‘discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan’”).
\item \textsuperscript{253} \textit{Id.}
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discretionary clauses in insurance forms that did not relate to an ERISA benefit plan.\footnote{Id.}

After Verla died, MetLife approved the claim of Verla’s daughter Terri Hancock for life insurance but denied AD & D benefits.\footnote{Id. at 1143-1144 (Verla Hancock died in 2004. Verla’s daughter Terri discovered her mother’s body; the police report stated that a bottle of Oxycontin was found nearby. The medical examiner, however, listed the cause of death as undetermined because the toxicology results and the autopsy showed no evidence of disease, injury, or intoxication sufficient to explain death. Verla had designated Terri Hancock as her beneficiary under the plan. Ms. Hancock filed a claim for life insurance and AD & D benefits in 2005).} MetLife’s notification letter explained that Hancock was ineligible for AD & D benefits because the record failed to establish that Verla’s death had been accidental.\footnote{Id. at 1144-1145 (Hancock subsequently appealed the denial of benefits and cited two conversations she had with the investigating detective and the medical examiner, both of whom stated that Verla’s death may have resulted from a slip and fall accident. MetLife denied the appeal on the ground that Hancock’s evidence was conjecture and did not show that an accident caused Verla’s death. Hancock submitted additional evidence in 2006 but MetLife never responded. Hancock then sued MetLife in Utah state court, alleging breach of contract and breach of the duty of good faith and fair dealing, among other claims. MetLife reaffirmed its denial of AD & D benefits just a day later and also filed a motion to remove the case to federal court”).} In 2007, Hancock moved for partial summary judgment in District Court on the standard of review and argued that the court should apply \textit{de novo} review to MetLife’s denial of AD & D benefits.\footnote{Id.} Hancock asserted that Rule 590-218 deprived MetLife of discretionary authority that would justify a deferential standard of review.\footnote{Id.} MetLife subsequently moved for a bench trial on the papers and argued that its denial of benefits was “reasonable and supported by substantial evidence.”\footnote{Id. (Hancock also argued that MetLife had a conflict of interest and made procedural errors in handling her claim. The district court decided each motion on the merits.)}

The district court denied Hancock’s motion for partial summary judgment on the ground that ERISA preempted Rule 590-218 and MetLife was entitled to deferential review.\footnote{Id. (‘The district court] denied Ms. Hancock’s motion for partial summary judgment, holding that ERISA preempted Rule 590-218 and that MetLife was entitled to arbitrary-and-capricious review’).}

The district court also denied Hancock’s motion for summary judgment because Hancock
failed to show that a covered loss had occurred under the plan. Finally, the district court granted MetLife’s motion and held that MetLife’s denial of AD & D benefits was not arbitrary and capricious.

On appeal, the Tenth Circuit considered whether Firestone deference was warranted. With regard to the appropriate standard of review, the Tenth Circuit reasoned that this determination rests on whether the discretionary clause in the plan complies with Utah’s insurance Rule 590-218. MetLife argued that ERISA preempts the application of Rule 590-218. Hancock argued against preemption, but also asserted that even if the plan’s discretionary clause were valid, the court must apply less deference because of MetLife’s conflict of interest and procedural defects in MetLife’s benefit determination.

The Court of Appeals noted that Rule 590-218 permits ERISA-governed employee benefit plans to include discretionary clauses only if the clause language resembles the safe-harbor language under the rule. This meant that Rule 590-218 could apply to an employee benefit plan only if it survived ERISA preemption. ERISA preempts any state law that relates to an employee benefit plan unless the law regulates insurance. The Supreme Court held in Miller that a state law regulates insurance if it is specifically directed toward the insurance industry and substantially affects the risk pooling arrangement between insurer and

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261 Id.
262 Id.
263 Id. at 1145-1146.
264 Id. at 1146.
265 Id.
266 Id.
267 Id.
268 Id. at 1148 (“Rule 590-218 can be applied to the Plan only if it is not preempted by ERISA. ERISA expressly preempts any state law ‘insofar as [it] may now or hereafter relate to any employee benefit plan,’ see 29 U.S.C. § 1144(a), unless the law ‘regulates insurance, banking, or securities,’ id. § 1144(b)(2)(A). The issue before us is whether Rule 590-218 regulates insurance”).
269 Id.

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MetLife did not dispute that Rule 590-218 satisfied the first prong of the *Miller* test.

The Tenth Circuit found that ERISA expressly preempts the application of Rule 590-218 to the plan, because “[t]he rule does not remove the option of insurer discretion from the scope of permissible insurance bargains in ERISA plans.” Instead, the rule permitted discretionary clauses so long as they conform to particular wording requirements. As such, the rule had no substantial effect on the risk pooling arrangement between the insurer and the insured. In short, Rule 590-218 failed to satisfy the second prong of the *Miller* test.

Interesting, the Tenth Circuit suggested that the result might have been different had Rule 590-218 prohibited all discretionary clauses. The Court of Appeals pointed to the *Ross* and *Morrison* decisions as holding that an absolute bar on discretionary clauses substantially affects risk pooling by restricting the scope of permissible bargains between insurers and the insured. *Hancock*, however, involved no such prohibition on the use of discretionary clauses and the Tenth Circuit consequently concluded that a less than complete bar failed the second part of the *Miller* test.

Hancock raised several other arguments regarding the effect of Rule 590-218 on the

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270 *Id.* (quoting Ky. Ass’n of Health Plans v. Miller, 538 U.S. 329, 342 (2003)).
271 *Id.*
272 *Id.* (“MetLife does not dispute that Rule 590-218 satisfies *Miller’s* first prong. We therefore turn to prong two”).
273 *Id.* at 1149.
274 *Id.*
275 *Id.*
276 *Id.*
277 *Id.* ("If Rule 590-218 imposed a blanket prohibition on the use of discretion-granting clauses, we would have a different case").
278 *Id.*
279 *Id.*; Ky. Ass’n of Health Plans. v. Miller, 538 U.S. 329, 333 (2003) (In order to determine if a practice falls within the business of insurance, it has to form “part of the policy relationship between the insurer and the insured”).
risk pooling arrangement. First, she asserted that Rule 590-218 affects the risk pooling arrangement because a failure to conform substantially to the rule’s safe-harbor language invalidates a discretionary clause and deprives the insurer of deferential review by the courts.\(^{280}\) The Tenth Circuit dismissed Hancock’s argument as untenable because noncompliance with any trivial requirement would trigger \textit{de novo} review and alter the risk pooling arrangement.\(^{281}\) The Court found that a change in the risk pooling arrangement must result from compliance with the state law rather than its violation.\(^{282}\)

Second, Hancock asserted that Rule 590-218 limits insurer discretion because the rule requires the language in a discretionary clause to state that a federal court will determine the appropriate level of deference to a plan administrator’s decision.\(^{283}\) The Tenth Circuit correctly noted that this language merely recognizes the extent of the federal courts’ authority even when a plan grants discretionary authority to the administrator.\(^{284}\) The extent of judicial deference depends on the presence of conflicts of interest and compliance with procedural requirements instead of merely the inclusion of a discretionary clause in the plan terms.\(^{285}\)

\(^{280}\) \textit{Id.} at 1150.

\(^{281}\) \textit{Id.} at 1149-1150 ("Ms. Hancock contends that Rule 590-218 affects risk pooling because if discretion-granting clause does not substantially conform to the rule’s safe-harbor language, the clause is invalid, the insurer is deprived of discretion, and the resulting de novo review affects the risk pool by causing more reversals of benefit denials. Her argument proves too much. By her logic, any requirement, no matter how trivial (for example, a requirement that the plan be printed on mauve paper), affects risk pooling simply because an insurer's noncompliance would divest it of discretion, trigger de novo review, and change its risks. We decline to interpret \textit{Miller} so broadly").

\(^{282}\) \textit{Id.} at 1150 ("The change in risk pooling must result from \textit{compliance} with the state law, not its \textit{violation}").

\(^{283}\) \textit{Id.}

\(^{284}\) \textit{Id.}

\(^{285}\) \textit{Id.} at 1150-1151 (Hancock also raised two contentions at oral argument which the Tenth Circuit dismissed on the merits. Hancock first argued that Rule 590-218 only permits insurers to restrict the scope of review but not the standard of review. Hancock asserted that the scope of review comprehends the material that a court may examine in evaluating a plan administrator’s decision, whereas the standard of review involves the level of judicial deference. The Tenth Circuit rejected Hancock’s argument as it leads to the conclusion that Rule 590-218 categorically prohibits deferential review. The Court of Appeals rejected such an interpretation as “nonsensical” in light of the rule’s safe-harbor language granting the administrator discretion to interpret the plan terms and to determine eligibility for benefits. The Court concluded that the phrase “scope of review” in the safe-harbor..."
The court next considered whether to apply arbitrary and capricious or de novo review in light of Ms. Hancock’s assertion that MetLife’s benefit determination process failed to substantially comply with ERISA regulations.\(^{286}\) Specifically, Ms. Hancock argued that MetLife’s benefit determination was procedurally defective because MetLife’s denial letters did not include information required under ERISA and because MetLife did not provide a full and fair review of her appeal.\(^{287}\) The appellate court rejected both contentions.\(^{288}\) First, it concluded that MetLife’s denial letters complied with procedural requirements by stating the reasons and the relevant plan provisions justifying the denial of benefits and by describing the information Ms. Hancock needed to provide in order to perfect her claim.\(^{289}\) In addition, the court determined that MetLife had provided Ms. Hancock a full and fair review of her claim because MetLife did not ignore her evidence but instead merely found it inconclusive.\(^{290}\)

\(^{286}\) Id.

\(^{287}\) Id.

\(^{288}\) Id. at 1153.

\(^{289}\) Id. at 1153.

\(^{290}\) Id. at 1154 (“MetLife received Ms. Hancock's [appeal] letter on February 13, 2006. Ten days later it informed her that it would be ‘willing to conduct a further administrative review,’ id. at 142, provided that she agree that her submissions be part of the administrative record that could be reviewed by a court. On March 3 Ms. Hancock agreed and asked MetLife to proceed with its review. More than three months passed with no decision from MetLife. On June 27, 2006, Ms. Hancock's attorney wrote to MetLife, noting that he had contacted MetLife over 20 times in the previous months and was always told only that ‘the claim is in the review process,’ without additional explanation. Id. at 134. The letter threatened suit for breach of contract if MetLife did not pay the disputed AD&D benefits within ten days. On September 12 Ms. Hancock, still without a decision on her appeal, filed suit. MetLife denied Ms. Hancock's second appeal the next day. The denial letter stated that it only supplemented the first appeal-denial letter and did not replace it. It again cited the Plan's AD&D provision and summarized MetLife's reasons for denying the claim and the first appeal. It then stated that the MRA report ‘d[id] not demonstrate with certainty that the decedent had an accident’ and that the slip-meter test said nothing about Verla Hancock's actual cause of death. Id. at 132. From this correspondence we cannot conclude that MetLife denied Ms. Hancock a full and fair review. MetLife did not ignore her evidence; it merely found it inconclusive.
Finally, the Court of Appeals noted that prior to *Glenn* the presence of a conflict had reduced or withheld deference.\textsuperscript{291} Since *Glenn* rejected burden-shifting rules and held that conflicts of interest are but one factor that a reviewing court must take into account,\textsuperscript{292} the court considered MetLife’s conflict using *Firestone* deference saying MetLife’s benefit denial needed only to be sufficiently supported by facts to survive arbitrary and capricious review.\textsuperscript{293} The Court of Appeals concluded that “MetLife reasonably decided that Ms. Hancock failed to prove accidental death.”\textsuperscript{294} Although circumstantial evidence indicated that accidental death was a possibility, the autopsy failed to establish any cause of death at all.\textsuperscript{295} MetLife’s reliance on official government conclusions proved that its denial of AD & D benefits had not been arbitrary and capricious.\textsuperscript{296}

**B. Obama Care and Meaningful External Review**

1. **Mechanics**

Prior to the PPACA, ERISA had established a process of internal/external review available to claimants in instances of benefit claims denial. Very simply, this process required a plan

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Both appeal-denial letters took into account the information Ms. Hancock had submitted and then reasonably explained why the information was insufficient to support the accidental-death theory”).

\textsuperscript{291} Id. (“Ordinarily, we review discretionary benefit decisions under an arbitrary-and-capricious standard. *See Kellogg*, 549 F.3d at 825. But if the plan administrator or fiduciary operates under a conflict of interest, we decrease our deference in proportion to the seriousness of the conflict. *See Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004) (per curiam). At one time we distinguished between standard conflicts and inherent conflicts to determine how much deference to withhold. If the conflict was standard—that is, if the fiduciary's or administrator's ‘dual role jeopardized [its] impartiality,’ *id.* at 1005 (internal quotation marks omitted)—and the claimant could not establish that the conflict was serious, we considered the conflict as one factor in determining whether the benefit denial was arbitrary and capricious, *see id.* But if the conflict was inherent—for example, if the administrator of the plan was also its insurer—the burden shifted to the conflicted party to prove that its decision was not arbitrary and capricious. *See id.* at 1006”). This approach arose out of the Court of Appeals’ uncertainty as to how to apply the Supreme Court’s holding in *Firestone* that a conflict of interest must be taken into account on review of a discretionary benefit denial. The approach in the Tenth Circuit had been to withhold some degree of deference and shift the burden to the conflicted party to prove that its benefit determination had not been arbitrary and capricious.

\textsuperscript{292} Id.

\textsuperscript{293} Id.

\textsuperscript{294} Id. at 1156.

\textsuperscript{295} Id.

\textsuperscript{296} Id.
participant to pursue an internal appeal through the plan’s administrative review process.\textsuperscript{297} After exhausting the internal appeals procedures a claimant could then pursue a claim for benefits typically in federal court.\textsuperscript{298} \textit{Firestone}, of course, meant that this “external” process in federal court was highly deferential to the decision making process of the plan administrator.

As we have seen, some states confronted \textit{Firestone} deference head on and banned discretionary clauses. In addition, some states enacted their own external review processes for claims denied by HMOs and insured plans.\textsuperscript{299} In order to understand how external review works under the PPACA, it is critical to recognize the important features of the health insurance landscape—first, the PPACA now creates two classes of plans, those that are grandfathered and not subject to all PPACA provisions and those that are fully covered by the new statute. Second, health plans are either insured or self-insured. Both insured and self-insured plans may be grandfathered or not.\textsuperscript{300} Section 1001 of the PPACA refers to the “consumer protections” set forth in the Uniform Health Carrier External Review Model Act developed by the National Association of Insurance Commissioners (“NAIC”)\textsuperscript{301} and deems these consumer protections the floor below which an external review process cannot fall.

\textsuperscript{297} See generally ERISA section 503.

\textsuperscript{298} ERISA section 502(a)(1)(B).

\textsuperscript{299} In \textit{Rush Prudential HMO v. Moran}, 536 U.S. 355 (2002) the Supreme Court held that state external review processes were not preempted by ERISA. These procedures do not apply to self-insured plans.

\textsuperscript{300} As one might expect there are a number of ways in which a plan can lose its grandfathered status.

\textsuperscript{301} I am indebted to Colleen Medill for the following summary of the model act. See Medill, Instructor’s Note to Student Supplemental Materials (Fall 2010) at www.medill-employee-benefits.com. “Under the Model Act, the participant must first exhaust the plan’s internal grievance procedure and receive a final adverse determination of the claim before seeking external independent review of the plan administrator’s decision. Model Act section 7. The participant must file a request for external independent review with the state insurance commissioner. Model Act section 8. Among the consumer protections provided by the Model Act, the independent reviewer must be an expert in the treatment of the participant’s medical condition that is the subject of the participant’s claim. If a physician serves as an external reviewer, the physician must be currently licensed and be certified by a recognized American medical specialty board in the area or areas that are the subject of the review. Model Act section 3B. The participant may submit additional written information to the independent reviewer to support the participant’s claim that was not initially submitted to the plan’s administrator. In rendering an opinion, the independent reviewer is not bound by the prior judgments or opinions of the plan administrator. The decision of the independent external reviewer is binding on the plan administrator and cannot be appealed through litigation. Model Act section 11.”

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Some states have adopted the NAIC model act; others have not. Some states have followed the model act’s provisions closely; others have not. What this is means is that there currently exists a broad range of external review procedures—some states have no procedures in place, others have procedures that vaguely resemble the model act, still more follow the model act closely and others have adopt the model act verbatim. In response to this varied landscape, the PPACA “encourages” states to adopt external review procedures that are consistent with NAIC’s standards. If a claimant resides in a state that has no external review, or has procedures that do not conform to the NAIC standards, then that claimant is free to use the federal external review program.

PPACA external review is certain to be a jolting change for self insured plans that are not grandfathered. Instead of an internal process the outcome of which is sometimes affected by the plan’s own financial stake in the outcome, followed by deferential external review, self insured plans now face external review in an explicitly non-deferential forum which is less likely than a federal court bound by Firestone to uphold the plan administrator’s decision.

What is less clear is whether NAIC model external review will somehow manage to identify and engage truly disinterested reviewers. The pool of board certified, licensed physicians who are expert in rare diseases and disorders will surely be limited and one would expect insurers and self insured plans that have a significant financial stake in the outcome to come up with creative ways to try and game the external review process.

302 According to BNA, forty four states currently have some kind of external review procedure in place. All states have until July 1, 2011 to amend their procedures to comply with NAIC’s model act. BNA, “Administration Issues Rules Strengthening Health Plan Coverage Appeals Process” 37 Pension and Benefits Reporter No. 29 at 1628. July 27, 2010.

303 See, e.g. Holmstrom and Glenn.

304 See e.g. Holmstrom’s condition—and describe.
2. Who is Grandfathered?

The PPACA creates a new distinction between plans that were in effect on March 23, 2010 and those that become effective subsequent. A grandfathered plan is an insured or self-insured plan that existed on or before March 23, 2010 and has not taken any steps that cause it to lose grandfather status. The distinction matters because some provisions of the PPACA do not apply to grandfathered plans; specifically, grandfathered plans are exempt from the requirements of the statute regarding independent, external review. (In addition grandfathered plans are exempt from the new rules governing no cost sharing for immunizations, patient choice for maternal and pediatric services, emergency services, no cost sharing for preventive care.

Given the importance of grandfather status, one might expect plans will pay close attention to plan design changes or failures to act that will cause them to lose it. It is worth noting that maintenance of grandfathered status comes at an explicit cost of having to observe rules that restrict a plan’s ability to change plan terms and cost-sharing arrangements. Over time, and given the upward trajectory of health insurance costs, it is not unreasonable to expect that plan sponsored by small employers will lost grandfathered status more rapidly than those sponsored by large employer who may be able to withstand upward cost pressure for a longer period of time before giving in to pressure to amend the plan. Any plan that loses its status and is no longer grandfathered will have to comply with the PPACA’s requirements for health plans, including the obligation to provide for independent, external review.

305 Long note here on how to maintain or lose grandfather status.
306 Note here citing to each of these sections of the statute.
307 List all things plan must do to hold onto grandfathered status and things that, if done, will cause them to lose it.
308 Give explicit examples and cite to statute.
Over time, both small employers and large (the former more quickly I suspect) will lose grandfathered status and find themselves subject to all of the PPACA’s new requirements. For self insured plans this will mean a much less deferential forum in which to resolve disputes about claims. For insured plans, especially those in states which already have an independent, external review process that closely mirrors the NAIC requirements, the transition should be far less traumatic. What remains to be seen is whether the NAIC-based model will result in fewer outcomes which are broadly perceived to be unjust. If it works, this part of Obama Care may mean the federal courts will no longer see a large volume of benefit claims litigation. In the meantime, though, the federal courts of appeal will continue to operate under *Firestone* deference—at least to resolve pre-PPACA cases and those still in contention following state or federal external review.

**C. *Firestone* Deference and Distrust**

The twin keys success of the new PPACA external review process will be cost and trust. If, at reasonable cost the process is widely perceived by the affected parties to be fair and predictable, one would expect to see a significant drop in appeals in the federal courts. This should represent a cost savings for both claimants and plans. A perception that the process is impartial is key. The biggest risk is that insurers will game the process. Imagine the following scenario: a certain rare and complicated diseases for which there is only a handful of qualified reviewers. Each would like to continue to perform this work for insurers. It is not hard to imagine that the desire to please the insurer and become a repeat player could compromise a reviewer’s work.
The emerging litigation—all pre-PPACA—(only three courts of appeals decisions so far) over discretionary clauses is symptomatic of a substantial portion of post-Firestone ERISA common law. States struggle to find ways to indirectly confront perceived unfairness by plans and their insurers because direct measures are expressly prohibited by ERISA’s expansive preemption language. The states resort to devices likely to survive preemption analysis under the savings clause and sometimes this strategy succeeds. The core problem as the Supreme Court noted in *Rush Prudential HMO Inc. v. Moran* is

> [t]he unhelpful drafting of [the preemption language at 29 U.S.C. §1144 (a) and the Savings Clause 29 U.S.C. §1144 (b)] these antiphonal clauses occupies a substantial share of this Court’s time. In trying to extrapolate intent in a case like this, when Congressional intent seems simultaneously to preempt everything and hardly anything, we have no choice but to temper the assumption that the ordinary meaning … accurately expresses the legislative purpose . . . .

Neither strategizing by the states nor the litigation reaction it invariably triggers from plans and insurance companies can be said to directly encourage any of the oft-stated purposes of the statute—the encouragement of efficiency, predictability and uniformity in the administration of employee benefit plans.

Over and over again plans and their insurers have suggested that any expansion of the states’ role in regulating ERISA plans would prove destructive to the very consumers the states purport to protect. Two arguments routinely offered by insurers—cost and efficient plan administration—are relevant to discretionary clauses. The first claim is that any state interference will raise premiums which are often paid jointly by plan sponsors and

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309 “Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)].” 29 U.S.C. § 1144(a) (2010).
312 Rush, at 364-65.
employees. Recently, a spokesman for American Health Insurance Plans (AHIP) asserted that a ban on discretionary clauses “will result in an increase in costs.” However, BNA recently noted that a report by Millman Inc. commissioned by AHIP in 2005 “does not show that insurance costs will face any sort of dramatic increase if discretionary clauses are prohibited.”

The second common argument against state interference is that it is inconsistent with the uniformity Congress hoped would encourage employers to voluntarily sponsor benefit plans. The claim is that any action which discourages employers from sponsorship is therefore harmful to current and future participants. The PPACA, with its NAIC-based standards, should address the uniformity concern, at least in the long run. As plans lost their grandfathered status and are forced to justify their adverse decisions to an independent reviewer, all plans—insured or self insured—should find themselves on a roughly level playing field irrespective of the state in which they operate.

Lawyers representing plans who were asked to comment on the role of discretionary clauses in the decision to sponsor an ERISA plan noted that the clauses provide plan administrators with a fast and inexpensive way to deal with benefits claims litigation when it arises.

Banning discretionary clauses would have significant unintended consequences for patients and employers. Discretionary clauses give patients consistency and uniformity in determining the benefits they are eligible for. They also allow

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316 Id.
317 Id.
employers to provide more affordable, reliable health care coverage to the employees.\textsuperscript{318}

The argument in favor of retaining the Firestone deference model and preempting discretionary clauses is essentially that a ban will prove costly to insurers who, in turn, can be expected to pass these costs onto employers and participants. Although it does not have a lot of empirical support\textsuperscript{319}, this argument is not a trivial one. As the recent national discussion about how to provide health insurance for the approximately 47 million or so uninsured illustrates, cost is an extremely important part of the equation. What the argument does not address, however, is the primary concern of the states and plaintiffs in benefits claims cases—substantial evidence\textsuperscript{321} that the arbitrary and capricious standard emboldens some insurers, especially those in Glenn\textsuperscript{322}-type conflicts, to deny meritorious claims. Hopefully, the PPACA process will go some distance toward addressing this issue. Even if it does, some dissatisfied claimants will no doubt proceed to federal court. A truly impartial independent review process should make most of these cases easy to dispose of employing Firestone deference.

For now, the Sixth and Ninth Circuits seem willing to risk premium increases and other costs in order to try and rectify some of the imbalance between insurers and participants. And, 

\textsuperscript{318} Id.
\textsuperscript{322} Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 128 S. Ct. 2343, 2348 (2008) (“The first question asks whether the fact that a plan administrator both evaluates claims for benefits and pays benefits claims creates the kind of ‘conflict of interest’ to which Firestone’s fourth principle refers. In our view, it does. That answer is clear where it is the employer that both funds the plan and evaluates the claims. In such a circumstance, ‘every dollar provided in benefits is a dollar spent by . . . the employer; and every dollar saved . . . is a dollar in [the employer’s] pocket.’ Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144 (CA3 1987). The employer’s fiduciary interest may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary. Thus, the employer has an ‘interest . . . conflicting with that of the beneficiaries,’ the type of conflict that judges must take into account when they review the discretionary acts of a trustee of a common-law trust’”).
the 10th Circuit has indicated that it agrees with the conclusion that complete bans are not preempted by ERISA.\textsuperscript{323} Although it is conceivable that all the federal circuits will adopt the position of Ross\textsuperscript{324} and Morrison\textsuperscript{325}, complete uniformity among the federal courts of appeal in ERISA matters is not common.\textsuperscript{326} Should a conflict arise or even in the odd absence of a conflict, it is hard to believe that the Supreme Court would allow more than 20 years of \textit{Firestone} deference to disappear easily.

In \textit{Conkright v. Frommert}\textsuperscript{327} the majority gave no hint that it was concerned about the affects of the now-commonplace arbitrary and capricious standard on participants’ ability to obtain contractually promised benefits. On the contrary, Justice Roberts explained:

\begin{quote}
Congress sought “to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.” ERISA induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred. \textit{Firestone} deference protects those interests and, by permitting an employer to grant primary interpretive authority over an ERISA plan to the plan administrator, preserves the “careful balancing” on which ERISA is based. Deference promotes efficiency by encouraging resolution of benefits disputes
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\footnote{323}{Hancock v. Metro. Life Ins. Co., 590 F.3d 1141, 1149 (10th Cir. 2009) (“If Rule 590-218 imposed a blanket prohibition on the use of discretion-granting clauses, we would have a different case. Two circuits have held that such a prohibition substantially affects risk pooling. They reasoned that by preventing insureds from accepting a discretion-granting clause in return for a lower premium, the prohibition narrows the scope of permissible insurance bargains. \textit{See Standard Ins. Co. v. Morrison,} 584 F.3d 837, 840, 844-45 (9th Cir. 2009) (\textit{Miller} prong two is satisfied by Montana’s practice of disapproving all insurance forms containing discretion-granting clauses); \textit{Am. Council of Life Insurers v. Ross,} 558 F.3d 600, 606-07 (6th Cir. 2009) (Michigan’s prohibition on discretion-granting clauses satisfies \textit{Miller} prong two because it limits the contracts that insurers and insureds can enter into, preventing them from granting the insurer "unfettered discretionary authority"). But that reasoning does not apply here. Rule 590-218, although initially stating a prohibition, see Rule 590-218-2 ("prohibit[ing] the use of reservation of discretion clauses"), permits discretion-granting clauses in ERISA plans so long as they substantially conform to the rule's safe-harbor language and use bold, 12-point font, see Rule 590-218-5(3), (4). Indeed, the rule's title--"Permitted Language for Reservation of Discretion Clauses"--belies any notion that Rule 590-218 prohibits discretion").}
\footnote{324}{Am. Council of Life Insurers v. Ross, 558 F.3d 600 (6th Cir. 2009)}
\footnote{325}{Standard Ins. Co. v. Morrison, 584 F.3d 837 (9th Cir. 2009), \textit{cert. denied} 78 U.S.L.W. 3667 (May 17, 2010).}
\footnote{326}{\textit{See Metro. Life Ins. Co. v. Glenn,} 554 U.S. 105, 128 S. Ct. 2343, 2351 (2008). The Supreme Court in \textit{Glenn} rejected burden-sharing rules and special procedures that had developed in the Courts of Appeals as a result of confusion about how to “consider” a plan administrator’s conflict of interest on review of a benefit claim decision.}
\footnote{327}{Conkright v. Frommert, 130 S. Ct. 1640, 176 L. Ed. 2d 469 (2010).}
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through internal administrative proceedings, rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review. Moreover, Firestone deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions—a result that “would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.” [cites omitted].

The open empirical question is how a ban on discretionary clauses would affect an employer’s decision whether or not to sponsor a plan. What is certain, though, is that some insurers take advantage of the deference they enjoy under the “arbitrary and capricious” standard and deny claims that might well have been paid following a de novo review.

The central dilemma in discretionary clause cases is what to do about the atmosphere of profound distrust in which all parties must operate. Insurers worry (sometimes with justification) that they are bombarded by fraudulent claims brought by ignorant or unscrupulous plan participants. Deferential review reduces insurer anxiety, of course, and insulates the judgment of the plan administrator under most circumstances. Deferential review is also clearly the preferred standard for a financially conflicted insurer like Met-Life in Glenn.

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328 Conkright, 130 S.Ct. at 1649.
329 Hammonds v. Hartford Fire Ins. Co., 501 F. 3d 991, 999 (8th Cir. 2007) (finding that the insurer did not act in bad faith where it terminated a claimant’s benefits for attendant care as a result of his refusal to provide documentation regarding his attendant care); Lewis v. Scientific Supply Co., 897 P. 2d 905, 909 (Colo. Ct. App. 1995) (affirming an ALJ’s order to terminate the claimant’s workers’ compensation benefits because the claimant admitting faking his injury); Tribune Co. v. Purcigliotti, 869 F. Supp. 1076, 1082 (S.D.N.Y. 1994) (plaintiff corporation sued on the ground that defendants, some of whom were unionized workers, submitted fraudulent filings for worker’s compensation benefits).
330 Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 128 S. Ct. 2343, 2346-2347 (2008). Deferential review precludes the courts from questioning a plan administrator’s discretionary interpretation of a plan unless the administrator’s decision is clearly unreasonable.
Claimants also worry (sometimes with justification) that financial considerations and not contract of adhesion based promises dominate the evaluation of their claim. Instead of an impartial review, claimants and their advocates anticipate a profit-conscious process like the one described by Professor Langbein. 331 Understandably, they are typically anxious to receive the benefits they contracted for, especially in cases involving disability, severe illness and loss of employment.

The only way forward which respects the financial concerns of insurers and the legitimate expectations of participants in an atmosphere pervaded by distrust is the creation of a truly impartial third party who can be counted on to review claims without conflict. Some will remember that a few years ago Senator John McCain and others 332 proposed allowing a claimant to appeal to an independent, non-insurer affiliated board for \textit{de novo} review. The PPACA is arguably the result of that effort, although perhaps not exactly what the Senator had

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331 John Langbein, “Trust Las as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA,” 101 Nw. U. L. Rev. 1315, 1318-1319 (2007) (“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. 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 and CBS's 60 Minutes 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.’ 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. Some claims-processing employees who objected to these practices later contended that they had been intimidated into acquiescing, or dismissed for not complying”).

332 Henry Quillen, “State Prohibition of Discretionary Clauses in ERISA-Covered Benefit Plans,” J. Pension Planning & Compliance 67, 80 (2006) (Senator John McCain introduced the Bipartisan Patient Protection Act in 2001, which would have required an external review of a benefit denial at the request of the insured individual. If an external reviewer determined that a medical review was necessary, an independent medical reviewer would examine the case and make the final determination of benefit eligibility. Senator McCain’s proposal also prohibited plans and patients from selecting the external review entity. Additionally, Senator Dole introduced a bill in the 1990s which would have required \textit{de novo} review of benefit denials, but would have also allowed for deferential review of a fiduciary’s conclusions if those conclusions “affirm those of a party who did not have a significant interest which would be adversely affected by a decision in favor of the participant or beneficiary”).
in mind. At the time, some of the details elicited criticism, but the basic intuition was sound. The new interim final regulations create a more complicated system in which the quality of external review will depend in large part upon the ability of a plan sponsor to hold onto grandfathered status. Years of Firestone deference have demonstrated that what insurers and claimants need is an impartial, independent, inexpensive and efficient process that refuses to focus on the financial concerns of often conflicted insurers to the exclusion of explicit promises made to the claimant. Ordinarily, de novo review in federal court would meet all of these requirements except perhaps for efficiency and low cost. A model closer to an arbitration panel with complete independence from industry associations would come closer to the ideal. Irrespective of the details, the goal should be a regime in which insurers know what their costs will be because they routinely pay all legitimate claims in full and in a manner consistent with promises made via employer sponsored contracts of adhesion.

IV. Conclusion

The formal state of the law on discretionary clauses in ERISA-governed employee benefit plans has undergone little shift in the last two decades. In Firestone, the Supreme Court held that federal courts must apply de novo review to an adverse benefit determination unless the plan grants the administrator discretionary authority to interpret plan terms and make benefit decisions. The existence of a discretionary clause in a plan triggers a deferential

333 Quillen, supra note 311, at 80 (Quillen criticized Senator McCain’s proposal on the ground that “[a]lthough the bill required qualified external review entities and independent medical reviewers to be to be professionally and financially independent of the insurer, it is hard to see how this requirement would prevent the misuse of independent review. Even if a reviewer is ostensibly independent of an insurer, the reviewer still has an incentive to find in the insurer’s favor in order to gain more business”).

standard of review unless the court finds a clear abuse of discretion by the administrator.

*Firestone* has triggered criticism because of a perception that discretionary clauses weaken ERISA’s goal of protecting the interests of plan participants and beneficiaries. However, as the fairly recent decisions in *Glenn* and *Conkright* demonstrate, the Supreme Court remains attached to *Firestone* deference.

In the last few years, states have undertaken efforts to limit discretionary clauses. Today, approximately twelve states prohibit discretionary clauses in insurance policies and several others limit the use of such clauses.\(^ {335}\) The insurance industry has begun to challenge these state efforts to ban discretionary clauses on ERISA preemption grounds. A handful of Courts of Appeals have reached a quick consensus that state rules barring discretionary clauses survive ERISA preemption because they regulate insurance and consequently fall under ERISA’s savings clause. Only the Sixth, Ninth, and Tenth Circuits have thus far considered cases challenging state bans on discretionary clauses. Notably, the Supreme Court denied certiorari in *Standard Insurance Co. v. Morrison*. One likely reason for the denial of certiorari is the lack of a circuit split on the issue of whether ERISA preempts laws that prohibit discretionary clauses.\(^ {336}\) It may well be that the importance of discretionary clauses declines if the hard cases are resolved by and external reviewer. If external review never gains the confidence of plans and participants, though, the bans on discretionary clauses could continue to be an important part of the calculus in benefits claim cases.

State efforts to proscribe discretionary clauses undeniably provide more protection to plan participants and beneficiaries because administrators can no longer expect courts to defer

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\(^{336}\) “Supreme Court Declines to Review Ruling Allowing State Ban on Discretionary Clauses,” 37 Pens. & Benefits Rep. (BNA) No. 21, at 1214 (May 25, 2010).
to their benefit decisions. As the Sixth Circuit explained in *Ross*, the effect of state rules barring discretionary clauses may be to mandate *de novo* review by the courts. On the other hand, it remains unclear how employers will react to an increase in regulatory pressure from the states. Chief Justice Roberts argued in *Glenn* that judicial deference to a fiduciary’s discretionary authority “encourages employers to provide medical and retirement benefits to their employees through ERISA-governed plans-something they are not required to do.”

Therefore, while plan participants and beneficiaries may be better off in the short term as a result of limits on discretionary clauses, the long-term effect on plan creation is more difficult to ascertain. The latest rulings coming out of the Circuit Courts of Appeals have generally dismissed such concerns in favor of protecting individual interests in employee benefits. Ideally, the creation of an efficient and impartial forum for review of benefit claims denials, like that called for in the PPACA, would reassure claimants that legitimate claims were, indeed, being paid, while saving cost-conscious employers and insurers from lengthy and expensive federal litigation. The Supreme Court’s attachment to *Firestone* deference seems certain to collide with the decisions in *Ross* and *Morrison*. Nonetheless, states will presumably look to the adoption of outright bans in order to rectify the unfairness that *Firestone* deference could continue to create for plan participants and beneficiaries.

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337 *Ross*, 558 F.3d at 609.