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ERISA PLAN ADMINISTRATIVE DECISIONS**

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Post-*Firestone* Skirmishes: The Patient Protection and Affordable Care Act, Discretionary Clauses, and Judicial Review of ERISA Plan Administrator Decisions

Maria O'Brien Hylton*

Since the Supreme Court's Firestone decision, ERISA plan administrators have enjoyed broad discretion and deferential review in benefits claims litigation. Language in Firestone that offered discretion and deference in exchange for a simple discretionary clause led, in time, to attempts by various state insurance commissioners to limit or ban the use of discretionary clauses on the ground that they often lead to unjust outcomes for plan participants. Various state efforts to inject a degree of fairness into the benefits denial review process have been met with preemption challenges, however. This article contrasts the Court's consistent support for discretionary clauses with the thus-far unanimous support of the federal courts of appeal for the position that states can ban or limit the use of such clauses without running afoul of ERISA's broad preemption language. This paper also evaluates the PPACA's requirement of universal and independent external review and suggests that, at least in the near term, the contested terrain of discretionary clauses will not change significantly.

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 cases involving denial of benefits. This is because *Firestone*, while acknowledging that Congress did not specify a standard of review in civil actions to recover benefits,² 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."³ 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.⁴ While *de novo* review is still technically available—for example, in cases

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in which the plan drafters failed to include a discretionary clause⁵—as a practical matter, plaintiffs in most benefit denial cases are at a huge disadvantage.⁶ Since *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.⁷

In the years following *Firestone*, employee benefit plan administrators in all fifty states quickly inserted discretionary clauses into governing plan documents, which has led many state insurance commissioners to attempt to limit or ban the use of these clauses.⁸ 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 met preemption challenges.⁹ In this respect, ongoing litigation 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 in a way that it believes will rectify ERISA's bias in favor of plan autonomy, after which the plan community and insurers respond with a preemption challenge.¹⁰

In March of 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA)¹¹—sometimes referred to colloquially as “Obama Care.” This statute, together with the Health Care and Education Reconciliation Act that the President signed into law one week later,¹² amended certain provisions of part A of title XXVII of the Public Health Service Act relating to group health plans and health insurance issuers of group and individual coverage.¹³ The Departments of the Treasury, Labor, and Health & Human Services issued interim final regulations in May, June, and July of 2010 that effectively implemented new requirements for group health plans and health insurers in both the group and individual markets.¹⁴ The PPACA also added section 715(a)(1) to ERISA and section 9815(a)(1) to the Internal Revenue Code (IRC) in order to incorporate part A of title XXVII of the Public Health Service Act into ERISA and the IRC.¹⁵ The addition of these sections was intended to make the statutes applicable to group health plans and health insurance providers who offer coverage related to group health plans; however, section 1251 of the PPACA provides that certain “grandfathered plans” or health insurance coverage existing as of the statute's March 2010 enactment are subject to only some of the PPACA's provisions.¹⁶ As we shall see, a plan can lose its grandfathered status if its administrator takes certain affirmative steps or fails to take required actions.¹⁷ Most importantly, all plans are now subject to new, complex external review requirements that depend on whether they are grandfathered and whether they are insured or self-insured.¹⁸

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 that the plan administrator considers during the ERISA-mandated internal review.¹⁹ As of March 2010, if the internal review results in denial, the participant can request an independent external review subject to the applicable state insurance rule²⁰ and the governing plan's status.²¹ If no appropriate state process is available, the participant may resort to the federal external review process.²²

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).²³ Some insured plans were subject to *Rush*-type external review requirements, such as an independent medical review of benefit denials, depending upon applicable state insurance regulations.²⁴ Participants in insured plans could sue to recover promised benefits as well.²⁵

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 appeals 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 term, 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 case²⁶), 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 imposing external review requirements on non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage²⁷ are certain to complicate matters for both plans and claimants.²⁸ Should the Court continue to favor the use of discretionary clauses, the states will once again find themselves in the familiar position of trying to employ devices to regulate ERISA insurance plans that are immune from attack on preemption grounds but that now also have to comply with the requirements of the PPACA.

This paper argues that an independent external review process that would correct and/or avoid the kinds of defects that *Firestone* deference has engendered would be superior to the current regime, which promises a high degree of deference to plan administrators at the occasional expense of

fairness for claimants. It remains to be seen, however, whether the kind of external review mandated by the PPACA interim final regulations will provide both the operational simplicity that plans need and the substantive fairness that claimants hope for.

I. 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.²⁹ 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.”³⁰ 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.³¹

Congress ensured that employee benefit regulation would be “exclusively a federal concern” by enacting “expansive pre-emption provisions” under ERISA § 514.³² 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.”³³ However, Congress retained an exception to § 514(a) by providing in § 514(b)(2)(A) that “[n]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”³⁴ Section 514(b)(2)(A), commonly known as the “savings clause,”³⁵ 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 “[n]either 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.”³⁶ 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.³⁷ Therefore, the deemer clause limits the reach of the savings clause and fortifies ERISA’s pre-emption 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 fiduciary of a benefits claim denial.³⁸

It is not surprising that plan drafters have taken advantage of ERISA's unspecified standard of review regarding 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 of whether state regulations banning discretionary clauses are a valid exercise of the state power to regulate insurance, and whether courts must apply the plan's 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.³⁹ 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."⁴⁰

In *Firestone*, several former Firestone Tire employees sought severance benefits under a termination pay plan after Firestone sold the plants where they worked to Occidental Petroleum Company.⁴¹ 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.⁴² Under the terms of the termination pay plan, a reduction in work was a requirement for severance benefit eligibility.⁴³ 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."⁴⁴

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."⁴⁵ Discretionary clauses require courts to review benefit denials under an abuse of discretion standard.⁴⁶ 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,"⁴⁷ such as an insurance company that acts as payor of benefits and evaluator of benefit claims.⁴⁸ 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.”⁴⁹

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.⁵⁰ Mark DeBofsky has also argued that *Firestone* changed the relationship between insurers and insureds by permitting insurers to include favorable terms in their insurance policies, which deprive benefit claimants of plenary review in the courts.⁵¹ 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.”⁵²

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 the Illinois HMO Act.⁵³ Through her husband, Moran was the beneficiary of an employer-sponsored and ERISA-governed welfare benefit plan.⁵⁴ The plan contracted with Rush to provide medical services to plan participants and their beneficiaries.⁵⁵ The plan also granted Rush the “broadest possible discretion” to determine whether a medical service is covered under the plan as “medically necessary.”⁵⁶

By contrast, the Illinois HMO Act sought to regulate the decision making of health maintenance organizations (HMOs).⁵⁷ The 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.⁵⁸ The Act stated that the HMO “shall provide the covered service” if the independent reviewer determines it to be medically necessary.⁵⁹

Moran’s primary care physician recommended she undergo surgery, but Rush refused to pay for the procedure on the ground that it was not medically necessary.⁶⁰ Rush continued to deny Moran’s claim even after an independent reviewer concluded that the surgery was medically necessary.⁶¹ Moran consequently had the surgery at her own expense and sued Rush in state court under the Illinois HMO Act.⁶² Rush removed the case to federal court, arguing that Moran’s claim for benefits was “completely preempted by ERISA’s civil enforcement provisions.”⁶³ 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 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.”⁶⁴ The Court reasoned that although the Illinois statute precludes deferential review, “this effect of 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.”⁶⁵ 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.”⁶⁶

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.”⁶⁷ The Court noted that there were clear limits on the enforceability of discretionary clauses, as nothing in ERISA permits insurers to “displace any state regulation simply by inserting a contrary term in plan documents. This interpretation would virtually rea[d] the saving clause out of ERISA.”⁶⁸ 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*].”⁶⁹

Notably, the *Rush* Court declined to clarify “the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review.”⁷⁰ The Court found instead that *Rush* did not require an answer to this question.⁷¹ 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 determinations.”⁷² While the Court noted that discretionary clauses are “simply a matter of plan design or the drafting of an HMO contract” and are not required by ERISA,⁷³ it was silent about the extent of judicial deference when a court reviews a discretionary decision of a plan administrator who both funds the plan and evaluates benefit claims.⁷⁴

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.⁷⁵ Respondent Wanda Glenn was employed by Sears and was diagnosed with a heart condition, the symptoms of which included fatigue and shortness of breath.⁷⁶ Glenn also participated in an ERISA-governed long-term disability insurance plan through Sears.⁷⁷ Petitioner MetLife served as the plan administrator and insurer.⁷⁸ The plan granted MetLife discretion to determine eligibility for benefits and to pay valid benefit claims.⁷⁹

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.⁸⁰ MetLife also directed Glenn to a law firm that would help her apply for Social Security benefits.⁸¹ In 2002, an administrative law judge found that Glenn’s disability prevented her from performing any jobs for which she could qualify and which exist “in significant numbers in the national economy.”⁸² As a result, the Social Security Administration granted Glenn permanent disability benefits retroactive to 2000.⁸³ Glenn,

however, kept none of the retroactive benefits because three-quarters went to MetLife to offset its more generous plan benefits, and the rest went to Glenn's lawyers.⁸⁴

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.'"⁸⁵ MetLife refused to extend Glenn's disability benefits because it found that she could perform full-time sedentary work.⁸⁶ Glenn subsequently filed a federal lawsuit challenging MetLife's denial of benefits.⁸⁷ The district court denied relief and Glenn appealed to the Sixth Circuit Court of Appeals.⁸⁸ The Sixth Circuit applied *Firestone* deference in its review because the plan explicitly granted MetLife discretion to determine eligibility for benefits.⁸⁹ The court also treated MetLife's conflict of interest as a relevant factor.⁹⁰

The Sixth Circuit set aside MetLife's denial of benefits because of the conflict of interest and other issues.⁹¹ MetLife sought review before the Supreme Court on the question of whether a plan administrator who evaluates and pays benefit claims operates under a conflict of interest.⁹² 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.⁹³ The Court granted certiorari on both questions.⁹⁴

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.⁹⁵ The first question that 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 in *Firestone*.⁹⁶ The Court determined that the plan administrator was indeed conflicted.⁹⁷ The Court also acknowledged that a conflict of interest exists in the case of an employer who both funds the plan and evaluates benefit claims.⁹⁸ Not surprisingly, then, the Court held that judges must consider an employer's conflict of interest in reviewing discretionary benefit determinations.⁹⁹

MetLife argued that an employer who funds and administers a plan has implicitly approved the resulting conflict of interest.¹⁰⁰ The Supreme Court rejected this argument based on principles of trust law.¹⁰¹ The *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.¹⁰² 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.¹⁰³ 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.¹⁰⁴ MetLife also claimed that to find a conflict of interest violates 29 U.S.C. § 1108(c)(3), permitting employers to administer their own plans.¹⁰⁵ The

Court again rejected MetLife's arguments and concluded that, "taken together, we believe them outweighed by 'Congress's desire to offer employees enhanced protection for their benefits.'"¹⁰⁶

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.¹⁰⁷ Once again, the Court found three reasons for a conflict of interest.¹⁰⁸ First, an employer choosing a plan administrator would typically prefer an insurance company with low rates to one with accurate claims processing;¹⁰⁹ second, ERISA imposes clear duties of care and loyalty on insurers to act in the best interests of plan participants and beneficiaries;¹¹⁰ 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.¹¹¹ Noting that insurers have a strong incentive to provide accurate claims processing because the marketplace punishes companies that offer subpar insurance products,¹¹² the Court suggested this market pressure might reduce "the *significance* or *severity* of the conflict in individual cases."¹¹³

The Supreme Court next examined how judges should account for a conflict of interest in reviewing discretionary benefit determinations.¹¹⁴ 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.¹¹⁵ 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.¹¹⁶ Instead, judges must continue to apply a deferential standard where conflicted trustees make discretionary decisions.¹¹⁷ At the same time, judges must also consider a trustee's conflict of interest in determining if there has been an abuse of discretion.¹¹⁸

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."¹¹⁹ The Court declined to take such an action without more explicit guidance from Congress.¹²⁰ The Court also refused to create special burden-of-proof rules in cases where there is a conflict of interest.¹²¹ Instead, the Court held that conflicts of interest are "but one factor among many that a reviewing judge must take into account."¹²² 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.¹²³ In other instances, a conflict of interest could prove less important because the administrator "has taken active steps to reduce potential bias and to promote accuracy," such as imposing penalties for inaccurate decision-making.¹²⁴ The Supreme Court ultimately affirmed the judgment of the Sixth Circuit Court of Appeals.¹²⁵

In 2010, the high court once again took up discretionary clauses in *Conkright v. Frommert*.¹²⁶ 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.¹²⁷ 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.¹²⁸ 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.¹²⁹ The administrator had general authority under the plan to construe the plan terms.¹³⁰

Respondents challenged the phantom account method in administrative proceedings.¹³¹ After the administrator denied the challenge, respondents sued in federal court under ERISA.¹³² 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.¹³³ 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."¹³⁴

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."¹³⁵ 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."¹³⁶ 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.¹³⁷ Instead, the district court found that the plan was ambiguous and adopted the respondents' approach.¹³⁸ This approach did not account for the time value of money and reduced 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 today."¹³⁹ 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.¹⁴⁰

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.¹⁴¹ However, the Supreme Court found it necessary to address only the first question.¹⁴² 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.¹⁴³ The Court rejected the Second Circuit's rule as having no basis in *Firestone* or in the terms of the plan.¹⁴⁴ *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."¹⁴⁵ Moreover, the Court had recently refused in *Glenn* to create exceptions to the *Firestone* standard, holding that even a systemic conflict of interest does not strip the plan administrator of deference.¹⁴⁶ 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."¹⁴⁷

The *Conkright* Court also looked to principles of trust law, but determined that trust law "is unclear on the narrow question before us."¹⁴⁸ Instead, the Supreme Court found that the guiding principles underlying ERISA resolved the issue in the case.¹⁴⁹ According to the Court, *Firestone* deference protects important Congressional interests relating to employee benefit plans.¹⁵⁰ Deference preserves the balance in ERISA between ensuring enforcement of plan rights and encouraging plan creation.¹⁵¹ Additionally, deference "promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation."¹⁵² Finally, deference protects interests in predictability and uniformity by "helping to avoid a patchwork of different interpretations of a plan, like the one here."¹⁵³ In other words, nothing in *Glenn* or *Conkright* suggests that the Court is losing its enthusiasm for *Firestone* deference. Nonetheless, Justice Breyer dissented sharply from the Court's opinion.¹⁵⁴

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 that 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 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 only indirectly addresses the problem of *Firestone* deference by creating independent external review for all plan participants.¹⁵⁵ The new statute does directly tackle the problem of conflicted decision making by insisting on impartial, external reviewers in benefits denial cases.¹⁵⁶ Whether the post-PPACA reviews will in fact be independent and beyond the scope of insurer influence remains to be seen.

II. 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."¹⁵⁷ The response in many cases was to ban the clauses for insured (but not for self-insured)¹⁵⁸ plans. This response to the near-universal use of discretionary clauses has predictably led to several challenges in the courts of appeals.

In *American Council of Life Insurers v. Ross*, the Sixth Circuit upheld Michigan's ban on discretionary clauses in insurance contracts and policies.¹⁵⁹ 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."¹⁶⁰ 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."¹⁶¹

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.¹⁶² The Sixth Circuit applied the Supreme Court's test in *Kentucky Ass'n of Health Plans, Inc. v. Miller*¹⁶³ to determine whether Michigan's rules regulated insurance under ERISA's savings clause.¹⁶⁴ 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.¹⁶⁵ State laws are directed toward the insurance industry if they regulate "insurers with respect to their *insurance practices*."¹⁶⁶ 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."¹⁶⁷ 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."¹⁶⁸

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.¹⁶⁹ The industry asserted that ERISA preempted state laws that provide a cause of action for plan benefits "outside of, or in addition to, ERISA's remedial scheme."¹⁷⁰ 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."¹⁷¹ 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."¹⁷² The Sixth Circuit rejected this argument as well because 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*.¹⁷³

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.¹⁷⁴ 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.¹⁷⁵ 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 conflict of interest by prohibiting discretionary clauses in the first place.”¹⁷⁶

In *Standard Ins. Co. v. Morrison*, the Ninth Circuit followed the Sixth Circuit’s decision in *Ross* to uphold Montana’s ban on discretionary clauses.¹⁷⁷ The facts in *Morrison* closely resemble those in *Ross*. Montana law required its insurance commissioner to disapprove any insurance form that contained “inconsistent, ambiguous, or misleading clauses . . . which deceptively affect the risk purported to be assumed in the general coverage of the contract.”¹⁷⁸ Montana’s Commissioner of Insurance, John Morrison, interpreted the statute as requiring him to disapprove any insurance contract that contained a discretionary clause.¹⁷⁹ Accordingly, Commissioner Morrison denied Standard Insurance Company’s request for approval of proposed disability insurance forms that contained discretionary clauses.¹⁸⁰ Standard sued in district court and challenged Morrison’s practice as preempted by ERISA.¹⁸¹ The district court granted summary judgment to Morrison and Standard appealed.¹⁸²

The legal issue on appeal was simply whether ERISA preempted Commissioner Morrison’s practice of denying insurance forms with discretionary clauses.¹⁸³ Because Morrison’s practice related to ERISA-governed employee benefit plans, the Ninth Circuit reasoned that the practice is preempted unless it falls under the savings clause pursuant to 29 U.S.C. § 1144(b)(2).¹⁸⁴ The Ninth Circuit applied the two-pronged *Miller* test to determine if Morrison’s disapproval of discretionary clauses came within the reach of the savings clause.¹⁸⁵ The Ninth Circuit found that Morrison’s practice satisfied both requirements and survived ERISA preemption.¹⁸⁶ In reaching this conclusion, the Ninth Circuit rejected each of the following five arguments—two in the first prong and three in the second—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.¹⁸⁷ The Ninth Circuit rejected this argument, finding instead that ERISA plans are also a form of insurance and that Morrison’s practice regulated insurance by limiting the terms that insurance companies could include in their policies.¹⁸⁸ In its holding, the

Ninth Circuit expressly agreed with the Sixth Circuit in *Ross*, which held that rules imposing conditions on an insurer's right to engage in the business of insurance within a particular state are directed toward the insurance industry.¹⁸⁹

Second, Standard suggested that Commissioner Morrison's practice was still not specifically directed toward the insurance industry because it "merely applie[d] 'laws of general application that have some bearing on insurers.'" ¹⁹⁰ 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.¹⁹¹ 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.¹⁹² Montana's prohibition on discretionary clauses "addresse[d] an insurance-specific problem, because discretionary clauses generally do not exist outside of insurance plans."¹⁹³ The Ninth Circuit found Morrison's practice of requiring all insurers to exclude discretionary clauses from their policies to be "an application of a special order" as opposed to a general rule.¹⁹⁴ 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 *Miller* test.¹⁹⁵

Turning to the second prong of the *Miller* test, Standard's third contention was that disapproval of discretionary clauses did not substantially affect the risk pooling arrangement between insurers and insureds.¹⁹⁶ Standard asserted that risk pooling occurs when an insurance contract is made instead of when a claim is made.¹⁹⁷ Consistent with this definition, risk pooling, claim investigations, the appeals process, and litigation should fall outside the risk pooling arrangement.¹⁹⁸ The Ninth Circuit rejected Standard's argument in favor of a broader notion of risk pooling.¹⁹⁹ Specifically, the Ninth Circuit found that Morrison's practice changed the scope of permissible bargains between insurers and insureds because insureds "may no longer agree to a discretionary clause in exchange for a more affordable premium."²⁰⁰ The Court noted that Montana's policy of barring discretionary clauses and "removing the benefit of a deferential standard of review from insurers" would result in more claim payouts because insurers would be forced to explain their claim decisions.²⁰¹ The Court also found that Morrison's practice affected the risk pooling arrangement because it altered the terms "by which the presence or absence of the insured contingency [was] determined."²⁰² The Court finally held that Commissioner Morrison's practice of disapproving discretionary clauses falls under the savings clause and survives ERISA preemption.²⁰³

Fourth, Standard also claimed that Morrison's practice interfered with ERISA's exclusive remedial scheme pursuant to 29 U.S.C. § 1132(a).²⁰⁴ ERISA preempts "any state-law cause of action that duplicates,

supplements, or supplants the ERISA civil enforcement remedy.”²⁰⁵ 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.²⁰⁶ The court acknowledged that this practice would likely lead to *de novo* review in the federal courts, but found no conflict with ERISA because *de novo* had been the default standard of review since the Supreme Court’s decision in *Firestone*.²⁰⁷ The Court thus distinguished Morrison’s disapproval of discretionary clauses from “cases in which a state attempts to meld a new remedy to the ERISA framework.”²⁰⁸

Finally, Standard asserted that Montana’s bar on discretionary clauses contravened the purpose and policy behind ERISA of balancing employees’ right to benefits and incentivizing employers to create benefit plans.²⁰⁹ 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.²¹⁰ 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.”²¹¹

The Ninth Circuit found that the appropriate test was to balance ERISA’s preemption scheme against the state insurance regulation.²¹² The Court noted that the Supreme Court’s refusal to mandate *de novo* review did not necessarily preclude states from issuing insurance regulations that had such effect.²¹³ Additionally, while the Supreme Court in *Firestone* and *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.”²¹⁴ 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 Commissioner Morrison’s practice likewise prohibited insurers from inserting terms into policies that advantaged the insurer.²¹⁵ The Ninth Circuit held that there was no conflict with ERISA and expressly declined to limit the reach of the savings clause.²¹⁶ Nonetheless, the Court acknowledged the tension between Commissioner Morrison’s practice and the federal common law regarding the appropriate standard of review in benefits denial cases.²¹⁷

Finally, the Tenth Circuit recently cited, with approval, the decisions in *Ross* and *Morrison*.²¹⁸ The court distinguished *Ross* and *Morrison* as inapplicable to the facts at hand but agreed with their reasoning.²¹⁹

Verla Hancock participated in an employer-sponsored ERISA-covered

plan that offered life insurance and accidental death and dismemberment (AD&D) benefits.²²⁰ The plan paid AD&D benefits for loss of life if (1) the participant was injured in an accident covered under the plan, (2) the accident was the sole cause of the injury, and (3) death occurred within one year of the accident.²²¹ However, the plan did not cover injuries resulting from physical or mental illness.²²² MetLife was the plan's insurer and claim fiduciary, responsible for resolving benefit claims and reviewing appeals.²²³ The plan granted MetLife discretion to interpret the plan terms and to determine eligibility for benefits.²²⁴ 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."²²⁵ Additionally, Rule 590-218 completely prohibited discretionary clauses in insurance forms that did not relate to an ERISA benefit plan.²²⁶

After Hancock died, MetLife approved the claim of her daughter Terri for life insurance but denied AD&D benefits.²²⁷ MetLife's notification letter explained that Hancock was ineligible for AD&D benefits because the record failed to establish that Hancock's death had been accidental.²²⁸ In 2007, Hancock moved for partial summary judgment in district court on the standard of review and argued that the court should apply *de novo* review to MetLife's denial of AD&D benefits.²²⁹ Hancock asserted that Rule 590-218 deprived MetLife of discretionary authority that would justify a deferential standard of review.²³⁰ MetLife subsequently moved for a bench trial and argued that its denial of benefits was "reasonable and supported by substantial evidence."²³¹

The district court denied Hancock's motion for partial summary judgment on the ground that ERISA preempted Rule 590-218 and ruled that MetLife was entitled to deferential review.²³² The district court also denied Hancock's motion for summary judgment because she failed to show that a covered loss had occurred under the plan.²³³ Finally, the district court granted MetLife's motion and held that MetLife's denial of AD&D benefits was not arbitrary and capricious.²³⁴

On appeal, the Tenth Circuit considered whether *Firestone* deference was warranted.²³⁵ 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 590-218.²³⁶ MetLife argued that ERISA preempts the application of Rule 590-218.²³⁷ 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.²³⁸

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.²³⁹ This meant that Rule 590-218 could apply to an employee benefit plan only if it survived ERISA preemption.²⁴⁰ ERISA preempts any state law that relates to an employee benefit plan unless the law regulates insurance.²⁴¹ 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 insured.²⁴² MetLife did not dispute that Rule 590-218 satisfied the first prong of the *Miller* test.²⁴³ Therefore, the Tenth Circuit's analysis focused on *Miller's* second prong.²⁴⁴

The Tenth Circuit found that ERISA expressly preempted the application of Rule 590-218 to the plan because "[t]he rule [did] not remove the option of insurer discretion from the scope of permissible insurance bargains in ERISA plans."²⁴⁵ Instead, the rule permitted discretionary clauses so long as they conformed to particular wording requirements.²⁴⁶ As such, the rule had no substantial effect on the risk pooling arrangement between the insurer and the insured.²⁴⁷ In short, Rule 590-218 failed to satisfy the second prong of the *Miller* test.²⁴⁸

The Tenth Circuit suggested that the result might have been different had Rule 590-218 prohibited all discretionary clauses.²⁴⁹ 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.²⁵⁰ *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.²⁵¹

Hancock raised several other arguments regarding the effect of Rule 590-218 on the 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 invalidated a discretionary clause and deprived the insurer of deferential review by the courts.²⁵² The Tenth Circuit dismissed *Hancock's* argument as untenable because noncompliance with any trivial requirement would trigger *de novo* review and alter the risk pooling arrangement.²⁵³ The court found that a change in the risk pooling arrangement must result from compliance with the state law rather than its violation.²⁵⁴

Second, *Hancock* asserted that Rule 590-218 limited insurer discretion because the rule required the language in a discretionary clause to state that a federal court would determine the appropriate level of deference to a plan administrator's decision.²⁵⁵ The Tenth Circuit correctly noted that this language merely recognized the extent of the federal courts' authority, even when a plan grants discretionary authority to the administrator,²⁵⁶ and recognized that 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.²⁵⁷

The court next considered whether to apply arbitrary and capricious or *de novo* review in light of Hancock's assertion that MetLife's benefit determination process failed to substantially comply with ERISA regulations.²⁵⁸ Specifically, 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.²⁵⁹ The appellate court rejected both contentions.²⁶⁰ First, it concluded that MetLife's denial letters complied with procedural requirements by stating the reasons and relevant plan provisions justifying the denial of benefits and by describing the information Hancock needed to provide in order to perfect her claim.²⁶¹ In addition, the court determined that MetLife had provided Hancock a full and fair review of her claim because MetLife did not ignore her evidence, but instead merely found it inconclusive.²⁶²

Finally, the court of appeals noted that prior to *Glenn* the presence of a conflict had reduced or withheld deference.²⁶³ Since *Glenn* rejected burden-shifting rules and held that conflicts of interest are but one factor that a reviewing court must take into account,²⁶⁴ 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.²⁶⁵ The court of appeals concluded that "MetLife reasonably decided that Ms. Hancock failed to prove accidental death."²⁶⁶ Although circumstantial evidence indicated that accidental death was a possibility, the autopsy failed to establish any cause of death at all.²⁶⁷ MetLife's reliance on official government conclusions proved that its denial of AD&D benefits had not been arbitrary and capricious.²⁶⁸

B. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 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 participant to pursue an internal appeal through the plan's administrative review process.²⁶⁹ After exhausting the internal appeals procedures a claimant could then pursue a claim for benefits, typically in federal court.²⁷⁰ *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 *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.²⁷¹ 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.²⁷² Section 1001 of the PPACA²⁷³ 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)²⁷⁴ and deems these consumer protections the floor below which an external review process cannot fall. Some states have adopted the NAIC model act; others have not. Some adopting states have followed the model act’s provisions closely; others have not. This means that there is currently a broad range of external review procedures: some states have no procedures in place; others have procedures that vaguely resemble the model act; still others follow the model act closely; others have adopted the model act verbatim.²⁷⁵ In response to this varied landscape, the PPACA “encourages” states to adopt external review procedures that are consistent with NAIC’s standards.²⁷⁶ 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.²⁷⁷

The PPACA external review program is certain to be a jolting change for self-insured plans that are not grandfathered. Instead of an internal process (whose outcome is sometimes affected by the plan’s own financial stake in the outcome), followed by deferential external review,²⁷⁸ self-insured plans now face external review in an explicitly non-deferential forum that is less likely than a federal court (which is bound by *Firestone*) to uphold the plan administrator’s decision. What is less clear is whether the NAIC model of 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 disorders²⁷⁹ 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 game the external review process.

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 subsequently. 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 grandfathered status.²⁸⁰ 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.²⁸¹

Given the importance of grandfathered status, one might expect that

plans will pay close attention to plan design changes or failures to act that endanger this status. 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.²⁸² Over time, and given the upward trajectory of health insurance costs, it is not unreasonable to expect that plans sponsored by small employers will lose grandfathered status more rapidly than those sponsored by large employers, who may be able to withstand upward cost pressure for longer before succumbing to that pressure and amending 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.

Over time, both small and large employers (small quicker than large) 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 that already have an independent external review process closely mirroring 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 that are broadly perceived to be unjust. If it works, this part of Obama Care may mean that 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 appealed from state or federal external review.

C. FIRESTONE DEFERENCE AND DISTRUST

The twin keys to success of the new PPACA external review process will be cost and trust. If, at reasonable cost, the process were widely perceived by the affected parties to be fair and predictable, one would expect to see a significant drop in appeals to the federal courts. This should represent a cost savings for both claimants and plans. A perception that the process is impartial is important. The biggest risk is that insurers will game the process. Imagining that a certain rare and complicated disease has only a handful of qualified reviewers, and that each would like to continue to perform this work for insurers, it is not hard to conceive that the desire to please the insurer and become a repeat player could compromise a reviewer's work.

The emerging litigation—all pre-PPACA (there have been 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 ERISA's expansive preemption language expressly prohibits direct measures.²⁸³ The states resort to devices likely to survive preemption analysis under the savings clause, and

sometimes this strategy succeeds.²⁸⁴ 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 at 29 U.S.C. §1144 (b)] 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 state strategies nor the litigation they invariably trigger 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.²⁸⁵

Repeatedly, 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.²⁸⁶ 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 that are often paid jointly by plan sponsors and employees.²⁸⁷ Recently, a spokesman for American Health Insurance Plans (AHIP) asserted that a ban on discretionary clauses “will result in an increase in costs.”²⁸⁸ However, the Bureau of National Affairs (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.”²⁸⁹

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 that 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 lose their grandfathered status and are forced to justify their adverse decisions to an independent reviewer, all plans—both insured and self-insured—should find themselves on a roughly level playing field irrespective of the state in which they operate.

When asked to comment on the role of discretionary clauses in the decision to sponsor an ERISA plan, lawyers representing plans noted that the clauses provide plan administrators with a fast and inexpensive way to deal with benefits claim litigation when it arises.²⁹⁰ 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 employers to provide more affordable, reliable health care coverage to the employees.²⁹¹

The argument in favor of retaining the *Firestone* deference model and preempting discretionary clause bans is essentially that a ban will prove costly to insurers who, in turn, can be expected to pass these costs on to employers and participants. Although it lacks significant empirical support,²⁹² this argument is not a trivial one. As the recent national discussion about how to provide health insurance for the approximately 47,000,000 uninsured²⁹³ 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 evidence²⁹⁴ that the arbitrary and capricious standard emboldens some insurers, especially those in *Glenn*²⁹⁵-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 it easy to dispose of most of these cases by employing *Firestone* deference.

For now, the Sixth and Ninth Circuits seem willing to risk premium increases and other costs in order to rectify some of the imbalance between insurers and participants. The Tenth Circuit has indicated that it agrees with the conclusion that complete bans are not preempted by ERISA.²⁹⁶ Although it is conceivable that all the federal circuits will adopt the position of *Ross*²⁹⁷ and *Morrison*,²⁹⁸ complete uniformity among the federal courts of appeal in ERISA matters is not common.²⁹⁹ 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 twenty years of *Firestone* deference to disappear easily.

In *Conkright v. Frommert*³⁰⁰ the majority gave no hint that it was concerned with the affects of the now commonplace arbitrary and capricious standard on participants' ability to obtain contractually promised benefits. On the contrary, Justice Roberts explained:

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. *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 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.”³⁰¹

The open empirical question is how a ban on discretionary clauses would affect an employer’s decision of whether 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 *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)³⁰² 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 MetLife in *Glenn*.³⁰³

Claimants 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.³⁰⁴ Understandably, they are typically anxious to receive the benefits for which they contracted, especially in cases involving disability, severe illness and loss of employment.

The only way forward that 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 others³⁰⁵ proposed allowing a claimant to appeal to an independent, non-insurer affiliated board for *de novo* review. The PPACA is arguably the result of that effort, although perhaps not exactly what the Senator had in mind. At the time, some of the details elicited criticism,³⁰⁶ but the basic intuition was sound. The new interim regulations create a more complicated system in which the quality of external review will depend largely 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 efficiency and low cost. A model akin to an arbitration panel,³⁰⁷ 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.

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 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.³⁰⁸ 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 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*, the Ninth Circuit case that uphold Montana's ban on discretionary clauses. 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.³⁰⁹ It may well be that the importance of discretionary clauses will decline if the hard cases are resolved by an 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 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.³¹⁰ 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."³¹¹ 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.

¹ 489 U.S. 101 (1989).

² *Id.* at 108–09 ("Although it is a 'comprehensive and reticulated statute,' *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980), ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations.").

³ *Id.* at 115 (italics added) ("As this case aptly demonstrates, the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue. Consistent with established principles of trust law, we hold that a denial of benefits challenged under 1132(a)(1)(B) 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.").

⁴ D. Andrew Portinga, *OFIS Bans Discretionary Clauses in Insurance Policies*, 1 J. INS. & INDEM. L. 1, 11 (2008) ("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.").

⁵ 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 *21–22 (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 *9 (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).

⁶ 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.” Jo-el J. Meyer, *States Beef Up Bans on “Discretionary Clauses” as Courts Rule Out ERISA Hurdle*, 37 PENS. & BEN. REP. (BNA) 377 (Feb. 16, 2010). Mark DeBofsky has also noted that “[t]he presence of discretionary clauses means that a benefit claimant needs to prove the insurer’s decision was ‘unreasonable, and not merely incorrect.’” *Discretionary Clauses and Insurance*, 25 J. INS. REG. 15 (2006) (quoting *Herzberger v. Standard Ins. Co.*, 205 F.2d 327, 329 (7th Cir. 2000)).

⁷ 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); see also *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); *Nance v. Sun Life Assur. Co. of Can.*, 294 F.3d 1263, 1269–75 (10th Cir. 2002) (holding that Sun Life’s denial of long-term disability benefits to a plaintiff suffering from back pain and depression was not arbitrary and capricious because Sun Life reasonably determined that plaintiff’s conditions were not disabling prior to his termination from employment; and acknowledging that this standard is a “difficult one for a claimant to overcome”).

⁸ At present, 22 states have or are in the process of limiting or banning outright the use of discretionary clauses. Meyer, *supra* note 6.

⁹ ERISA § 514(a) preempts all state laws that relate to an ERISA-governed employee benefit plan. 29 U.S.C. § 1144(a) (2006). 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) (2006). 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) (2006). 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) (“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*.”).

¹⁰ For examples of other attempts by the states to regulate around ERISA, *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); *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001) (holding that ERISA preempted a Washington state law that revoked the designation of a spouse as the beneficiary of a nonprobate asset upon the dissolution of marriage because the law directly conflicted with ERISA's requirement that plans be administered and benefits be paid in accordance with plan documents); *De Buono v. NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 815 (1997) (holding that ERISA did not preempt a New York state law that imposed a tax on medical centers operated by ERISA plans because the law merely burdened the plans' administration and therefore did not "relate to" them within the meaning of ERISA); *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 334 (1997) (holding that ERISA did not preempt a California state law that required contractors on public projects to pay all of their workers the prevailing wage except those workers participating in a state-approved apprenticeship program because the law merely altered the incentives without dictating the choices facing ERISA plans); *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995) (holding that ERISA did not preempt a New York state law that imposed surcharges on hospital bills that were paid by commercial insurance or HMO coverage purchased through an ERISA plan because the law produced only indirect economic effects on ERISA plans and therefore did not "relate to" them within the meaning of ERISA); *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 pregnancy in employee benefit plans); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 526 (1981) (holding 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); *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 546 F.3d 639, 661 (9th Cir. 2008) (holding that ERISA did not preempt the San Francisco Health Care Security Ordinance that imposed healthcare spending requirements on employers because those requirements did not "establish" an ERISA plan or have an impermissible connection with or reference to such 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, 819–20 (8th Cir. 2001) (holding that ERISA preempted parts of the Minnesota Sprinkler Fitter Licensing Law and rules that mandated the standards for an approved apprenticeship program but offered no choice of compliance with either state and federal standards); *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 that prohibited employers who provided any type of medical insurance from reducing or canceling such benefits while an employee was on temporary total disability).

¹¹ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–48, 124 Stat. 119.

¹² Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–52, 124 Stat. 1024.

¹³ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection Affordable Care Act, 75 Fed. Reg. 43,331 (July 23, 2010).

¹⁴ *Id.* at 43,330; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726 (July 19, 2010); Patient Protection and Affordable Care Act; Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37,188 (June 28, 2010); Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538 (June 17, 2010); Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection Affordable Care Act, 75 Fed. Reg. 27,122 (May 13, 2010).

¹⁵ Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 34,539 (June 17, 2010).

¹⁶ *Id.*; Patient Protection and Affordable Care Act of 2010, § 1251; as of this writing, the government has also exempted some non-grandfathered from certain provisions of the Patient Protection and Affordable Care Act (PPACA). Certain health insurance plans and issuers can now obtain waivers from the minimum annual limit requirements under the PPACA through the Health and Human Services Office of Consumer Information and Insurance Oversight. OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, OCIIO SUB-REGULATORY GUIDANCE (OCIIO 2010–1): PROCESS FOR OBTAINING WAIVERS OF THE ANNUAL LIMITS REQUIREMENTS OF PHS ACT SECTION 2711 (2010). The Secretary of Health and Human Services' waiver authority was provided for in the interim final rules relating to annual limits. Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37,188, 37,230 (June 28, 2010).

The interim final rules state: “[d](3) Waiver authority of the Secretary. For plan years (or in the individual market, policy years) beginning before January 1, 2014, the Secretary may establish a program under which the requirements of paragraph (d)(1) of this section relating to annual limits may be waived (for such period as is specified by the Secretary) for a group health plan or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits provided under paragraph (d)(1) of this section if compliance with paragraph (d)(1) of this section would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.” *Id.*

Section (d)(1) in the interim final rules allows group health plans or health insurance issuers offering group or individual health insurance coverage, with respect to plan years beginning after September 23, 2010 and before January 1, 2014, to establish for any individual an annual limit on the dollar amount of benefits, which are “essential health benefits” under section 1302(b) of the PPACA and applicable regulations, as long as the limit does not fall below the amounts specified in the interim final rules. *Id.* Therefore, the Secretary’s waiver authority constitutes an exception to Section (d)(1). For plan or policy years beginning on or after January 1, 2014, however, no annual limits will be permitted except in grandfathered plans. *Id.* at 37, 191.

The interim final rules also provided that “Guidance from the Secretary of Health and Human Services regarding the scope and process for applying for a waiver is expected to be issued in the near future.” *Id.* On September 3, 2010, the Health and Human Services Office of Consumer Information and Insurance Oversight issued a Bulletin which clarified that the waiver process was contemplated largely within the context of “limited benefit” or “mini-med” plans that have annual limits well below the restricted annual limits set out in the regulations and would have trouble complying with the requirements of Section (d)(1). Regardless of the PPACA and the regulations, the low annual limits for these plans would stay in place pursuant to a waiver. Since waivers are issued on a one-year basis, group health plans and health insurance issuers have to reapply for a waiver for each subsequent plan or policy year prior to January 1, 2014, when the waiver practice is set to expire. OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, OCIO SUB-REGULATORY GUIDANCE (OCIO 2010-1): PROCESS FOR OBTAINING WAIVERS OF THE ANNUAL LIMITS REQUIREMENTS OF PHS ACT SECTION 2711 (2010), http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf.

The New York Times reported in October 2010 that the Obama administration had granted at least 30 waivers. Reed Abelson, *Waivers Aim at Talk of Dropping Health Coverage*, N.Y. TIMES, Oct. 7, 2010, at B1. The most recent statistic from the Department of Health and Human Services states that 222 waivers have been granted as of December 3, 2010. U.S. Department of Health & Human Services, *Approved Applications for Waiver of the Annual Limits Requirements of the PHS Act Section 2711 as of December 3, 2010*, http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html.

The HHS Office of Consumer Information and Insurance Oversight issued another clarification of the waiver process in a Bulletin on November 5, 2010. First, group health plans and health insurance issuers who obtain a waiver will have to notify their participants that their plan or policy does not meet the restricted annual limits for essential benefits which are set out in the Interim Final Rules (IFR), and that the plan or issuer has received a waiver of that requirement. Second, in order for issuers to be able to comply with state laws that require, issuers to offer policies with annual limits that are below the minimum requirements established in the Interim Final Rules, a state can now apply for a waiver of the restricted annual limits “on behalf of issuers of state-mandated policies in the

state if state law required the policies to be offered by the issuers prior to September 23, 2010. Although the state may apply on the issuers' behalf, the application must still satisfy the standard established in the IFR that compliance by the issuers would result in a 'significant decrease in access to benefits' or a 'significant increase in premiums.'" Any state waiver applications will be effective retroactively to September 23, 2010. OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, OCIO SUB-REGULATORY GUIDANCE (OCIO 2010—1A) SUPPLEMENTAL GUIDANCE (2010), http://www.hhs.gov/ocio/regulations/11-05-2010annual_limits_waiver_bulletin.pdf.

Finally, certain plans that were granted waivers of the annual limits requirements have also requested an exemption from the PPACA's medical loss ratio ("MLR") provisions. These provisions, which are found in Section 2718 to the Public Health Service Act (PHSA), require issuers of group and individual coverage to submit annual reports to the Secretary of Health and Human Services about the percentage of premiums that the issuer spends on reimbursement for clinical services or improving health care, if the amount of spending doesn't meet the minimal standards for a particular plan year. The MLR requirement will go into effect on January 1, 2011. Mini-med plans have expressed concern about meeting this requirement and the Secretary is expected to issue regulations implementing the MLR provisions and taking into account the special circumstances of mini-med plans. *Id.*

¹⁷ 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. Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 34,562 (June 17, 2010).

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. *Id.* at 34,562–65.

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. *Id.*

Recently, an amendment to the regulations concerning grandfathered group health plans and health insurance issuers has introduced the following changes. A group health plan or any health insurance coverage offered in connection with the group health plan does not cease to have grandfathered status if the plan or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective on or after November 15, 2010, provided that the plan remains in compliance with the other requirements for grandfathered plans. Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70,114, 70,116 (Nov. 17, 2010). However, the amendment does not apply retroactively and if a group health plan or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, the plan loses its grandfathered status. *Id.* at 70,121. Additionally, a group health plan that changes its insurance coverage must provide to the new health insurance issuer documentation of plan terms under its prior health coverage sufficient to determine whether a change causing a loss of grandfathered status has occurred. *Id.* In contrast to group health plans, when health insurance coverage is provided in the individual market, a change in issuers would be considered a change in the health insurance coverage in which the individual was enrolled on March 23, 2010, and the new policy, certificate, or contract of insurance would not be a grandfathered health plan. *Id.* at 70,116.

¹⁸ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,354–58 (July 23, 2010).

¹⁹ 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 *3–17 (7th Cir. 2010).

²⁰ See discussion of *Rush Prudential HMO v. Moran*, *infra* at Section II.B.

²¹ A State external review can take place following either an initial or final benefit denial pursuant to internal claims and appeals procedures. In the event that the State external review process requires exhaustion of internal procedures, such a requirement must not apply if the plan or issuer has waived it; if the plan or issuer is deemed to have exhausted the internal claims and appeals procedures under applicable law (such as by failing to comply with the standards for internal review outlined in the regulations); or if the claimant has applied for expedited external review at the same as applying for an expedited internal appeal. Additionally, the State external review must be based on the plan or issuer's requirements for "medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit." Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,356 (July 23, 2010).

²² *Id.* at 43,357.

²³ 29 U.S.C. § 1132(a)(1)(B) (2006).

²⁴ *Rush Prudential HMO v. Moran*, 536 U.S. 355, 359–61 (2002) ("Section 4-10 of Illinois's Health Maintenance Organization Act, 215 Ill. Comp. Stat., ch. 125, § 4-10 (2000), provides recipients of health coverage by such organizations with a right to independent medical review of certain denials of benefits. . . . [The Illinois HMO Act

provides that] “[e]ach Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient . . . primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.”).

²⁵ See *supra* note 23; see also *Rush*, 536 U.S. 355.

²⁶ KEVIN M. CLERMONT, *PRINCIPLES OF CIVIL PROCEDURE* 127 (2005) (“A showing of a conflict in decisions of the courts of appeals . . . is likely to weigh strongly with the Court as a factor favoring review . . .”); Amanda Frost, *Overvaluing Uniformity*, 94 VA. L. REV. 1567, 1569 (2008) (stating that the Justices’ concern with ensuring uniformity and resolving circuit splits drive the case selection process at the U.S. Supreme Court and account for seventy percent of the Court’s docket).

²⁷ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,354–58 (July 23, 2010).

²⁸ See Langbein, *supra* note 7.

²⁹ 29 U.S.C. § 1002(1) (2006).

³⁰ 29 U.S.C. § 1001(b) (2006).

³¹ 29 U.S.C. § 1132(a)(1)(B) (2006).

³² *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

³³ 29 U.S.C. § 1144(a) (2006).

³⁴ 29 U.S.C. § 1144(b)(2)(A) (2006).

³⁵ *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 365 (2002).

³⁶ 29 U.S.C. § 1144(b)(2)(B) (2006).

³⁷ *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

³⁸ 29 U.S.C. § 1133(2) (2006).

³⁹ See D. Andrew Portinga, *OFIS Bans Discretionary Clauses in Insurance Policies*, 1 J. INS. & INDEM. L. 1, 11 (2008); Henry Quillen, *State Prohibition of Discretionary Clauses in ERISA-Covered Benefit Plans*, 32 J. PENSION PLAN. & COMPLIANCE 67, 69 (2006).

⁴⁰ John Langbein, *supra* note 7, at 1316.

⁴¹ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 105 (1989).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.* at 115.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ Langbein, *supra* note 7, at 1326.

⁴⁹ *Firestone*, 489 U.S. at 115.

⁵⁰ Langbein, *supra* note 7, 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.”).

⁵¹ Mark DeBofsky, *Discretionary Clauses and Insurance*, 25 J. INS. REG. 15, 15 (2006).

⁵² *Id.* (quoting *Herzberger v. Standard Ins. Co.*, 205 F.2d 327, 331 (7th Cir. 2000)).

⁵³ *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 363 (2002).

⁵⁴ *Id.* at 359

⁵⁵ *Id.* at 360.

⁵⁶ *Id.* at 359–60.

⁵⁷ *Id.* at 359

⁵⁸ *Id.* at 361.

⁵⁹ *Id.*

⁶⁰ *Id.* at 360.

⁶¹ *Id.* at 362–63.

⁶² *Id.*

⁶³ *Id.* at 363.

⁶⁴ *Id.*

⁶⁵ *Id.* at 387.

⁶⁶ *Id.*

⁶⁷ *Id.* at 385, n. 16.

⁶⁸ *Id.*

⁶⁹ *Id.* at 386–87.

⁷⁰ *Id.* at 15.

⁷¹ *Id.*

⁷² *Id.* at 385.

⁷³ *Id.* at 386.

⁷⁴ The Supreme Court’s failure to clarify the extent of judicial deference in cases where a plan administrator is conflicted and also enjoys *Firestone* deference resulted in a variety of approaches to this issue in 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).

⁷⁵ *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 108–09 (2008).

⁷⁶ *Id.* at 109.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 109.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ Petition for Writ of Certiorari at 31a, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (No. 06-923) (“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.”).

⁸⁷*Metro.*, 554 U.S. at 109.

⁸⁸*Id.*

⁸⁹ *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”).

⁹⁰*Metro.*, 554 U.S. at 110.

⁹¹ *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 consideration 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.”).

⁹² *Metro.*, 554 U.S. at 110.

⁹³ Brief for the United States as Amicus Curiae Supporting Respondent at 2, *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.”).

⁹⁴*Metro.*, 554 U.S. at 110.

⁹⁵ *Id.* at 111.

⁹⁶ *Id.* at 112.

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *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.”).

¹⁰⁰ Transcript of Oral Argument at 55, *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”); Brief for Petitioners 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.”).

¹⁰¹ *Metro.*, 554 U.S. at 112.

¹⁰² *Id.* at 113.

¹⁰³ Reply Brief for Petitioners 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.”).

¹⁰⁴ Brief for Petitioners 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.”).

¹⁰⁵ *Metro.*, 554 U.S. at 113 (“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).”).

¹⁰⁶ *Id.* at 114.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 114–15.

¹⁰⁹ *Id.* at 114 (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).

¹¹⁰ *Metro.*, 554 U.S. at 115.

¹¹¹ *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.”).

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Metro.*, 554 U.S. at 115.

¹¹⁵ *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.’”).

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 116.

¹²⁰ *Metro.*, 554 U.S. at 116 (“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.

¹²¹ *Id.*; 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 (2008) (“*Met Life*”), our sliding scale approach is no longer tenable.”).

¹²² *Metro.*, 554 U.S. at 116.

¹²³ *Id.* at 117 (“We believe that *Firestone* means what the word ‘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.”).

¹²⁴ *Id.*

¹²⁵ *Id.* at 119 (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).

¹²⁶ *Conkright v. Frommert*, 130 S. Ct. 1640, 176 L. Ed. 2d 469 (2010).

¹²⁷ *Id.* at 1645.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.* at 1647.

¹³¹ *Id.* at 1645.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*; *Frommert v. Conkright*, 433 F.3d 254, 265–66 (2d Cir. 2006), rev’d, 130 S. Ct. 1640 (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.”).

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Frommert v. Conkright*, 472 F. Supp. 2d 452, 456–58 (W.D. N.Y. 2007).

¹³⁹ *Conkright v. Frommert*, 130 S. Ct. 1640 at 1645.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.* at 1651–52 (“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.

¹⁴³ *Id.* at 1646.

¹⁴⁴ *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 430–31 (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* . . .”).

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* at 1646–47 (“[*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. . . . ([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. *See* *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.

¹⁴⁷ *Id.* at 1647.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 1648–49 (“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 (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 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (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).”).

¹⁵⁰ *Id.* at 1649.

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *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.’”).

¹⁵⁴ *Id.* at 1652–61 (Breyer, J., dissenting) (In his dissent, which Justices Stevens and Ginsburg joined, 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 the Court committed a second error by affirming the district court’s acceptance of 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 neither the 1989 plan nor the 1989 Summary Plan Description said anything about the “phantom account” method. 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. The court of appeals instructed the district court to “employ equitable principles when determining the appropriate [benefit] calculation and fashioning the appropriate remedy.” On remand, the district court determined that the appropriate remedy was to subtract out

the amount of 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 a third mistake in *Conkright*. Citing *Firestone*, the Court stated that trust law governs the standard of review 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 they will exercise that discretion in all instances." 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. 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. The district court initially found that the plan administrator abused his discretion by using the "phantom account" method to adjust the participant-respondents' benefits. 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. Justice Breyer concluded that the district court reasonably could have found it necessary to rely on its own remedial authority under the circumstances. Unlike the majority in *Conkright*, Justice Breyer would have relied on the principles of trust law to answer the question of whether the district court was required to defer to the plan administrator's alternative interpretation of the plan terms.

Besides disagreeing with the *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. 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. 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 weight to give to a plan administrator's remedial opinion" on review.

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. He reasoned that answering this question would depend "on how one characterizes the Court of Appeals' decision." 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 *Firestone* would be *de novo*. 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 would be abuse of discretion. The district court's 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. As such, Justice Breyer stated that it was appropriate for the court of appeals to review the district court's decision for abuse of discretion. 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).

¹⁵⁵ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,354–58 (July 23, 2010).

¹⁵⁶ *Id.* at 43,352–54.

¹⁵⁷ Quillen, *supra* note 39, at 71.

¹⁵⁸ *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.” *Id.* at 61.

¹⁵⁹ Am. Council of Life Insurers v. Ross, 558 F.3d 600, 602 (6th Cir. 2009).

¹⁶⁰ *Id.* at 603.

¹⁶¹ *Id.* at 602.

¹⁶² *Id.* at 604–05.

¹⁶³ Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 334 (2003).

¹⁶⁴ *Ross*, 558 F.3d at 605.

¹⁶⁵ *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].’”).

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 606–07 (“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 company the conditions under which it must pay for the risk it has assumed.’ *Miller*, 538 U.S. at 339 n.3. We therefore conclude that the rules regulate

insurance because they substantially affect the risk-pooling arrangement between insureds and insurers. As such, the rules fall within the scope of ERISA's savings clause.”).

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 607–08 (“Even if a state law regulates insurance such that it falls within ERISA’s savings clause, it may nevertheless be preempted by that statute’s § 502(a) civil enforcement provisions. In relevant part, § 502(a) allows an ERISA plan participant or beneficiary to file a civil action ‘to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.’ 29 U.S.C. § 1132(a)(1)(B). Accordingly, ERISA’s civil enforcement provisions are the ‘sort of overpowering federal policy that overrides a statutory provision designed to save state law from being preempted.’ *Rush Prudential*, 536 U.S. at 375. In *Aetna Health*, 542 U.S. at 217–18, the Supreme Court explained that ERISA’s savings clause does not obviate the need for conflict preemption analysis, stating: ERISA § 514(b)(2)(A) must be interpreted in light of the congressional intent to create an exclusive federal remedy in ERISA § 502(a). Under ordinary principles of conflict preemption, then, even a state law that can arguably be characterized as ‘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. However, there is no state-law claim at issue in this case that implicates ERISA’s civil enforcement provisions. The rules do not authorize any form of relief in state courts, either expressly or impliedly; they do not grant a plan participant the ability to ‘recover benefits under the plan, enforce his rights under the plan, or otherwise clarify his rights to future benefits under the terms of the plan.’ 29 U.S.C. § 1132(a)(1)(B). Put simply, the rules do not create, duplicate, supplant, or supplement any of the causes of action that may be alleged under ERISA. Nor is there any evidence that the rules serve as an alternative enforcement mechanism, outside of ERISA’s civil enforcement provisions such that the rules permit a plan beneficiary to assert a claim that could otherwise be asserted under ERISA. *Briscoe*, 444 F.3d at 498. The rules at most may affect the standard of judicial review if, and when, such a claim is brought before a court. Accordingly, Michigan’s rules do not conflict with ERISA’s civil enforcement provisions; thus, they are not removed from ERISA’s savings clause on this basis.”).

¹⁷² *Id.* at 608.

¹⁷³ *Id.* at 608–09.

¹⁷⁴ *Id.* at 609.

¹⁷⁵ *Metro.*, 554 U.S. at 116.

¹⁷⁶ *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 609 (6th Cir. 2009). (“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.”).

¹⁷⁷ *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009), *cert. denied* 78 U.S.L.W. 3667 (May 17, 2010).

¹⁷⁸ *Id.* at 840.

¹⁷⁹ *Id.* at 840–42.

¹⁸⁰ *Id.* at 841.

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.* at 842.

¹⁸⁵ *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).

¹⁸⁶ *Id.* at 849.

¹⁸⁷ *Id.* at 842.

¹⁸⁸ *Id.*

¹⁸⁹ *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 605⁴); *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 (‘[The laws] regulate [] insurance by imposing conditions on the right to engage in the business of insurance.’)”).

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.* at 843.

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 844.

¹⁹⁵ *Id.* at 842–44 (“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.’ *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.”).

¹⁹⁶ *Id.* at 844.

¹⁹⁷ *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.’ *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. 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. *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.”).

¹⁹⁸ *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 *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.

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 844–45 (“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.”).

²⁰¹ *Id.* at 845.

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.* at 846.

²⁰⁵ *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)).

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *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 pre-empted.’ *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).

²⁰⁹ *Id.* at 847.

²¹⁰ *Id.*

²¹¹ *Id.* (quoting *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350 (2008)).

²¹² *Id.* (“[W]e must balance ERISA’s preemptive scope with its ‘antiphonal’ acceptance of state insurance regulation. *Rush Prudential*, 536 U.S. at 364.”).

²¹³ *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 create a system of universal de novo review does not necessarily mean that states are categorically forbidden from issuing insurance regulations with such effect. After all, the states have retained power to institute quite a number of rules affecting ERISA plans pursuant to their savings clause powers. *See, e.g., Kentucky Ass’n*, 538 U.S. at 329; *Rush Prudential*, 536 U.S. at 355; *UNUM Life*, 526 U.S. at 358; *Metro. Life*, 471 U.S. at 724”).

²¹⁴ *Id.* at 847–48.

²¹⁵ *Id.* at 848

²¹⁶ *Id.* at 848–49.

²¹⁷ *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.”).

²¹⁸ *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141 (10th Cir. 2009).

²¹⁹ *Id.* at 1149.

²²⁰ *Id.* at 1144.

²²¹ *Id.*

²²² *Id.*

²²³ *Id.*

²²⁴ *Id.* (“[T]he Plan grant[ed] 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.’”).

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.* at 1143–44 (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).

²²⁸ *Id.* at 1144–45 (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).

²²⁹ *Id.*

²³⁰ *Id.* at 1145.

²³¹ *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.)

²³² *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.”).

²³³ *Id.*

²³⁴ *Id.*

²³⁵ *Id.* at 1145–46.

²³⁶ *Id.* at 1146.

²³⁷ *Id.*

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ *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.”).

²⁴¹ *Id.*

²⁴² *Id.* (quoting *Ky. Ass’n of Health Plans v. Miller*, 538 U.S. 329, 342 (2003)).

²⁴³ *Id.*

²⁴⁴ *Id.* (“MetLife does not dispute that Rule 590-218 satisfies *Miller*’s first prong. We therefore turn to prong two.”).

²⁴⁵ *Id.* at 1149.

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Id.* at 1149.

²⁴⁹ *Id.* (“If Rule 590-218 imposed a blanket prohibition on the use of discretion-granting clauses, we would have a different case.”).

²⁵⁰ *Id.*

²⁵¹ *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.”).

²⁵² *Id.* at 1149–50.

²⁵³ *Id.* (“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 *Miller* so broadly.”).

²⁵⁴ *Hancock*, 590 F.3d at 1150 (“The change in risk pooling must result from *compliance* with the state law, not its *violation*.”).

²⁵⁵ *Id.*

²⁵⁶ *Id.*

²⁵⁷ *Id.* at 1150–51 (*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 language must be a reference to the extent of judicial deference to the plan administrator and not the materials a court may consider. Hancock also asserted at oral argument that the rule’s safe-harbor provision only applies if the insurance company is the plan administrator. The Tenth Circuit rejected Hancock’s argument because the rule plainly reserves discretion to the plan administrator *or* the insurance company acting as a plan administrator. The Court refused to interpret the safe-harbor provision in a way that would render the term “plan administrator” redundant. The Court reiterated its holding that ERISA preempts Rule 590-218 because the rule has no substantial effect on risk pooling and fails to qualify as a law regulating insurance. The Court held that MetLife’s discretionary clause was valid.)

²⁵⁸ *Id.*

²⁵⁹ *Id.*

²⁶⁰ *Id.* at 1153.

²⁶¹ *Id.*

²⁶² *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. 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.”).

²⁶³ *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.

²⁶⁴ *Id.*

²⁶⁵ *Id.*

²⁶⁶ *Id.* at 1156.

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ See generally Employee Retirement Security Act of 1974, Pub. L. No. 93-406, §503, 88 Stat 829, 893 (1974).

²⁷⁰ *Id.* at § 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B) (2006).

²⁷¹ In *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.

²⁷² As one might expect, there are a number of ways in which a plan can lose its grandfathered status.

²⁷³ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119.

²⁷⁴ 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)*, 2010, at <http://www.medill-employee-benefits.com/display.asp?displayID=Fall2010SS.pdf>. “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.”

²⁷⁵ 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. *Administration Issues Rules Strengthening Health Plan Coverage Appeals Process*, 37 PENS. & BEN. REP. (BNA) No. 29 at 1628. July 27, 2010.

²⁷⁶ Section 2719 of the Public Health Service Act, as amended by Section 1001 of the Patient Protection and Affordable Care Act, requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide an external review process that, “at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans.” Patient Protection and Affordable

Care Act, § 1001. Plans and issuers must comply with the applicable State or Federal external review process. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,330, 43,356 (July 23, 2010).

Generally, if a State external review process that applies to and is binding on an issuer offering group health insurance coverage includes “at a minimum the consumer protections in the NAIC Uniform Model Act, then the issuer must comply with the applicable State external review process and is not required to comply with the Federal external review process” that is set forth in the regulations. *Id.* Group health plans do not have to comply with either the State or Federal external review process to the extent that the benefits they offer are provided through group health insurance coverage. *Id.* However, if a group health plan offers benefits other than through health insurance coverage (e.g. if the plan is self-insured) and is subject to a State external review process that is not preempted by ERISA and includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan must comply with the applicable State external review process and is not required to comply with the Federal external review process. *Id.* The Department of Health and Human Services will determine whether the applicable State external review process contains all the minimum consumer protections in the NAIC Uniform Model Act. *Id.* Minimum standards for State external review processes include, among others, effective written notice to participants about their rights to external review, shifting the cost of an independent review organization (IRO) onto the plan or issuer against whom a request for external review is filed, random IRO assignment, exclusion of IROs with conflicts of interest, and no minimum claim threshold for the claim to be eligible for external review. *Id.* at 43,356–57.

²⁷⁷ If a plan or issuer does not have to comply with a State external review process, then the plan or issuer must comply with the federal external review process that is set forth in the regulations. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,357 (July 23, 2010).

²⁷⁸ See *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 111 (2008) (“Where the plan provides to the contrary by granting ‘the administrator or fiduciary *discretionary authority* to determine eligibility for benefits,’ *Firestone*, 489 U.S. at 115 (emphasis added), ‘[t]rust principles make a *deferential standard* of review appropriate,’ . . .”); *Holmstrom v. Metro. Life Ins. Co.*, 615 F.3d 758, 766 (7th Cir. 2010) (“Judicial review of an ERISA administrator’s benefits determination is *de novo* unless the plan grants the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Firestone*, 489 U.S. at 115 (1989). When the administrator has such discretionary authority, as the vast majority now do, the court applies a more deferential standard, seeking to determine only whether the administrator’s decision was ‘arbitrary and capricious.’ . . . The plan here provided such discretionary authority, so we review under the arbitrary-and-capricious standard.”).

²⁷⁹ See *Holmstrom v. Metro. Life Ins. Co.*, 615 F.3d 758, 761–62 (7th Cir. 2010) (“This case illustrates the difficult problems presented by claims for disability insurance by people with serious and painful conditions that do not have objectively measurable symptoms. Plaintiff Lanette Holmstrom . . . participated in an employee welfare benefit plan administered by defendant Metropolitan Life Insurance Company (‘MetLife’). . . . In late 1999, Holmstrom sought the care of Dr. Eric Lomax to treat pain, numbness, and tingling she experienced in her right upper arm. In January 2000, Holmstrom had surgery to remedy a right ulnar nerve compression and neuropathy. The surgery provided little relief, and her symptoms soon worsened. In June 2000, she had another surgery to relieve what was thought to be nerve compression. Her symptoms worsened further after this

second procedure, prompting her to visit a pain clinic. The clinic doctors diagnosed CRPS Type I, a chronic neurological syndrome characterized by severe pain. In March 2002, Holmstrom underwent a third surgery, which also failed to relieve her symptoms. She saw another pain specialist, Dr. Weber. According to MetLife's records, Dr. Weber 'made a definitive diagnosis of . . . complex regional pain syndrome.' It was clear to Holmstrom and her doctors that surgery could do nothing to help her, leaving medication as her only recourse. Holmstrom's pain medication regimen has included a variety of powerful drugs, including Amitriptyline, Bextra, Clonidine, methadone, MS Contin, MSIR, Neurontin, Oxycontin, Oxycodone, Oxyfast, Percocet, Topamax, and (prior to its recall) Vioxx. Holmstrom's symptoms persisted without improvement for the next three years. MetLife's records from 2003 describe a 'high pain med[ication] regimen' causing side effects such as confusion and memory loss, and pain of such intensity that Holmstrom was 'considering having nerve severed since all other kinds of pain management techniques have failed.' The record reveals no improvement through 2004 and 2005. Dr. Ted Vant, who has been Holmstrom's treating physician from 2004 to the time of this lawsuit, prescribed significant doses of strong medications in an attempt to manage her symptoms."').

²⁸⁰ Interim Final Rules on Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 34,562–65 (June 17, 2010).

²⁸¹ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,330, 43,354 (July 23, 2010).

²⁸² Interim Final Rules on Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 35,564–65 (June 17, 2010).

²⁸³ "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 U.S.C.S. § 1003(a)] and not exempt under section 4(b) [29 U.S.C.S. § 1003(b)]." 29 U.S.C. § 1144(a) (2010).

²⁸⁴ Ky. Ass'n of Health Plans v. Miller, 538 U.S. 329 (2003).

²⁸⁵ Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 364–65 (2002).

²⁸⁶ *Id.* at 402 (Thomas, J., dissenting).

²⁸⁷ *Id.* ("For the reasons noted by the Court, independent review provisions may sound very appealing. Efforts to expand the variety of remedies available to aggrieved beneficiaries beyond those set forth in ERISA are obviously designed to increase the chances that patients will be able to receive treatments they desire, and most of us are naturally sympathetic to those suffering from illness who seek further options. Nevertheless, the Court would do well to remember that no employer is required to provide any health benefit plan under ERISA and that the entire advent of managed care, and the genesis of HMOs, stemmed from spiraling health costs. To the extent that independent review provisions such as 4-10 make it more likely that HMOs will have to subsidize beneficiaries' treatments of choice, they undermine the ability of HMOs to control costs, which, in turn, undermines the ability of employers to provide health care coverage for employees. As a consequence, independent review provisions could create a disincentive to the formation of employee health benefit plans, a problem that Congress addressed by making ERISA's remedial scheme exclusive and uniform. While it may well be the case that the advantages of allowing States to implement independent review requirements as a supplement to the remedies currently provided under ERISA outweigh

this drawback, this is a judgment that, pursuant to ERISA, must be made by Congress. I respectfully dissent.”).

²⁸⁸ *States Beef Up Bans on “Discretionary Clauses” as Courts Rule Out ERISA Hurdle*, 37 PENS. & BEN. REP. (BNA) No. 7, at 377, (February 16, 2010). Since passage of the PPACA, a spokesperson for America’s Health Insurance Plans (AHIP) said that health plans “have a long track record of supporting third-party review to give patients greater peace of mind about their health care coverage.” *Administration Issues Rules Strengthening Health Plan Coverage Appeals Process*, 37 PENS. & BEN. REP. (BNA) No. 29, at 1628 (July 27, 2010).

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ *Id.*

²⁹² “Private-sector employees contributed \$79.5 billion to employment-based private health insurance premiums in 2000, up from \$22.8 billion in 1987.” *See Employer Spending on Health Care: 1987–2000*, Employee Benefits Research Institute, <http://www.ebri.org/publications/facts/index.cfm?fa=1202fact> (last visited July 19, 2010).

²⁹³ Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica Smith. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* at 18 (2007), <http://www.census.gov/prod/2007pubs/p60-233.pdf>.

²⁹⁴ *See* John Langbein, *supra* note 7, at 1324 (2007).

²⁹⁵ *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 (3d Cir. 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.”).

²⁹⁶ *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. *See Standard Ins. Co. v. Morrison*, 584 F.3d 837, 840, 844–45 (9th Cir. 2009) (*Miller* prong two is satisfied by Montana’s practice of disapproving all insurance forms containing discretion-granting clauses); *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 606–07 (6th Cir. 2009) (Michigan’s prohibition on discretion-granting clauses satisfies *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.”).

²⁹⁷ *Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009)

²⁹⁸ *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009), *cert. denied* 78 U.S.L.W. 3667 (May 17, 2010).

²⁹⁹ *See Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 128 S. Ct. 2343, 2351 (2008). The Supreme Court in *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.

³⁰⁰ *Conkright v. Frommert*, 130 S. Ct. 1640, 176 L. Ed. 2d 469 (2010).

³⁰¹ *Conkright*, 130 S.Ct. at 1649 (citations omitted).

³⁰² *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).

³⁰³ *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, (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.

³⁰⁴ John Langbein, *supra* note 7, at 1318–19 (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.”).

³⁰⁵ Henry Quillen, *State Prohibition of Discretionary Clauses in ERISA-Covered Benefit Plans*, J. PENSION PLAN. & 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 *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.”).

³⁰⁶ *Id.* 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 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.”).

³⁰⁷ *Ford v. Lehman Bros.*, No. H-07-2693, 2007 U.S. Dist. LEXIS 92848, at *18 (S.D. Tex. Dec. 18, 2007) (granting the defendant’s motion to compel arbitration in an employment law case); *Millar v. Reliastar Life Ins. Co.*, 157 F. Supp. 2d 645, 657 (W.D.N.C. 2000) (granting the defendant’s motion to compel arbitration in an insurance dispute); William L. Corbett, *Arbitrating Employment Disputes*, 68 MONT. L. REV. 415, 416 (2000) (noting the substantial increase in the use of arbitration to resolve employment disputes).

³⁰⁸ *States Beef Up Bans on “Discretionary Clauses” as Courts Rule Out ERISA Hurdle*, 37 PENS. & BEN. REP. (BNA) No. 7, at 377, (February 16, 2010).

³⁰⁹ *Standard of Review: Supreme Court Declines to Review Ruling Allowing State Ban on Discretionary Clauses*, 37 PENS. & BEN. REP. (BNA) No. 21, at 1214 (May 25, 2010).

³¹⁰ *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 609 (6th Cir. 2009).

³¹¹ *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 120 (2008). (Roberts, C.J., concurring).