
**CONFLICT OF INTEREST AND THE STANDARD OF
REVIEW IN ERISA CASES: THE SEVENTH
CIRCUIT'S REFUSAL TO ACKNOWLEDGE
WHAT OTHER CIRCUITS ALREADY KNOW.**

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INTRODUCTION

The Employee Retirement Income Security Act (“ERISA”)¹ was enacted by Congress to “promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits.”² While perhaps best known as the “pension reform law,” ERISA litigation for benefits under employee welfare plans now constitutes the largest category of ERISA litigation.³ For employees, the stakes in such litigation are high: denial of medical care, disability benefits, severance pay, accident and life insurance, and a variety of

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¹ Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* (2000). Citation hereafter is to ERISA § numbers rather than to U.S.C. numbers.

² *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (citations and internal quotation marks omitted). “Employee benefit plans” include both pension and welfare plans. ERISA § 1002(3).

³ See John Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 208 (1990) (discussing how the *Firestone* decision is of great practical importance for employee welfare plans).

other contractual entitlements.⁴ Particularly in the area of disability benefits, employees – and indeed much of this country - depend upon private insurers to carry out the essential public function of ensuring that disability does not lead to poverty.⁵

But the stakes for the companies sponsoring unfunded plans (i.e., plans that are not funded through the establishment of a trust), are also high, because whenever benefits are paid, the money comes directly out of the company's own revenue.⁶ This profit motive creates a strong incentive for private insurers to cut costs by denying valid claims.⁷ It is easy to see, therefore, that where a company sponsoring an unfunded plan is also empowered to administer and thus make claims decisions under the plan, the company is faced with an inherent conflict of interest in approving or denying a given claim.⁸

This Comment will focus on how, in defiance of the Supreme Court's dictate in *Firestone Tire & Rubber Co. v. Bruch*, and contrary to the wisdom of nearly every other circuit court of appeals, the Seventh Circuit has failed to account for this conflict of interest when formulating its standard of review. Part I of this Article examines the background and legal basis of the *Firestone* decision. Part II follows

⁴ ERISA broadly defines “employee welfare plan[s]” or “welfare plan[s]” to include any “plan, fund or program which ... was established or is maintained for the purpose of providing for its participants or their beneficiaries, though the purchase of insurance or otherwise, (A) medical surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacations benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services....” ERISA § 1002(J) (2000).

⁵ See *Radford Trust v. First Unum Life Insur. Co. of Am.*, 321 F. Supp. 2d 226, 240 (D. Mass. 2004).

⁶ Although ERISA requires employers to fund employee pension plans through the establishment of a trust or through the purchase of insurance, the statute specifically exempts employee welfare plans from these funding requirements. ERISA § 1081(a)(1).

⁷ See *Radford*, 321 F. Supp. 2d at 240.

⁸ The ERISA statute itself gives rise to this conflict by providing that employers may appoint their own officers to administer ERISA plans even if the company is a “party in interest,” in conjunction with exempting employee welfare plans from its funding requirements. ERISA § 1108(c)(3) (2000).

the Seventh Circuit's evolution towards its current approach to the conflict of interest issue, with a focus on how its standard solidified in the past year. Part III critiques the various rationales offered by the Seventh Circuit in support of its decisions, and Part IV suggests how an inherent conflict of interest should be acknowledged and taken into account by reviewing courts.

*I. The Supreme Court Addresses the Question Left Open by ERISA:
What is the Applicable Standard of Review for Claims
Determinations?*

The ERISA statute affords every participant and beneficiary of employee benefit plans the right to bring suit “to recover benefits due to him under the terms of the 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.”⁹ The ERISA statute further specifies that in accordance with regulations of the Secretary, every employee plan shall:

- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for the denial, written in a manner calculated to be understood by the participant, and
- (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.¹⁰

Notably absent from the statute, however, is any indication as to what standard of review courts should use when reviewing the decision of a plan administrator to deny benefits.¹¹ Instead, the courts were

⁹ ERISA § 1132(a)(1)(B) (2000).

¹⁰ ERISA § 1133 (2000).

¹¹ *Firestone*, 489 U.S. at 109.

instructed to develop a “federal common law of rights and obligations under ERISA-regulated plans.”¹²

By the late 1980s, the overwhelming majority of courts, including the Seventh Circuit, were using the extremely deferential “arbitrary and capricious” standard of review.¹³ The courts differed greatly, however, as to how to apply the standard in cases where there is a conflict.¹⁴ In 1989, the Supreme Court finally granted certiorari to provide guidance on this important issue.¹⁵

In *Firestone Tire & Rubber Co. v. Bruch*, a group of plaintiffs sued their employer for wrongfully terminating benefits under an unfunded plan.¹⁶ Applying the labor law “arbitrary and capricious” standard, the district court upheld the employer’s decision to deny benefits.¹⁷ The Third Circuit reversed, finding that de novo review is the proper standard where the employer is both the fiduciary and administrator of an unfunded plan.¹⁸ The court held that “[t]he

¹² *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

¹³ Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 Am. U. L. Rev. 1083, 1109-119 (2001). For the purposes of this Comment, the terms “deferential review,” “arbitrary and capricious,” and “abuse of discretion” will be used interchangeably. Most courts find that these terms are a “distinction without a difference.” *Chambers v. Family Health Plan Corp.*, 100 F.3d 818 (10th Cir. 1996) (citing *Cox v. Mid-America Dairymen, Inc.*, 965 F.2d 569, 572 n.3 (8th Cir. 1992)). Courts adopted this standard from 29 U.S.C. § 186(c), a provision of the Labor Management Relations Act of 1947. *Firestone*, 489 U.S. at 109. The Seventh Circuit will uphold a plan administrator’s decision under the “arbitrary and capricious” standard as long as: (1) “it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome,” (2) the decision “is based on a reasonable explanation of relevant plan documents,” or (3) the administrator “has based its decision on a consideration of the relevant factors that encompass the important aspects of the problem.” *Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund*, 900 F.2d 1138, 1142-43 (7th Cir. 1990) (internal citations omitted).

¹⁴ See Kennedy, *supra* note 13. at 1110 n.141. (collecting cases).

¹⁵ *Firestone*, 489 U.S. 101 at 108.

¹⁶ *Id.* at 105.

¹⁷ *Firestone Tire & Rubber Co. v. Bruch*, 640 F.Supp. 519, 522 (E.D. Pa. 1986).

¹⁸ *Firestone Tire & Rubber Co. v. Bruch*, 828 F.2d 134, 145 (3rd Cir. 1987).

principles of trust law instruct that when a trustee is thought to have acted in his own interest and contrary to the interest of the beneficiaries, his decisions are to be scrutinized with the greatest possible care.”¹⁹

Affirming the specific holding of the lower court, the Supreme Court held that the standard of review is *de novo*, “*unless* the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”²⁰ Explaining the standard, the Court stated that “[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers.”²¹ In so doing, the Supreme Court adopted a significantly different rationale than the Third Circuit, focusing on whether the plan administrator retained discretionary powers, rather than whether the plan administrator was impartial.²² As a result of this holding, plan sponsors simply needed to add boilerplate language to its policies conferring discretion to secure deferential review by the courts.²³ As many legal scholars predicted, companies quickly seized upon this opportunity.²⁴

¹⁹ *Id.* at 145.

²⁰ *Firestone*, 489 U.S. at 111.

²¹ *Id.* A discussion of how the *Firestone* decision misapplied trust principles is outside the scope of this Comment; however, much commentary has already been devoted to this topic. See e.g., John Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 208 (1990) (noting that unfunded plans are different in a crucial respect from other trusts: there is no neutral fiduciary in ERISA plans, because the employer “has continuing economic interests in the plans that it sponsors.”); Donald Bogan, 38 J. MARSHALL L. REV. 629 (2004), *ERISA: Re-Thinking Firestone in light of great-west—implications for standard of review and the right to a jury trial in welfare benefit claims*, (“[F]ederal courts continue to overlook the fundamental premise that unfunded and insured ERISA plans are not trusts.”)

²² *Firestone*, 489 U.S. at 115.

²³ The National Association of Insurance Commissioners (NAIC) enacted Model Act #42, which prohibits these sorts of discretionary clauses in health and disability policies. To date, Illinois and California have both adopted this law. 29 Ill. Reg. 10172 (July 15, 2005); California Insurance Code § 10291.5(f). As one commenter noted, states that adopt Model Act #42 “significantly assist ERISA plan

But even in situations where a company has reserved such discretion, *Firestone* left open the possibility that conflict or bias could affect the standard of review.²⁵ The Court stated in dicta that while a deferential standard of review is appropriate when a trustee exercises discretionary powers, “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, *that conflict must be weighed as a ‘factor in determining whether there is an abuse of discretion.’*”²⁶

Courts have taken a variety of different approaches to giving effect to this statement in the context of unfunded plans.²⁷ As the Third Circuit Court of Appeals aptly noted in *Pinto v. Reliance Standard Insurance Co.*, “[s]ince *Firestone*, courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator’s decision to deny benefits.”²⁸ Of all the circuit courts of appeals, the Seventh Circuit has distinguished itself by refusing to both acknowledge that a significant inherent conflict exists, and in turn provide for an adjusted standard of review when such a conflict is shown.²⁹

participants in gaining an equal footing with ERISA plan insurers in disputes arising from insured ERISA benefits plans.” Bogan, *supra* note 21, at 740.

²⁴ See *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 383 n.2 (3rd Cir. 2000) (remarking that Professor Langbein, in his article, *supra* note 21 at 217, accurately predicted that plan sponsors would quickly add grants of discretion to their plans and that “problems of how courts should deal with conflicted fiduciaries would resurface”).

²⁵ *Firestone*, 489 U.S. at 115.

²⁶ *Id.* (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)) (emphasis added).

²⁷ See *infra* Section IV, discussing these various approaches.

²⁸ *Pinto*, 214 F.3d at 383. Interestingly, the author of *Pinto*, Judge Becker, also authored the Third Circuit’s decision in *Firestone*.

²⁹ See *Mers v. Marriott Int’l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (finding that an insurance company who pays benefits out of its own assets and interprets its own policies has a “potential” conflict, but that this “is not enough to show an actual bias” worthy of adjusting the standard of review). In more recent cases, the Seventh Circuit has arguably

II. *The Evolution of the Seventh Circuit's Standard of Review for Conflicts*

Although a complete survey of the Seventh Circuit's decisions regarding plan administrator conflict of interest is beyond the scope of this Comment, the following cases were all instrumental in the development of how the court recognizes (or fails to recognize) a conflict of interest. With the exception of the *Van Boxel* decision discussed below, the following cases all involve unfunded plans in which either the employer or insurer also administers the plan, thus giving rise to the conflict of interest.

A. *Pre-Firestone: Judge Posner's Influential Van Boxel v. Journal Company Employees Pension Trust Decision*

The plaintiffs in *Van Boxel v. The Journal Company Employees' Pension Trust*, directly challenged the district court's use of the "arbitrary and capricious" standard of review.³⁰ Although ultimately rejecting the challenge, the court stated in an opinion by Judge Richard Posner, that "[w]e are not entirely unsympathetic to the challenge, and notice that although the weight of authority is against him there is

acknowledged - at least on a semantic basis - that there is some sort conflict. *See, e.g., Rud v. Liberty Life Assurance Co. of Am.*, 438 F.3d 772, 775 (7th Cir. 2006) ("There is no contract the parties to which do not have a conflict of interest in the same severely attenuated sense, because each party wants to get as much out of the contract as possible."); *Hess v. Reg-Ellen Machine Tool Corp.*, 423 F.3d 653, 660 (7th Cir. 2005) ("we have repeatedly rejected arguments for a heightened standard of review solely because a corporation or insurer interprets its on plan to deny benefits.").

³⁰ 836 F.2d 1048, 1049 (7th Cir. 1987). The plaintiff in this case challenged the decision of the Company's pension trust fund to reject his claim for a pension. *Id.* Although this pension plan was funded, the court noted that there is still an issue whether the plan is "adequately funded," noting ERISA's exemption of certain benefit plans from its funding requirements. *Id.* at 1050-1051. Thus, the concerns over neutrality on the part of plan administrators discussed in this decision have equal, if not more, force in the context of unfunded plans.

growing skepticism about the orthodox approach.”³¹ Notably, the court cited the Third Circuit’s *Firestone* decision as one example of such skepticism.³² The court also noted that although the “arbitrary and capricious” standard is used in the administrative law context, ERISA plans are easily distinguishable because the administrators of such plans are not operating under a broad grant of delegated power.³³

Without committing to one specific approach, Judge Posner ultimately employed a law and economics rationale for applying some form of deferential, rather than de novo review.³⁴ He reasoned that the impact on a company’s welfare of granting or denying an individual application for benefits “will usually be too slight” to compromise the impartiality of the administrators, even if they are all associated with the company.³⁵ For example, a corporation which generates annual revenues of six billion dollars is not likely to flinch at paying out \$240,000 on one claim.³⁶ Judge Posner also noted that dealing fairly with claims is in the company’s “long-run best interest” because if claims are treated unfairly, because employees will in turn demand

³¹ *Id.* at 1049.

³² *Id.*

³³ *Id.* at 1050; see generally, Mark DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727 (2004) (discussing the myriad of ways that administrative law principles have been improperly imported to the ERISA context).

³⁴ *Van Boxel*, 836 F.2d at 1051-52. The Seventh Circuit gave the “law and economics” label to this approach in subsequent cases. See e.g., *Mers v. Marriott Int’l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (“we have rejected the theory that an inherent conflict is sufficient to alter the standard of review by applying a law-and-economics rationale to establish that no conflict exists.”). As Judge Posner has explained in other writings, the purpose of applying economic analysis to the law “is to construct and test models of human behavior for the purpose of predicting and (where appropriate) controlling that behavior.” RICHARD A. POSNER, *OVERCOMING LAW* 15-16 (Harvard University Press 2002) (1995). While not an infallible calculator, the individual imagined by this approach is assumed to pursue goals in a “forward-looking fashion by comparing the opportunities open to him at the moment he must choose.” *Id.*

³⁵ *Van Boxel*, 836 F.2d at 1051.

³⁶ This is the example used in *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995), a case that relied on *Van Boxel*’s law and economics rationale.

higher wages.³⁷ This is all assuming, of course, that the employee is “rational and well informed.”³⁸

Notably, however, Judge Posner explicitly acknowledged the limitations of this rationale, stating:

pension rights are too important these days for most employees to want to place them at the mercy of a biased tribunal subject only to a narrow form of “arbitrary and capricious” review, relying on the company’s interest in its reputation to prevent it from acting on its bias. Nor is it clear that the contractual perspective is the correct one in which to view claims under ERISA. A congress committed to the principles of freedom of contract would not have enacted a statute that interferes with pension arrangements voluntarily agreed on by employers and employees. ERISA is paternalistic; and it seems incongruous therefore to deny disappointed pension claimants a meaningful degree of judicial review on the theory that they might be said to have implicitly waived it.³⁹

Judge Posner then discussed how several courts do not apply the “arbitrary and capricious” standard of review where the presumption of neutrality fails, ultimately proposing a “sliding scale” approach within the “arbitrary and capricious” standard of review framework.⁴⁰ Under this rule, reviewing courts are allowed to “make the necessary adjustments for possible bias in the trustees’ decision.”⁴¹ The court did not, however, ultimately determine whether a conflict of interest

³⁷ *Van Boxel*, 836 F.2d at 1051.

³⁸ *Id.*

³⁹ *Id.* at 1052.

⁴⁰ *Id.*

⁴¹ *Id.* at 1053.

was present in this case, finding that the decision of the trustee was “clearly” reasonable.⁴²

B. Post-*Firestone* Decisions: 1995 to 2004.

In *Chalmers v. Quaker Oats Co.*, the Seventh Circuit again invoked the law and economics rationale articulated in *Van Boxel*, but gave the first of many indications that the drawbacks of the approach would not have much bearing on the standard of review applied.⁴³ *Chalmers* involved an employee’s claim for benefits under a severance program, after being discharged for violating Quaker’s sexual harassment policy.⁴⁴ Although *Chalmers* admitted to violating the policy, he argued that his conduct fell short of a Title VII claim, and that therefore, he was still entitled to benefits under Quaker’s severance program.⁴⁵ *Chalmers* further argued that the court’s deference to Quaker’s decision should be limited because the officers of Quaker who served on the committee that makes benefits decisions had an inherent conflict of interest by both administering and funding the plan.⁴⁶

Rejecting these challenges, the court first noted that ERISA specifically endorses the notion of a corporate officer who doubles as a plan administrator.⁴⁷ Noting its previous decision in *Van Boxel*, the court also held that rejecting *Chalmers*’s claim would have little effect on the company’s bottom line and that denying meritorious claims would be a poor business decision.⁴⁸ In so doing, the court reaffirmed its stance that the structure of an unfunded plan merely constitutes a

⁴² *Id.*

⁴³ *Id.* at 1344.

⁴⁴ *Id.* at 1342.

⁴⁵ *Id.* at 1343-45.

⁴⁶ *Id.* at 1344.

⁴⁷ *Id.* (citing ERISA § 1108(c)(3), which allows employers to appoint their own officers to administer ERISA plans even if the company is a “party in interest.”).

⁴⁸ *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995).

“potential” conflict; not an actual or inherent one.⁴⁹ Such “potential” conflicts, therefore, do not justify a court engaging in any closer scrutiny of the plan administrator’s decision to deny benefits.⁵⁰

In *Mers v. Marriott International Group Accidental Death and Dismemberment Plan*, the Seventh Circuit rejected the district court’s presumption that the insurer was operating under an inherent conflict of interest by serving as the plan insurer and administrator.⁵¹ Reversing the district court’s decision, the Seventh Circuit adopted precisely the opposite presumption: “that a fiduciary is acting neutrally unless a claimant shows by specific evidence of actual bias that there is a significant conflict.”⁵² The court did not, however, elaborate upon what evidence would be required to show a “substantial conflict” or “actual bias.” That the court adopted this presumption is significant, because in so doing, the court explicitly acknowledged – and then rejected – the approach taken by several other circuits.⁵³

The Seventh Circuit again rejected a district court’s attempt to “put a thumb on the scale” against the administrator of an unfunded plan, in *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*.⁵⁴ Affirming the rationale used in *Mers*, the court stated that “it is unsound for the judiciary automatically to impute the plan administrator’s position to the person who decides on its behalf” because insurance companies “lack any stake in the outcome.”⁵⁵ The court further reasoned that because the plaintiff did not ask the court to investigate a specific compensation and promotion scheme within the company, that “we have no reason to think the actual decision-makers at UNUM [the insurer] approached their task any differently than do

⁴⁹ *Id.* at 1345.

⁵⁰ *Id.*

⁵¹ 144 F.3d 1014, 1020 (7th Cir. 1997).

⁵² *Id.* at 1020.

⁵³ *Id.* at 1021. (“While some courts have found that a denial of benefits is presumptively void and must be reviewed de novo where a similar conflict may exist, we have not.”) (internal citations omitted).

⁵⁴ 195 F.3d 975, 980 (7th Cir. 1999).

⁵⁵ *Id.* at 981.

the decisionmakers at the Social Security Administration....”⁵⁶ With this statement, the court continued its delineation of an extremely demanding burden on the claimant to prove bias (i.e., that the specific agents must have a stake in the outcome) and resurrected the administrative law analogy that the court specifically warned against in *Van Boxel*.⁵⁷ The court also, as Judge Wood noted in her dissenting opinion, reversed the district court’s decision despite its commitment to addressing mixed questions of law and fact (such as conflicts) with a “light appellate touch.”⁵⁸

In *Leipzig v. AIG Life Insurance Co.*, the court provided two additional rationales for not adjusting the standard of review.⁵⁹ First, the court made an efficiency argument, noting that “this plan puts decisions in the hands of medical specialists (which federal judges and juries assuredly are not) and curtails the cost of litigation, which makes it possible to provide workers with better benefits on a given budget.”⁶⁰ Second, the court set forth a freedom of contract argument, remarking that courts have no more authority to override a discretionary clause than they would to require benefits to be set at a higher percentage, or to change the definition of disability.⁶¹ Citing *Mers*, the court also articulated a rigid formulation of its “reputational incentives” rationale, stating that “[u]nless an insurer or plan administrator pays its staff more for denying claims than for granting them, the people who actually implement these systems are impartial.”⁶²

⁵⁶ *Id.*

⁵⁷ *Id.* See also *supra* note 33.

⁵⁸ *Id.* at 986 (Wood, D., dissenting) (citing *Dean Foods Co. v. Brancel*, 187 F.3d 609, 616 (7th Cir. 1999)). Judge Wood further stated that “[t]hus, while I do not mean to imply that this court must blindly follow a district court’s finding of a conflict, I think it inconsistent with our usual practice to dismiss the lower court’s conclusion without setting forth a powerful reason to do so.” *Perlman*, 195 F.3d at 986.

⁵⁹ 362 F.3d 406 (7th Cir. 2004).

⁶⁰ *Id.* at 408.

⁶¹ *Id.*

⁶² *Id.* at 409.

C. The Seventh Circuit Solidifies its Standard – 2005 to the Present

The Seventh Circuit began 2005 by solidifying its commitment to denying plenary review in conflict cases. In *Shyman v. Unum Life Insurance Co.*, the court flatly rejected a plaintiff's claim that a more searching review is necessary, stating that "the law of this circuit is otherwise."⁶³ Remarkably, however, the court nearly recognized a conflict in its *Hess v. Reg-Allen Machine Tool Corp.* decision.⁶⁴ At issue in *Hess*, was the plaintiffs' attempt to roll their plan distribution into an IRA account of their choosing.⁶⁵ Denying the claims, the administrator found that the plaintiffs were not entitled to diversify their stock until they were 55 years old, as required by a recent amendment to the plan.⁶⁶ The plaintiffs challenged the decision, arguing not only that there was an inherent conflict of interest, but also a more "significant" bias because the employer actually lacked sufficient assets to grant their requests for diversification.⁶⁷ This argument was bolstered by the employer's concession that paying out the requested amount would "change the whole forecasting going forward" as far as what the plan could provide to other plan participants.⁶⁸

Given these extraordinary facts, the Seventh Circuit conceded that the Hesses' claim of bias "has more teeth to it than similar claims that we have rejected in the past," and stated that "we may perform a slightly 'more penetrating review.'"⁶⁹ The court was also careful to reiterate, however, that "we have repeatedly rejected arguments for a heightened standard of review solely because a corporation or insurer

⁶³ 427 F.3d 452, 455 (7th Cir. 2005).

⁶⁴ 423 F.3d 653 (7th Cir. 2005).

⁶⁵ *Id.* at 657.

⁶⁶ *Id.*

⁶⁷ *Id.* at 659.

⁶⁸ *Id.* at 659.

⁶⁹ *Id.* at 660.

interprets its own plan to deny benefits.”⁷⁰ In the end, the court applied the “arbitrary and capricious” standard and upheld the plan administrator’s decision without any trace of a more searching review.⁷¹

The *Hess* case illustrates just how far the Seventh Circuit will go in rejecting conflict of interest arguments. The fact that the court only stated that they “*may* perform a slightly more penetrating review” in light of the conceded conflict of interest, begs the question as to what kind of conflict a plaintiff would have to show in order to have any meaningful review.⁷² This question has yet to be answered by the court.

In *Semien v. Life Insurance Co. of N. America*, the court added yet another obstacle to proving conflict: virtually no discovery.⁷³ In *Semien*, the plaintiff argued that the review of a disability claim by non-examining physicians doctors did not constitute sufficient grounds to deny her claim.⁷⁴ Noting its general disfavor of discovery in ERISA cases, the court held that claimants must make a prima facie showing of bias or show a “good faith basis to believe that limited discovery will produce such evidence.”⁷⁵ An example of an acceptable prima facie showing would be where evidence is provided that the claimant’s application was not given a “genuine evaluation” – for example where there is evidence that the plan administrator did not do what it said it did, such as throwing an application in the trash

⁷⁰ *Id.* at 659.

⁷¹ *Id.* at 663.

⁷² *Id.* at 660.

⁷³ 436 F.3d 805, 814 (7th Cir. 2006), *petition for cert. filed* (April 28, 2006) (No. 04-3664).

⁷⁴ Brief for Petitioner, *Semien v. Life Insur. Co. of N. Am.* (No. 04-3664).

⁷⁵ *Semien*, 436 F.3d at 814. (citing *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 985 (7th Cir. 2000); *see also, Perlman*, 195 F.3d at 982. (“[W]hen there can be no doubt that the application was given a genuine evaluation, judicial review is limited to the evidence that was submitted in support of the application for benefits....”).

rather than evaluating it on the merits.⁷⁶ Thus, a smoking gun is essentially required. Not surprisingly, the court found that because there was “no basis to believe that the physicians in this case did not conduct a full and fair evaluation of Semien’s condition,” the court denied her request for discovery.⁷⁷

Significantly, the court also offered a new rationale for refusing to question a plan administrator’s neutrality, stating:

Congress has not provided Article III courts with the statutory authority, nor the judicial resources, to engage in a full review of the motivations behind every plan administrator’s discretionary decisions. To engage in such review would usurp plan administrators’ discretionary authority and move towards a costly system....[that] would undermine one of the primary goals of the ERISA program: providing a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously.⁷⁸

In so doing, the *Semien* court clarified that plaintiffs must not only make a prima facie showing of bias or conflict before adjusting the standard of review, but must do so without conducting any discovery to prove that a conflict actually exists, thus compounding the already difficult task of overcoming the “arbitrary and capricious” standard of review.⁷⁹ The court also made clear that in the cost/benefit calculus, a claimant’s potential entitlement to benefits must cede to the plan sponsor’s interest in keeping costs down where discovery is required to prove the claim.

The Seventh Circuit’s recent decision, *Rud v. Liberty Life Assurance Co. of Boston*, provided a startling elaboration on the

⁷⁶ *Semien*, 436 F.3d at 814 (citing *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981-82 (7th Cir. 2000)).

⁷⁷ *Id.*

⁷⁸ *Id.* (internal quotes and cites omitted).

⁷⁹ *See Id.*

freedom of contract argument alluded to in *Leipzig*.⁸⁰ In *Rud*, the court again questioned whether the insurer's status and benefit payor and administrator created a conflict, stating that every contract has a conflict of interest in "the same severely attenuated sense" because "each party wants to get as much out of the contract as possible."⁸¹ The court reasoned that if an employer wishes to cut costs, lower wages and benefits would have been promised from the start; therefore, this is no need for employers to "steal" contracted-for benefits "through the back door" by denying meritorious claims.⁸² The court then analogized to the Supreme Court cases upholding forum selection clauses, even though they are rarely read by the consumer, reasoning that overriding the terms of the benefits contract in this case would "destabilize" large reaches of contract law.⁸³

III. Why the Seventh Circuit's Rationales for Refusing to Acknowledge an Inherent Conflict of Interest are Unsupportable.

As a preliminary matter, it bears noting that the Seventh Circuit is one of only two⁸⁴ courts of appeals that refuse to recognize an inherent conflict where the employer or insurer both funds and makes decisions

⁸⁰ 438 F.3d 772 (7th Cir. 2006).

⁸¹ *Id.* at 776.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ As of now, the Second Circuit does not recognize an inherent conflict; however, the court may be backing off from this view. *See* *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475 (2d Cir. 1997) (reasons not from effect but language, concluding that *Firestone* simply does not require anything but arbitrary and capricious review unless the plaintiff demonstrates how a conflict biased a fiduciary's decision.); *see also*, *Locher v. Unum Life Ins. Co.*, 389 F.3d 288, 296 (2d Cir. 2004) ("we do not conclude that a finding of a conflicted administrator, standing alone, can never constitute good cause. We need not address that possibility here, as it is not presented to us, but we note that it may be possible, in unforeseen circumstances, for good cause to rest entirely on the existence of a conflicted administrator."). As discussed in Section IV, however, unlike the Seventh Circuit, the Second Circuit grants de novo review after a conflict showing is made.

under the plan.⁸⁵ Section A of this Part will discuss the Third Circuit's critique of the Seventh Circuit's conclusion that reputational concerns and the bargaining power of employees protect against self-serving behavior on the part of a plan administrators. Section B will discuss how the multistate investigation of UnumProvident provides, at the very least, one example of how a company may deny meritorious claims to reduce costs. Part C will discuss why neither efficiency concerns nor a perceived lack of Article III court power justifies disallowing claimants discovery to prove a conflict of interest.

A. The Third Circuit Critiques the Seventh Circuit's "Overly Optimistic" Law and Economics Approach to Conflicts.

As described in Section II, the Seventh Circuit justifies its standard by claiming that the plan sponsor's reputational interests in conjunction with the negotiating power of employees negate any incentive for plan administrators to deny valid claims.⁸⁶ In *Pinto v. Reliance Standard Life Insurance Co.*, the Third Circuit directly addressed and convincingly refuted both of these assumptions.⁸⁷

To begin, the Third Circuit agreed with the Seventh Circuit that reputational concerns may motivate employer/insurer behavior to some extent; however, the court ultimately concluded these concerns do not negate the plan administrator's incentive to deny valid claims.⁸⁸ The court explained that because ERISA litigation generally arises

⁸⁵ See, e.g., *Evans v. UnumProvident Corp.*, 434 F.3d 866, 876 (6th Cir. 2006); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 387 (3d Cir. 2000); *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 295 (5th Cir. 1999); *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263 (8th Cir. 1997); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80 (4th Cir. 1993); *Brown v. Blue Cross Blue Shield of Ala.*, 898 F.2d 1556, 1561 (11th Cir. 1990); *Lang v. Long-Term Disability Plan Sponsor Applied Remote Tech., Inc.* 125 F.3d 794, 794 (9th Cir. 1997).

⁸⁶ See discussion *supra* Sections II(B)-(C).

⁸⁷ *Pinto v. Reliance Standard Life Ins. Co. of Am.*, 214 F.3d 377, 389 (3d Cir. 2000).

⁸⁸ *Id.* at 388.

only in close cases, there is little incentive for an insurer to treat these borderline cases “with the level of attentiveness and solicitude that Congress imagined when it created ERISA ‘fiduciaries.’”⁸⁹ Rather, insurance carriers have an active incentive to deny close claims in order to keep costs down so that companies will choose them as their insurers.⁹⁰ Interestingly, this sentiment echoes what the Seventh Circuit itself has stated: rights under a benefit plan are too important for most employees to rely on the “company’s interest in its reputation to prevent it from acting on its benefit.”⁹¹ As noted by the *Pinto* court, this economic consideration has unfortunately been since neglected by the Seventh Circuit.⁹²

The *Pinto* court also recognized the problems underlying the Seventh Circuit’s assumptions regarding the bargaining power of employees, stating:

while in a perfect world, employees might pressure their companies to switch from self-dealing insurers, there are likely to be problems of imperfect information and information flow. Employees typically do not have access to information about claim-denying by insurance companies...so long as obviously meritorious claims are well-handled, it is unlikely that an insurance company’s business will suffer because of its client’s dissatisfaction.⁹³

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ See *supra* Section II(a), discussing *Van Boxel*.

⁹² *Id.* at 388. Judge Posner actually acknowledged the Third Circuit’s critique in the *Rud v. Liberty Life* opinion, but ultimately ignored the societal importance of employee benefits. See 438 F.3d 772, 776 (7th Cir. 2006) (noting that ERISA is subject to contract law because employers are not required to establish such plans)

⁹³ 214 F.3d at 388; see also, *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 n.5 (1st Cir. 2005) (similarly acknowledging that other courts have rejected the Seventh Circuit’s market forces rationale).

This lack of information is particularly prevalent in many cases, where the claims for benefits occur after the individuals have left active employment and are seeking pension or disability benefits.⁹⁴ Similarly, access to information will also not likely be available where the company is dissolving or restructuring because the long-term relationship between the employer and employee is also dissolving.⁹⁵

While criticizing the Seventh Circuit's conclusions, the *Pinto* court did recognize that some assumptions about economic behavior are necessary.⁹⁶ The assumptions made however, are "less exceptional" than those of the Seventh Circuit, which has an "overly optimistic view of the flow of information and sophistication of employees."⁹⁷ Indeed, even assuming a less devious view of plan administrators, the Seventh Circuit's reasoning still fails. As the Fourth Circuit has observed, "even the most careful and sensitive fiduciary [when operating under a conflict of interest] may unconsciously favor its profit interest over the interests of the plan, leaving beneficiaries less protected than when the trustee acts without self-interest and solely for the benefit of the plan."⁹⁸

Moreover, as law and economics scholars have pointed out in other contexts, consumers cannot consider all dimensions of product quality because they generally have a limited ability to process complex information.⁹⁹ This "bounded rationality" in the ERISA

⁹⁴ *Pinto*, 214 F.3d at 388.

⁹⁵ Langbein, note 2 at 216; *see also*, *Radford Trust v. First Unum Life Insur. Co. of Am.*, 321 F. Supp. 2d 226, 240 (D. Mass. 2004) ("the complexity of the insurance market and the imperfect information available to consumers make it difficult to determine whether an insurer is keeping costs down through legitimate or illegitimate means.").

⁹⁶ *Pinto*, 214 F.3d at 388 ("We recognize that the preceding section involves implicit assumptions about economic behavior, but such assumptions have become necessary in the post-*Firestone* era as we, and other courts, must somehow determine when a conflict warrants close scrutiny.").

⁹⁷ *Id.*

⁹⁸ *Doe v. Group Hospitalization & Med. Serv.*, 3 F.3d 80, 86-87 (4th Cir. 1993).

⁹⁹ Russell Korobkin, *Bounded Rationality and Unconscionability: A behavioral Approach to Policing Form Contracts*, 70 U. CHI. L. REV. 1203 (2003).

context, means that employees do not have the bargaining power to meaningfully negotiate or bargain for plenary review by the courts. It is for this reason that California and Illinois have prohibited discretionary clauses altogether, thus requiring both state and federal courts to review claims on a de novo basis.¹⁰⁰

B. The UnumProvident Scandal: An Example of Where the Seventh Circuit's Rationale for Deferential Review Fails.

In November 2004, UnumProvident ("Unum") entered into a multistate settlement agreement, requiring Unum to pay a 15 million dollar fine, to reopen and review de novo over 200,000 previously denied claims, and to make significant changes to its claim review procedure and corporate governance.¹⁰¹ The multistate investigation¹⁰² leading up to the agreement identified several specific claim handling procedures of concern to the state regulators, including an excessive reliance on in-house medical staff to support the denial of benefits, unfair evaluation and interpretation of attending physician or independent medical examiner reports, failure to evaluate the totality of the claimant's medical condition, and an inappropriate burden

¹⁰⁰ See *supra* note 23, discussing the NAIC prohibition on discretionary clauses generally. See also Mark D. DeBofsky, *The Disability Insurance Industry's Attack on California's Consumer Protection Initiative*, INSUR. F., INC., Feb.-March 2006, discussing a recent lawsuit filed by several industry associations, challenging the California Commissioner's ability to prohibit discretionary clauses.

¹⁰¹ See UnumProvident Settlement Agreement, Exhibit D (Report of the Targeted Multistate Mark Conduct Investigation), *available at*: <http://www.state.tn.us/commerce/insurance/unum/UnumSettlementTn.pdf>. (Nov. 18, 2004).

¹⁰² On September 2, 2003, the chief insurance regulators of Massachusetts, Tennessee, and Main ("the lead regulators") called a multistate targeted market conduct examination to determine if Unum's individual and group long term disability income claims procedures reflected "unfair claim settlement practices," as defined by the National Association of Insurance Commissioners ("NAIC"). See UnumProvident Settlement Agreement, Exhibit D (Report of the Targeted Multistate Mark Conduct Investigation), *available at*: <http://www.state.tn.us/commerce/insurance/unum/UnumSettlementTn.pdf>. (Nov. 18, 2004).

placed on claimants to justify eligibility for benefits.¹⁰³ These procedures have been called into question in several cases.

In one such case, *McSharry v. UnumProvident Corp.*, the court unearthed striking and telling evidence of bias in Unum's claims handling procedures.¹⁰⁴ *McSharry* involved a wrongful termination claim by Dr. Patrick McSharry, who worked as a staff physician in Unum's claim department.¹⁰⁵ Dr. McSharry alleged that Unum had a policy of requiring medical professionals to use only language in their reports supporting a denial of benefits, to evaluate claimants' medical conditions in isolation rather in combination, and that the medical advisors were generally expected to render opinions about medical conditions outside of his or her specialty, without requesting review by a specialist.¹⁰⁶ In another decision, *Radford Trust v. First Unum Life Insurance Co. of America*, the court collected cases where the courts have commented "unfavorably" on Unum's conduct, including one court's description of Unum's behavior as "culpably abusive."¹⁰⁷

Thus, it is clear that in at least one case, an insurer was not able to resist the temptation to cut costs by denying benefits, and that reputational interests do not always save a benefits provider from this temptation. Indeed, it is hard to believe that Unum's actions were unique and that other insurers – operating under the same motivation – did not act with the same self-interest. It is arguably fair to say,

¹⁰³ Press Release, Tennessee Department of Insurance, *available at* <http://tennessee.gov/commerce/pdf/press/prsRls111804.pdf>. (Nov. 18, 2004).

¹⁰⁴ 237 F. Supp. 2d 875 (E.D. Tenn. 2002). This case arose on the Defendant's motion to remove the case to federal district court. The court denied the motion, holding that the claims were completely preempted by ERISA, and that the action was properly removed pursuant to 28 U.S.C. §§ 1331 and 1441(b) (2000). *Id.* at 876.

¹⁰⁵ *Id.* at 876.

¹⁰⁶ *Id.* at 877-88. Although Dr. McSharry attempted to follow these guidelines while still rendering truthful medical reports, he ultimately told his supervisors that he would not be able to participate in what he considered unethical and illegal practices. *Id.* at 877.

¹⁰⁷ 321 F. Supp. 2d 226, 249 n.20 (rev'd on other grounds) (D. Mass. 2004), (citing *Keller v. Unum Life Ins. Co. of Am.*, No. 90 Civ. 5718 (VLB), 1992 WL 346343, at *2 (S.D.N.Y. Sept. 20, 1993)).

therefore, that the Third Circuit's economic assumptions are "less exceptional" than those of the Seventh Circuit, and that there is an actual, readily apparent conflict; not just the mere potential for one.¹⁰⁸ The Unum investigation also shows that in order to protect an employee's entitlement to benefits, the court must undertake some review of the quality and quantity of evidence, even where the insurer has retained discretion.

C. Neither Concerns over Efficiency nor the Power of Article III Courts Justify Disallowing Discovery to Prove a Conflict of Interest.

For the reasons discussed above, an inherent conflict of interest should be recognized in cases where the plan sponsor both funds and makes eligibility determinations under the plan. But even if the Seventh Circuit is unwilling to presume this conflict, claimants at the very least, should be allowed to prove a conflict by conducting discovery – as several circuit courts of appeals already permit.¹⁰⁹ As per the Seventh Circuit's recent *Semien* decision, however, such discovery is not permitted absent a smoking gun or extraordinary circumstances.¹¹⁰

As discussed in Section II(C), the premise in support of this argument is that one of the primary goals of ERISA is to resolve disputes over benefits "inexpensively and expeditiously" and that providing a full review of the motivations behind claims decisions

¹⁰⁸ *Killian v. Healthsource Provident Administrators*, 152 F.3d 514, 521 (6th Cir. 1998).

¹⁰⁹ See e.g., *Evans v. UnumProvident Corp.*, 434 F.3d 866, 876 (6th Cir. 2006); *Liston v. Unum Corp. Officer Severance Plan*, 330 F.3d 19 (1st Cir. 2003); *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163 (2d Cir. 2001); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000); *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004); *Farley v. Arkansas Blue Cross & Blue Shield*, 147 F.3d 774 (8th Cir. 1998); *Tremain v. Bell Industries*, 196 F.3d 970 (9th Cir. 1999); *Moon v. American Home Assur. Co.*, 888 F.2d 86 (11th Cir. 1989).

¹¹⁰ See *supra* Section II(c), discussing when discovery is allowed.

would exceed the statutory authority provided by Congress.¹¹¹ This Article III rationale is the driving force behind Plaintiff Semien's petition for certiorari to the United States Supreme Court, appealing the Seventh Circuit's decision.¹¹² Indeed, after examining the purpose of the ERISA statute, the United States Constitution, and the Legislative history of ERISA, it is clear that Article III courts are empowered to allow discovery and that efficiency cannot justify giving claimants an important tool to prove their claim.

To begin unraveling the Seventh Circuit's rationale, it is instructive to look at the stated purpose behind the ERISA statute, which provides:

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing appropriate remedies, sanctions, and *ready access to the federal courts*.¹¹³

Nowhere does the stated purpose even hint at a desire to limit the authority of the federal courts.¹¹⁴ Indeed, Congress specifically empowered aggrieved individuals seeking employee benefits to bring a "civil action...to recover benefits due."¹¹⁵ Nor does the legislative

¹¹¹ Semien v. Life Insurance Co. of N. America, 436 F.3d 805, 815 (7th Cir. 2006).

¹¹² The arguments in this section are borrowed heavily from Semien's writ of certiorari, submitted by her attorney Mark DeBofsky.

¹¹³ (emphasis added) 29 U.S.C. § 1001(b) (2000).

¹¹⁴ There is also quite obviously no "ERISA" exception in the text of Article II, Section 2 of the United States Constitution, which extends the judicial power to "all cases, in law and equity."

¹¹⁵ ERISA § 1132(a)(1)(B) (2006).

history of ERISA support the conclusion that one of the “primary goals” of ERISA is to resolve disputes over benefits inexpensively and expeditiously. As one of ERISA’s main sponsors, Jacob Javits, explained, House conferees were opposed to an administrative dispute mechanism “on grounds it might be too costly to plans and a stimulant to frivolous benefit disputes, and at their insistence it was dropped in conference.”¹¹⁶

Moreover, even if efficiency were one of ERISA’s goals – which it decidedly is not - there would still be no justification for denying claimants discovery. As Professor Jay Conison convincingly stated:

[E]ven if there were some basis for believing that the treatment of a benefit suit as an evidentiary proceeding would interfere with the ‘prompt resolution of claims by the fiduciary, the rationale would still fail. For it to be plausible, one would have to add two premises: that ‘prompt resolution of claims’ is something Congress intended for the protection of sponsors and fiduciaries; and that such protection of sponsors and fiduciaries is more important than protection of the participants’ right to receive benefits due. Merely to state these premises is to reveal their untenability.¹¹⁷

These “untenable” premises are particularly clear given that the Supreme Court has stated that claimants should not fare worse under ERISA as they did before its enactment.¹¹⁸ Before ERISA’s enactment, claimants undoubtedly had a right to both discovery and an evidentiary hearing; taking away these rights, therefore, could not have been what Congress intended.¹¹⁹ As a practical matter, allowing discovery to prove the existence of a conflict is crucial – indeed, how

¹¹⁶ 3 Legislative History of ERISA, n.4 at 4769.

¹¹⁷ Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 57-60 (1992).

¹¹⁸ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114 (1989).

¹¹⁹ See Semien’s petition for certiorari at 74 U.S.L.W. (April 28, 2006).

is a claimant to prove bias without the means of investigating the benefits provider? The Supreme Court itself has stated that the physicians retained by benefits plans “may have an incentive to make a finding of ‘not disabled’ in order to save their employers money and preserve their own consulting arrangements.”¹²⁰ Authoritative medical journals such as the *New England Journal of Medicine* have remarked that “ERISA plans have a financial incentive to deny care...without liability, there is nothing in the law to counterbalance the financial incentive to deny care.”¹²¹ Without discovery, however, this proposition can never be proven. Accordingly, if the Seventh Circuit continues to refuse to acknowledge an inherent conflict of interest, the court should at the very least allow the claimants discovery to prove that a bias exists.

IV. How Conflicts of Interest Should Affect the Standard of Review

For the reasons stated in Section III, the Seventh Circuit should recognize that there is an inherent conflict where an insurance company both funds and administers an ERISA plan. A separate and perhaps even more important issue, however, is how to incorporate this conflict into the deferential review mandated by *Firestone*. The circuit courts have recognized essentially three approaches recognized approaches to dealing with conflict: de novo review, burden shifting, and the sliding scale. First I will discuss why the de novo and burden shifting approaches are unsatisfactory, and then I will suggest that the Seventh Circuit adopt the sliding scale approach because it comports with *Firestone*'s mandate, and adequately addresses the concerns behind the conflict.

A. De Novo Review and Burden Shifting: Two Unsatisfactory Approaches.

¹²⁰ *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832 (2003).

¹²¹ Wendy K. Mariner, *What Recourse? — Liability for Managed-Care Decisions and the Employee Retirement Income Security Act*, 343 *New England Journal of Medicine* 592, 595 (August 24, 2000).

Although remarkably stringent in requiring particular evidence that a conflict infected the decision-making process, the Second Circuit uses the de novo review standard once it credits such evidence.¹²² Thus, once a conflict is alleged, the “arbitrary and capricious” standard becomes a two-pronged test: first, whether the administrator’s decision was reasonable; and second, whether the evidence shows that the administrator was in fact influenced by the conflict of interest.¹²³ If the court determines that the decision was in fact affected by the conflict of interest, de novo review becomes the standard of review.¹²⁴

As desirable as de novo review may be in these cases, courts are currently bound by *Firestone*’s requirement that conflict be “a factor” within the “arbitrary and capricious” framework. Thus, unless and until the Supreme Court revisits *Firestone*, a better approach would be for the Second Circuit to relax the plaintiff’s burden in showing a conflict, and then to use conflict as a factor under the “arbitrary and capricious” standard, either using the burden shifting or sliding scale approach.¹²⁵

In contrast to the Second Circuit, the Ninth and Eleventh Circuits take a burden shifting (or “presumptively void”) approach.¹²⁶ As articulated by the Eleventh Circuit, the approach first requires a showing of an inherent or “substantial” conflict of interest; once the conflict is shown, the burden shifts to the fiduciary to demonstrate that the conflict did not infect the benefit determination.¹²⁷ To determine whether the conflict infected the denial process, the court examines

¹²² Sullivan v. LTV, 82 F.3d 1251, 1255-56 (2d Cir. 1996).

¹²³ *Id.* at 1255-56.

¹²⁴ *Id.*

¹²⁵ As the Third Circuit stated in *Pinto v. Reliance Standard Life Ins. Co.*, “only the Supreme Court can undo the legacy of *Firestone*.” 214 F.3d 377, 393 (3d Cir. 2000).

¹²⁶ See e.g., *Brown v. Blue Cross Blue Shield of Ala.*, 898 F.3d 1556 (11th Cir. 1990); *Atwood v. Newmont Gold Co*, 45 F.3d 1317, 1323 (9th Cir. 1995).

¹²⁷ *Brown*, 898 F.2d at 1556.

whether the decision was wrong from the perspective of de novo review.¹²⁸

Once the burden is shifted, the plan administrator can meet its burden by demonstrating a routine practice or by giving other plausible justifications for the decision; for example, by showing that the fiduciary was acting out of concern for other beneficiaries.¹²⁹ If the plan administrator is successful in meeting this burden, the court characterizes the decision as being “wrong but apparently reasonable.”¹³⁰ In so doing, the court seems to assume that the decision is wrong because of the bias, but presumed reliable under the “arbitrary and capricious” standard.¹³¹ If the administrator is unsuccessful in meeting its burden, the decision is then held arbitrary and capricious.¹³² This standard undoubtedly weighs heavily on the plan administrator to disprove that the denial was not tainted by a conflict of interest; therefore, while the burden-shifting approach purports not to be de novo, in practice, the two standards bear little difference.

B. The Sliding Scale: The Most Viable Approach

The sliding scale approach, applied by the majority of courts, lessens the deference afforded to the plan administrator’s decision in proportion to the conflict of interest at issue.¹³³ Notably and somewhat ironically, this is the approach advocated by the Seventh Circuit in *Van Boxel*, where the court set forth a sensible means to

¹²⁸ *Id.* at 1566-67.

¹²⁹ *See Id.* at 1567. (“Even a conflicted fiduciary should receive deference when it demonstrates that it is exercising discretion among choices which reasonably may be considered to be in the interests of the participants and beneficiaries.”)

¹³⁰ *Id.* at 1567.

¹³¹ *See Kennedy, supra* note 13, at 1160-1161 (2001).

¹³² *Brown*, 898 F.3d at 1567.

¹³³ *See, e.g., Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir. 2004); *Evans v. UnumProvident Corp.*, 434 F.3d 866 (6th Cir. 2006); *Woo v. Deluxe Corp.*, 144 F.3d 1157 (8th Cir. 1998); *Vega v. Nat’l Life Ins. Serv., Inc.*, 188 F.3d 287 (5th Cir. 1999).

adjust the standard of review, without adopting a de novo standard. The court stated:

[F]lexibility in the scope of judicial review need not require a proliferation of different standards of review; the arbitrary and capricious standard may be a range, not a point. There may be in effect a sliding scale of judicial review of trustees' decisions.¹³⁴

But as discussed, the Seventh Circuit rarely if ever finds a conflict; therefore, this standard has not really been put to practice by the court. Other courts, however, have found this standard to be a satisfactory means of staying within *Firestone* while lessening deference afforded to administrators operating under a conflict.

The Third Circuit recently adopted this approach in *Pinto*. The court found that the standard allows each case to be examined on its facts, including the ability to take into consideration the sophistication of the parties, the information accessible to them, and the exact financial arrangement between the insurer and the party.¹³⁵ Within this approach, the court is able to adhere to *Firestone*'s dictate that conflict must be considered a "factor," rather than doing away with the deferential standard altogether.¹³⁶ Thus, plan administrators are still given deference, but the deference is reduced to the extent needed to counteract any conflict.¹³⁷

The Tenth Circuit elaborated upon the sliding-scale standard employed by the *Pinto* court, in its *Fought v. Unum Life Insurance Co. of America* decision.¹³⁸ In *Fought*, the court elaborated upon "just how much less deference" a reviewing court should afford to the

¹³⁴ Van Boxel v. The Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1053 (7th Cir. 1987).

¹³⁵ Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 392 (3d Cir. 2000).

¹³⁶ Pinto, 214 F.3d at 392.

¹³⁷ See Vega, 188 F.3d at 296.

¹³⁸ 379 F.3d 997 (10th Cir. 2004).

decision of a conflicted administrator.¹³⁹ The court held that where an inherent conflict exists, the plan administrator will bear the burden of proving the reasonableness of its decision, using the “arbitrary and capricious” framework.¹⁴⁰ Although this standard uses “burden-shifting” as a step in the sliding-scale review, the standard still differs from the Eleventh Circuit’s approach, by providing for a greater “slide” or burden depending on the conflict or conflicts at issue.¹⁴¹

Like the burden shifting approach, the sliding-scale approach, may be fairly subject to the criticism that this is merely *de novo* review by another name. As the *Pinto* court noted, there is something “intellectually dissatisfying, or at least discomforting” in having a heightened “arbitrary and capricious” standard.¹⁴² To be sure, once conflict becomes a factor to consider, the “arbitrary and capricious” standard starts sounding like a form of intermediate scrutiny.¹⁴³ But because only the Supreme Court can undo the “legacy” of *Firestone*, the sliding scale approach best accommodates using conflict as a factor within the “arbitrary and capricious” framework.¹⁴⁴

CONCLUSION

The ERISA statute was enacted not only to protect employees’ expectations and ensuring that employees received promised benefits,

¹³⁹ *Id.* at 1005.

¹⁴⁰ *Id.* at 1006.

¹⁴¹ *Id.* at 1005-6. In addition to the “inherent” conflict of interest discussed in this Comment, the Tenth Circuit provided for several other situations warranting heightened scrutiny, including where there is a serious procedural irregularity, the plan administrator’s performance reviews or level of compensation are linked to the denial of benefits, and where the provision of benefits has a significant economic impact on the company administering the plan. *Id.* If one or more of these conflicts are shown, the court is required to “slide along the scale” and further reduce the deference afforded to the plan administrator’s decision. *Id.* at 1007.

¹⁴² *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3rd Cir. 2000).

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 393.

but also to foster the growth of private employee benefit plans.¹⁴⁵ And to be sure, allowing plenary review of benefits determinations will to some extent increase an employer's cost associated with providing such plans.¹⁴⁶ But because of the importance of these benefits, and the employees' expectation that benefits will be paid when they are due, the interests in cutting-costs cannot prevail. The courts must not abdicate their duty under ERISA and Article III of the United States Constitution to provide a real, substantive check on potential abuses.

That being said, there are essentially three ways that the conflict of interest issue can be resolved. First, Congress could amend the ERISA statute to specifically provide that *de novo* review must always be used when the plan at issue is unfunded. Alternatively, the Supreme Court could revisit *Firestone* and impose a similar requirement, or at least flesh out what constitutes a conflict and how that conflict must affect the standard of review. But barring any action from Congress or the Supreme Court, plaintiffs suing for ERISA benefits in the district courts of the Seventh Circuit should continue to argue that unfunded plans give rise to an inherent conflict that must adjust the standard of review. It is to be hoped that one day soon, the Seventh Circuit will finally acknowledge what every other circuit already knows.

¹⁴⁵ See Catherine L. Fisk, *Lochner Redux: The Renaissance of Laissez-Faire Contract in the Federal Common Law of Employee Benefits*, 56 Ohio St. L.J. 153 (1995) (discussing the inherent tension between Congress's aim of protecting benefits while maintaining employers' economic prerogative over the labor force and costs associated with labor).

¹⁴⁶ Any increase in cost, however, may be *de minimis*. According to a report issued on November 14, 2004 by Milliman, Inc., who was commissioned by America's Health Insurance Plans, the effect that prohibiting discretionary clauses will have on cost will be around 3 to 4 percent due to anticipated higher incidences of litigation, higher cost per litigated claim, and lower claim recovery costs.