THE EVOLVING JUDICIAL STANDARD OF REVIEW IN ERISA DISABILITY BENEFIT CLAIMS

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Employee benefits are governed by the federal law of ERISA. That law provides for various causes of action such that a participant or beneficiary can sue for benefits if they are denied by the plan administrator. While ERISA was silent on the appropriate judicial standard of review that a district court should afford the plan administrator's decision, the Supreme Court first attempted to resolve this issue in 1989, applying a de novo standard of review, unless the plan extended discretion to the plan administrator to interpret the terms of the plan and to determine eligibility for benefits. In the latter context, an abuse of discretion standard would apply, taking into account whether the plan administrator was operating under a conflict of interest.

ERISA also has a broad preemption provision so as to deprive states from regulating employee benefit plans, thereby assuring a uniform national set of causes of action and remedies. However, state insurance laws have been "saved" from preemption, allowing states to regulate in this space. By 2004, the National Association of Insurance Commissioners (NAIC) adopted model insurance laws prohibiting the use of discretionary language when the insurer interprets the insurance contract.

Outside of the group health insurance context, denial of benefits more frequently occurs in the context of disability income plans. Since 2004, twenty-three states have adopted the NAIC ban against discretionary clauses in disability income insurance policies, causing the de novo standard of review to apply. This Article provides a circuit-by-

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circuit review of the following issues:

- *What insurance language is sufficient to confer discretionary authority to the insurer and who has the burden of proving it?*
- *If a state law bans the use of discretionary clauses in disability insurance policies, is the law "saved" by ERISA's savings clause and thus, enforceable?*
- *If the state law ban survives ERISA's preemption and thus enforces a de novo standard of review, is the court limited to the administrative record before the plan administrator?*

As the use of the abuse of discretion standard in an employee benefits denial case is often outcome determinative and generally limited to the administrative record, when and how the de novo standard is used in the context of insured employee benefits is highly relevant to a plan participant or beneficiary. While the Supreme Court has denied certiorari in settling the above issues,[1] *it is important to have them resolved, as the circuit courts vary widely in their approaches. This Article provides a circuit-by-circuit review of how the above issues are determined and recommends a uniform path going forward.*

Introduction

Employee Retirement Income Security Act of 1974 (ERISA) is the federal law that regulates employee benefit plans provided by employers for their workforce.[2] While it provides for various causes of actions, including one for participants and beneficiaries to recover benefits due to them under such plans, ERISA was silent on the applicable judicial standard of review for the courts to apply in reviewing a benefits denial case.[3] The Supreme Court in the 1989 case of *Firestone Tire & Rubber Co. v. Bruch* appeared to settle the matter by providing for a *de novo* standard of review if the plan language failed to grant discretion to the plan administrator; if such discretionary powers were granted, an abuse of discretion standard would apply.[4] As the *Firestone* case involved a conflict of interest on the part of the plan administrator (who, in the case of *Firestone*, was the employer who self-funded and administered the plan), such conflict was weighed as a factor in determining whether

1. *See* Standard Ins. Co. v. Morrison, 584 F.3d 837, 849 (9th Cir. 2009), *cert. denied sub nom.* Standard Ins. Co. v. Lindeen, 560 U.S. 904, 904 (2010).
2. *See generally* Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.
3. *See generally id.* at §§ 1001–1461.
4. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

there was an abuse of discretion.[5] As a result, thousands of plans were amended overnight to grant such discretionary authority to the plan administrator in order to escape the *de novo* standard of review applied in *Firestone*.[6]

In addition, ERISA has a broad preemption clause so as to deprive states of the ability to regulate employee benefits plans.[7] However, certain types of state laws, including insurance laws, have been "saved" from preemption, and thus, are allowed to regulate *insured* employee benefit plans.[8] After *Firestone's* passage in 1989, insured employee benefit plans were not so easily amended, and thus, there was a considerable amount of litigation as to what insurance language conferred discretionary authority upon the insurer in reviewing a claim for benefits.[9] Generally, when an employer decides to *insure* benefits provided under its plans, the insurance company is not only insuring and paying out the benefits, but also becomes the plan administrator; hence, the insurer has a conflict of interest.[10] In 2004, the National Association of Insurance Commissioners (NAIC) adopted a model law that sought to prohibit the use of discretionary language in health and disability insurance policies, on the grounds that such discretionary language rendered the policy illusory.[11] Since 2004, twenty-three states have adopted this model law.[12]

Outside of the group medical context, denial of benefits most frequently occurs in the context of disability benefit plans.[13] Participants filing for disability benefits raise the following issues to be determined

5. *Id.*

6. Maria O'Brien Hylton, *Post-*Firestone *Skirmishes: The Patient Protection and Affordable Care Act, Discretionary Clauses, and Judicial Review of ERISA Plan Administrator Decisions*, 2 WM. & MARY POL'Y REV. 1, 2 (2010).

7. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144.

8. *Id.* at (b)(6)(a)(i).

9. Hylton, *supra* note 6, at 2.

10. PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT § 42 (NAT'L ASS'N INS. COMM'RS 2004), https://content.naic.org/sites/default/files/inline-files/MDL-042.pdf [https://perma.cc/77RT-XBV2].

11. *Id.* at § 42-4.A.

12. *Id.* at ST-42-3-6; *see generally* Mark Debofsky & Jo-el Meyer, *Discretionary Clauses in ERISA Health and Disability Plans–Are They Still Viable?*, Benefit Practitioners' Strategy Guide (2015), https://www.debofsky.com/pdfs/What-s-New/Discretionary-Clauses-in-ERISA-Health-and-Disability-Plans-Are-They-Still-Viable.pdf [https://perma.cc/VU53-D7PX].

13. *See Why So Many Social Security Disability Claims Are Denied by the SSA*, INJ. & DISABILITY L. CTR., https://www.idlawcenter.com/blog/major-reasons-that-ssdi-claims-are-denied.cfm (last visited Feb. 20, 2024) [https://perma.cc/58QG-AFRN].

by the plan administrator: what constitutes disability for purposes of plan benefits, and does the employee satisfy this definition?[14] If the employer decides to *insure* the disability benefits, the insurance company, as plan administrator, then determines whether a participant is eligible for benefits, and pays benefits from its own funds as the insurer of such benefits.[15]

If the insurer operates in a state that has adopted the NAIC model law, a variety of issues arise:[16]

- What insurance language is sufficient to confer discretionary authority to the insurance company as plan administrator so as to avoid the *de novo* standard of review?
- If the insurance policy is subject to one of these NAIC model laws, is the state NAIC model law "saved" under ERISA's savings clause, thereby allowing the insured plan to be subject to a ban on discretionary grants of authority to the insurance company as plan administrator? If so, then the courts must apply a *de novo* judicial standard of review.
- If the *de novo* standard of review applies, what is the scope of review by the courts—are they limited to the administrative record before the plan administrator, or may they allow additional evidence to be submitted at trial, especially as to the issue of the plan administrator's conflict of interest?

This Article provides a circuit-by-circuit review of the cases that discuss these issues, which arise when an employer decides to insure its disability benefits plan and selects the insurance company as the plan administrator. By answering these questions systematically, this author provides a roadmap for practitioners who do not practice in a given circuit court of appeal jurisdiction. However, the purpose of this Article is to demonstrate the split within the circuits and to emphasize the fact that these issues are ripe for review. The Article is divided into the following Sections:

14. *Health Benefits Advisor*, U.S. DEP'T LAB., https://webapps.dol.gov/elaws/ebsa/health/67.asp (last visited Feb. 20, 2024) [https://perma.cc/R4W3-EZS5].

15. *See id*.

16. *See* Travis Sales, Matthew Sheridan, Kristina Vu & Frank Mace, *State Bans on Discretionary Clauses: Implications for ERISA Plans*, BLOOMBERG L. (Nov. 2022), https://www.bloomberglaw.com/external/document/XCQMNS9C000000/health-welfare-benefits-professional-perspective-state-bans-on-d [https://perma.cc/RTK3-ZZSS].

- **Section I** provides background on ERISA's overall scheme, and then turns its attention to its claims procedures, causes of action, and preemption provisions;
- **Section II** discusses the various standards that an appellate court could use in reviewing a decision maker's determination, ranging from the *de novo* standard to a no review standard. It then discusses what judicial standard of review the courts have invoked since ERISA's adoption in 1974, as ERISA itself was silent on the appropriate judicial standard of review;
- **Section III** reviews the Supreme Court's adoption of the *de novo* standard of review in the case of a benefits denial claim in *Firestone Tire & Rubber Co. v. Bruch*, decided in 1989. It also examines how the judicial standard is applied in the context of a plan administrator's conflict of interest—as determined in the Supreme Court's decisions of *Metropolitan Life Ins. Co. v. Glenn* in 2008 and *Conkright v. Frommert* in 2010.
- **Section IV** examines what language is sufficient in an insurance policy to grant discretion to the insurer, so as to invoke the abuse of discretion standard of review.
- **Section V** discusses the NAIC's model law, initiated in 2004, which seeks to ban discretionary clauses in *insured* disability benefit plans, and whether such ban would be preempted under ERISA's provisions or saved under its savings clause.
- **Section VI** conducts a circuit-by-circuit review on the following issues: whether the plan administrator has the burden of providing whether the deferential standard of review applies; what insurance language is sufficient to confer discretionary authority in order to escape the *de novo* standard of review; and whether the court's review of a benefits denial case is limited to the administrative record created by the plan administrator in either a *de novo* review case or a deferential review case.
- **Section VII** summarizes the splits between the circuits on these issues and the need for Supreme Court clarification. It then recommends a uniform path going forward regarding the rules for adjudicating ERISA disability benefit claims.

Section I. Introduction to ERISA

A. Congressional Intent

For those unfamiliar with the federal law that governs an employee benefits plan, a brief introduction to ERISA is in order. The federal law known as ERISA was passed to extend protections for participants and beneficiaries covered under an employer-provided employee benefit plan and to set forth a uniform set of requirements for

employers who voluntarily provide such benefits.[17] Due to the tax preferential nature of the benefits provided, ERISA amended the labor provisions of 29 U.S.C., as well as the tax provisions of 26 U.S.C. References to ERISA throughout this article refer to its citation under 29 U.S.C. Some of the important themes of ERISA include:

- **Employee communication of benefits:** Congress wanted employers to submit reports to the Department of Labor (DOL) and the Internal Revenue Service (IRS) to ensure that ERISA's rules were being followed.[18] It also wanted covered employees to be notified of their rights and obligations under the plan, and if such rights and obligations changed over time.[19] All documents relied upon by the plan administrator in carrying out its duties must also be made available to participants and beneficiaries.[20]
- **Minimum vesting and funding requirements:** As the dominant employee benefit scheme in 1974 was retirement benefits from a defined benefit plan,[21] Congress wanted to restrict the use of onerous vesting schedules that an employer could impose on an employee in order to receive his or her retirement benefit.[22] It also wanted employers to fund promised defined benefit plans in advance, as opposed to paying such benefits on a pay-as-you-go basis.[23]
- **Fiduciary duties:** Once an employer decided to offer an employee benefit plan, Congress wanted to impose fiduciary standards regarding how a plan fiduciary was to act under the terms of an employee benefits plan.[24] While defined benefit and defined contribution plans necessitate the use of a trust to hold plan assets (unless insurance contracts or annuities were used), most employee benefit welfare plans do not mandate the use of a trust, as an employer can decide to fund such benefits on a pay-as-you-go basis.[25] However, Congress decided to impose

17. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in various sections of 26 and 29 U.S.C.).

18. 29 U.S.C. § 1021; *see History of EBSA and ERISA*, EMP. BENEFITS SEC. ADMIN., https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/history-of-ebsa-and-erisa (last visited Feb. 20, 2024) [https://perma.cc/A2BB-EMVJ].

19. 29 U.S.C. § 1021.

20. *Id.*; 29 C.F.R. § 2520.104b-1 (2020).

21. John W. Thompson, BUREAU LAB. STAT., DEFINED BENEFIT PLANS AT THE DAWN OF ERISA 1 (Mar. 30, 2005), https://www.bls.gov/opub/mlr/cwc/defined-benefit-plans-at-the-dawn-of-erisa.pdf [https://perma.cc/3KXC-US8X].

22. *Id.*; *see* 29 U.S.C. § 1053.

23. 29 U.S.C. § 1082.

24. *Id.* §§ 1101–14; *see Fiduciary Responsibilities*, U.S. DEP'T OF LAB., https://www.dol.gov/general/topic/retirement/fiduciaryresp (last visited Feb. 20, 2024) [https://perma.cc/XLV6-NFXA].

25. 29 U.S.C. § 1103.

fiduciary standards on *all* covered employee benefit plans—imposing standards such as acting in the exclusive purpose of the plan participants and beneficiaries; acting as a prudent person while discharging one's duties; and discharging one's duties in accordance with the terms of the plan which are consistent with ERISA.[26] Plan administrators who are fiduciaries are subject to these standards.[27]

- **Civil enforcement and ERISA's preemption clause:** ERISA sets forth various causes of action for participants and beneficiaries which, due to ERISA's preemption clause, are intended to be the exclusive and sole remedy.[28] In the context of a cause of action for denied benefits, ERISA's sole remedies are recovery of the promised benefits and any resulting monetary damages, as well as enforcement and declaratory relief.[29] ERISA generally preempts any state law that relates to employee benefit plans, with some notable exceptions.[30]
- **Settlor versus fiduciary status:** ERISA allows an employer to be both the settlor of the employee benefit plan, as well as the plan administrator and/or plan trustee.[31] Similarly, if the employer decides to insure the benefits under the plan (as many small businesses and even large businesses under a stop loss policy do), the insurer becomes both the payor of the benefits and the plan administrator.[32] Such situations pose an inherent conflict of interest as the employer and/or insurer are incentivized to deny an employee benefits claim in order to reduce costs under the plan.[33] Looking back, ERISA may have been better served if the plan administrator and/or plan trustee was required to be independent of the employer sponsor; however, such a result would have increased costs for employers.

B. ERISA's Claims Procedures

Once an employer decides to offer an employee benefits plan, ERISA requires that the plan be established and maintained pursuant to a written plan document, which outlines who is eligible for benefits and what the covered benefits are.[34] For example, under an employer

26. *Id.* §§ 1103–04.
27. *Id.* § 1104.
28. *Id.* § 1144.
29. *Id.*
30. *Id.*
31. *Id.* § 1102(c).
32. *Id.* § 1144.
33. The Supreme Court in Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 108 (2008) states that when the employer or the insurance company both "determines whether an employee is eligible for benefits and pays benefits out of its own pocket," this dual role creates a conflict of interest.
34. 29 U.S.C. § 1102(a)(1).

provided short-term disability plan, the plan may provide a monthly benefit of $2,000 for 26 weeks once the employee, as a result of injury or sickness, is unable to perform the material and substantial duties of his occupation. Under the disability benefit plan, the plan administrator then determines whether an employee meets this definition of disability, and if he does, distributes the monthly benefit of $2,000 for the next 26 weeks.[35] However, if the plan administrator determines the employee has not met that definition of disability, it will deny the benefit.[36] Under ERISA's enforcement rules, if a participant has been denied his claim for benefits, the plan administrator must provide the following: a clear explanation as to the specific reasons for the denial;[37] notice of the participant's right to internally appeal that decision;[38] and, if the employee decides to appeal that decision, a full and fair review of the claim on the internal appeal.[39]

Thus, a participant is afforded two levels of review for a claim for benefits: the initial determination made by plan administrator, and if the benefit is denied, an internal appeal of the benefits denial by an appropriate named fiduciary. The federal courts have fashioned an

35. *Id.* §§ 1102, 1104.

36. *Id.* § 1133.

37. *See id.* Within 45 days after his initial submission of a disability claim, the claimant must be given written notice as to whether the claim is denied in whole or in part. 29 C.F.R. § 2560.503-1(f)(3). Such notice must set forth the specific reasons for the denial, referencing the plan provisions that were used; it must provide additional information that the claimant may submit to "perfect" the claim, explaining why such information is relevant. To the extent the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule may be made available to the claimant. 29 C.F.R. § 2560.503-1(g)(1)(v)(A).

38. 29 C.F.R. § 2560.503-1(h)(4).

39. *See* 29 U.S.C. § 1133; *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987) ("ERISA's detailed provisions set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures . . . ERISA's civil enforcement remedies were intended to be exclusive."). Under the regulations, the internal appeal must be reviewed by a fiduciary who is not the initial claim reviewer (or a subordinate of such person); the appeal cannot defer to the original claim decision; the claimant must be informed as to the identity of any medical or vocational experts conferred in such claim; the claimant has the right to submit additional information which the reviewer must take into consideration; if the benefit denial was based on medical judgment, the reviewing fiduciary must consult with an appropriate health care professional; the claimant must be notified of the decision within 45 days; and the claimant must receive written or electronic notice of the decision upon review. 29 C.F.R. § 2560.503-1(j).

exhaustion doctrine that requires the participant to exhaust this internal appeal process before proceeding to litigation.[40] Use of this exhaustion doctrine provides the courts with an administrative record that documents the plan administrator's initial and final decisions, and allows the participant/beneficiary to submit additional evidence so as to perfect his claim for benefits.[41] Generally the administrative record contains the plan document (and insurance policy, if the benefits are insured) and the claim file (e.g., documents confirming the participant's disability).[42] As an aside, the phrase "administrative record" used by the courts suggests that it is reviewing an administrative agency decision, which of course, it is not. In fact, the court is reviewing a dispute between two private parties.[43] While the phrase "claim file" may be a more accurate one, the courts generally use the phrase "administrative record," in lieu of "claim file."[44]

In many situations, the administrative record may not document the fact that the plan administrator may have a conflict of interest in determining the claim for benefits, nor explain how the conflicted plan administrator reasoned his decision in light of the conflict.[45] Thus, the scope of review beyond the administrative record is important in

40. *See* 29 U.S.C. § 1133(1) (requiring participants to receive written notice of any claim denial). The Department of Labor's original claims procedure regulations required that the participant be afforded the opportunity for a full and fair review with adequate explanation of any benefit denial. *See* 29 C.F.R. § 2560.503-1 (1977). Although ERISA does not explicitly require exhaustion of the plan's internal claims procedures before judicial review of the denial, virtually all of the circuits affirm the use of such doctrine in ERISA benefit denial cases. *See, e.g.*, Lindemann v. Mobil Oil Corp., 79 F.3d 647, 649–51 (7th Cir. 1996); Hickey v. Digit. Equip. Corp., 43 F.3d 941, 945 (4th Cir. 1995); Variety Child.'s Hosp. v. Century Med. Health Plan, 57 F.3d 1040, 1042 (11th Cir. 1995); Costantino v. TRW, Inc., 13 F.3d 969, 974–75 (6th Cir. 1994); Commc'ns Workers Am. v. AT&T, 40 F.3d 426, 432 (D.C. Cir. 1994); Simmons v. Willcox, 911 F.2d 1077, 1081 (5th Cir. 1990); Curry v. Cont. Fabricators, Inc. Profit Sharing Plan, 891 F.2d 842, 846 (11th Cir. 1990); Leonelli v. Pennwalt Corp., 887 F.2d 1195, 1199 (2d Cir. 1989); Drinkwater v. Metro. Life Ins. Co., 846 F.2d 821, 825–26 (1st Cir. 1988).

41. *See* Marty Steinberg & David Massey, *ERISA Litigation Pitfalls—The "Deemed Exhausted" Rule and Its Strict Compliance Standard*, BLOOMBERG L. (May 1, 2018, 12:03 PM), https://news.bloomberglaw.com/employee-benefits/erisa-litigation-pitfalls-the-deemed-exhausted-rule-and-its-strict-compliance-standard [https://perma.cc/NB4U-D98X].

42. 29 U.S.C. § 1132; Howley v. Mellon Fin. Corp., 625 F.3d 788, 793 (3d Cir. 2010).

43. *See id.*

44. Noga v. Fulton Fin. Corp. Emp. Benefit Plan, 19 F.4th 264, 272 (3d Cir. 2021).

45. *Id.* at 273–74; 29 U.S.C. § 1132(a)(1)(B).

determining whether the conflict exists and whether such conflict tainted the plan administrator's decision to deny benefits.[46]

Under the DOL claims regulations, the initial determination as to whether to pay a benefit need not be made by a plan fiduciary; however, a fiduciary (while not required to be independent) must conduct the second level of review (i.e., the internal appeals process).[47] By virtue of ERISA's fiduciary duties, such fiduciary must act for the exclusive benefit of the plan participants and beneficiaries.[48] But ERISA allows fiduciaries to wear multiple hats, allowing them to be in a conflict of interest position.[49] When a plan fiduciary wears two hats, he/she must "wear only one at a time, and wear the fiduciary hat when making fiduciary decisions."[50] As noted above, ERISA imposes standards with which it judges whether the fiduciary fulfilled its duties properly.[51]

C. ERISA's Appeal Levels

If the participant has exhausted both levels of internal review of his benefits claim, ERISA explicitly provides for a federal cause of action to recover benefits due to a participant or beneficiary under the terms of the plan.[52] However, ERISA is silent as to how a court must

46. In contrast, due to the changes made by the Affordable Care Act, [the Patient Protection and Affordable Care Act was originally enacted on March 23, 2010, and modified by the Health Care and Education Reconciliation Act of 2010 on March 30, 2010, and referred to as ACA], the internal claims, appeals, and external review processes that apply to group health plans are different than those that apply to other welfare benefit plans. To the extent that the plan administrator fails to adhere to the claims procedures, the claimant is said to have exhausted the internal claims and appeals procedures and may adjudicate the claim in court. *See* 29 C.F.R. § 2590.715–2719(b)(2)(ii)(F). The Department of Labor regulations also requires plans and insurers to avoid conflicts of interest during the appeals process so as to encourage the independence and impartiality of the decision maker. *See* 29 C.F.R. § 2590.715–2719(b)(2)(ii)(D).

47. 29 C.F.R. § 2560.503-1(h)(2).

48. 29 U.S.C. § 1104.

49. *See* Pegram v. Herdrich, 530 U.S. 211, 225 (2000).

50. *See id*.; *see also* Beverly Cohen, *Divided Loyalties: How the Metlife v. Glenn Standard Discounts ERISA Fiduciaries' Conflicts of Interest*, 2009 UTAH L. REV. 955, 958–59 (2009), querying whether ERISA can provide undivided loyalty to plan participants and beneficiaries when their benefit claims are determined by fiduciaries who are conflicted.

51. 29 U.S.C. §§ 1104–14.

52. *See* 29 U.S.C. § 1132(a)(1)(B).

review the plan administrator's denial—referred to as the applicable judicial standard of review.[53] Should a court give deference to the plan administrator's decision, or decide the issue on its own? The level of scrutiny applied to the denial of benefits is dependent on the applicable standard of review, which clearly impacts the outcome of a claim for benefits.[54] For example, if the courts apply a *de novo* standard of review, the participant/beneficiary may get a second bite of the apple; whereas if the standard is highly deferential, the participant will struggle in asking the court to overturn the plan administrator's decision.[55] In fashioning a federal common law applicable to ERISA, courts have tried to maintain a delicate balance between the plan sponsor's ability to draft, amend, and terminate such plans and the protections afforded to plan participants and beneficiaries, as the benefits provided under such plans are *voluntary* in nature.[56] In fact, until the passage of the Affordable Care Act (ACA) in 2010, employers were not required to offer *any* employee benefits; ACA now imposes a tax on large employers who fail to offer an employer-sponsored group health plan to their full time employees or offer a group health plan with coverage that is not "affordable" or does not provide "minimum essential coverage."[57] But outside of the group health plan context, employee benefits remain voluntary on the part of the employer.[58]

When ERISA was passed in l974, the dominant employee benefit offered by employers was retirement benefits, either in the form of a defined benefit (similar to the type of benefit offered by the Social Security Administration) or defined contribution (where the employee's benefit depends on the balance in his account balance at retirement).[59] Thus, many of the Parts of Subtitle B of ERISA apply only to employer-provided retirement plans.[60] However, several Parts of Subtitle B—reporting and disclosure rules, fiduciary rules, and the administration

53. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989) ("ERISA does not set out the appropriate standard of review for actions . . . challenging benefit eligibility determinations.").

54. Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1084 (2001) [hereinafter Kennedy, *Standard of Review*].

55. *Id.* at 1094.

56. *Id.* at 1119.

57. 26 U.S.C. § 4980H.

58. *See* Kennedy, *Standard of Review*, *supra* note 54, at 1087.

59. *Id.* at 1104.

60. 29 U.S.C. §§ 1021–1191.

and enforcement rules—were made equally applicable to retirement plans and welfare plans (e.g., health and disability plans).[61]

D. ERISA's Causes of Action

29 U.S.C. § 1132 of ERISA sets forth the various causes of actions for a participant/beneficiary, a fiduciary under the plan, or the DOL Secretary to pursue.[62] Such causes of action apply to any covered employee benefit plan, regardless of whether it is a pension or welfare type of plan.[63] When a participant/beneficiary is denied a benefit set forth under a plan, his federal cause of action is known as a 29 U.S.C. § 1132(a)(1)(B) claim, requesting the recovery of promised benefits and any resulting monetary damages.[64] That provision also allows a suit to enforce the participant's rights under the plan and to obtain a declaratory judgment of future entitlement to benefits under the plan.[65] To the extent that ERISA's preemption clause is construed broadly by the courts to preempt state tort and contractual causes of actions, ERISA's federal cause of action for the payment of benefits becomes the sole cause of action and the only form of remedy for the participant.[66]

E. ERISA's Preemption Provisions

ERISA's legislative history envisioned an overall uniform set of federal rules applicable to employee benefit plans, in lieu of fifty different state laws.[67] To accomplish this, Congress drafted a very broad preemption clause to override state laws or regulations as they relate to any employee benefit plan.[68] The original language of the preemption clause is as follows:

61. *Id.*
62. 29 U.S.C. § 1132.
63. *Id.*
64. 29 U.S.C. § 1132(a)(1)(B).
65. *Id.*
66. *See* Kennedy, *Standard of Review*, *supra* note 54, at 1091–92.
67. *See* 120 CONG. REC. H29197 (daily ed. Aug. 20, 1974) (statement of Rep. Dent) (nothing that the legislation's greatest achievement is the "reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting any inconsistent State and Local regulations.").
68. *See* 29 U.S.C. § 1144(a) (stating that ERISA preempts state law).

> [T]he 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) . . . .[69]

But, in recognition of the fact that states have historically regulated insurance, banking and securities laws, ERISA's preemption clause has an express exception that provides for continued state regulation of these types of laws (referred to as its "savings clause").[70] In order to prevent states from circumventing the savings clause, Congress enacted a related "deemer clause" which prevents states from deeming employee benefit plans to be an insurer, bank, trust company, or investment company, which subjects such plans to state insurance, banking, or securities laws covered by the savings clause.[71] The deemer clause assures that a self-funded (i.e., funded solely by the employer) disability benefit plan is not deemed to be an "insurance company" for purposes of the state insurance laws, which are saved from preemption.[72]

While the author could pen an entire law review article on the Supreme Court's interpretation of ERISA's preemption clause, its savings clause, and its deemer clause, suffice it to say that the Supreme Court's interpretations have differed dramatically over ERISA's nearly 50-year history. For the first twenty years of ERISA's existence, the Court took an expansive view of preemption.[73] Quoting from the Supreme Court's decision in *Davila*, "ERISA includes expansive [preemption] provisions, which are intended to ensure that employee benefit plan regulation would be exclusively a federal concern."[74] But by 1995, the Supreme Court decided to rein in the far reach of ERISA's preemption clause by observing that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption

69. Employee Retirement Security Act of 1974, Pub. L. No. 93-406, § 514, 88 Stat. 829 (emphasis added).

70. *See* 29 U.S.C. § 1144(b)(2)(A) (referring to what is known as ERISA's "savings clause").

71. *See* 29 U.S.C. § 1144(b)(2)(B) (referring to what is known as ERISA's "deemer clause").

72. *See* Williby v. Aetna Life Ins. Co., No. 2:14-cv-04203, 2015 WL 5145499, at *5 (C.D. Cal. Aug. 31, 2015).

73. *See* Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 99 (1983).

74. *See* Aetna Health Inc. v. Davila, 542 U.S. 200, 200 (2004) (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981)); *see also* Wis. Pub. Intervenor v. Mortier, 501 U.S. 597, 604 (1991) (quoting Gibbons v. Ogden, 22 U.S. 1, 9 (1824)) (observing that the U.S. Supremacy Clause, U.S. CONST., art. VI, cl. 2, renders state laws invalid if they "interfere with, or are contrary to the laws of congress, made in pursuance of the constitution").

would never run its course."[75] Since then, the Supreme Court has carved out two categories of state laws that ERISA preempts.

First, to the extent a state law "references" an ERISA plan, it will be preempted.[76] The Court describes this category of state law in *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.* as one "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . , that 'reference' will result in pre-emption."[77] In the *Dillingham* case, a California law required a public works project contractor to pay its workers the prevailing wage in the project's locale, but permitted lower wages to workers in a state-approved apprenticeship program.[78] As the law did not make any reference to ERISA plans and because not all apprenticeship programs included ERISA plans, the Court held that ERISA preemption did not apply.[79]

Second, to the extent a state law has an impermissible "connection with" ERISA plans (i.e., the State law "governs . . . a central matter of plan administration" or "interferes with nationally uniform plan administration,"), it will be preempted.[80] In the *Egelhoff v. Egelhoff* case, a Washington law provided that the designation of a spouse as the beneficiary of a nonprobate asset was automatically revoked upon divorce.[81] The Supreme Court held that such law was preempted by ERISA, as it bound ERISA plan administrators to a particular choice of rules in ascertaining beneficiary status, forcing the plan administrators to pay benefits to the beneficiaries chosen by state law instead of those identified pursuant to the plan document.[82] Such a law "implicates an area of core ERISA concern" and runs afoul of the directives of ERISA.[83]

In addition, the Supreme Court has held that state laws that attempt to supplant or expand the exclusive remedies of ERISA's causes

75. *See* N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995).
76. Cal. Div. Lab. Standards Enf't v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 324–25 (1997).
77. *See id.* at 325.
78. *Id.* at 319.
79. *Id.*
80. *See* Egelhoff v. Egelhoff, 532 U.S. 141, 148 (2001).
81. *Id.* at 143.
82. *Id.* at 147.
83. *Id.* at 147–48.

of action are preempted, as they are inconsistent with Congress' objective under ERISA that such causes of action be enforced under a uniform national system (referred to as the "conflict preemption argument").[84] In *Rush Prudential HMO, Inc. v. Moran*, the Supreme Court examined whether an Illinois law regulating health maintenance organizations (HMOs) was preempted under ERISA, as it provided that if a patient's primary care physician determined that care was medically necessary, but the HMO declined to cover it, the patient was entitled to an independent medical review of his claim.[85] The Supreme Court held that such law was not preempted as it "provides no new cause of action under state law and authorizes no new form of ultimate relief."[86] Nor did the Illinois law "enlarge the claim beyond the benefits available" in a cause of action for benefits.[87] As a result, the law could be enforced against the employee benefit plan.[88]

Under its savings clause, the preemption clause has an exception whereby state insurance laws are "saved" from preemption.[89] The Supreme Court in *Kentucky Ass'n of Health Plans, Inc. v. Miller* simplified the test used in determining whether a state law falls within ERISA's savings clause and, thus, expanded the types of state laws that could regulate insurance.[90] In the *Miller* decision, the Court unanimously set forth a new test that has two elements: "[f]irst, the state law must be specifically directed toward entities engaged in insurance . . . . Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured."[91] The Supreme Court stated that the savings clause "saves laws that regulate *insurance*, not insurers;"[92] hence, the fact that the state law impacts other entities along with the regulated entities (i.e., insurers) does not remove the law from ERISA's savings clause.

Later, the Supreme Court in *UNUM Life Ins. Co. v. Ward* held that the first element of the *Miller* test is met when the law "homes in on the insurance industry," as opposed to simply having an impact on such

84. *See, e.g.*, Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142–45 (1990); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52–57 (1987).
85. *See* Rush Prudential HMO, Inc. v. Morgan, 536 U.S. 355, 359–60 (2002).
86. *Id.* at 379–80.
87. *Id.* at 357.
88. *Id.* at 379–80.
89. 29 U.S.C. § 1144(b)(2)(A).
90. *Id.*
91. Ky. Ass'n Health Plans, Inc. v. Miller, 538 U.S. 329, 342 (2003).
92. *Id.* at 334.

industry.[93] In *Ward*, California had a "notice-prejudice" rule that prohibited the insurer from denying a claim because the insured did not timely file such claim, unless the insurer could prove it was "prejudiced by the delay."[94] The Court held that the notice-prejudice rule was a rule of law governing the insurance relationship, and not a general rule of law "disfavoring forfeitures."[95] Thus, as a matter of common sense, such a state law regulated insurance.[96] Similarly, as will be discussed below, a state law banning the use of discretionary clauses in insured disability benefit plans should be found to regulate insurance, as it is directed solely towards the insurance industry by controlling the terms of the insurance policy.[97] Hence, it should satisfy *Miller's* first prong.

As to the second element of the *Miller* test, the Supreme Court in *Ward* explained that California's notice-prejudice rule affected the risk pooling arrangement because it "governs whether or not an insurance company must cover claims submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed."[98] Similarly, as will be discussed below, a state law banning the use of discretionary clauses in insured disability benefit plans alters the terms of the arrangement and dictates to the insurer the conditions under which it must pay for the bargained risk.[99] By upholding the ban on discretionary clauses, the insurer's denial of benefits will be subjected to a *de novo* court review, which alters the risk pooling bargain, as the insurer's denial will be exposed to a more thorough review of the claimant's claim by the courts.[100] Thus, a state law banning discretionary clauses in disability insurance contracts should be saved under ERISA's savings clause.

The deemer clause narrows the scope of the savings clause by applying preemption to state laws otherwise carved out by the savings clause.[101] The deemer clause states that no "employee benefit plan . . .

93. UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 368 (1999).
94. *Id.* at 364.
95. *Id.* at 373.
96. *Id.*
97. *See Miller*, 538 U.S. at 334.
98. *See id.* at 342 n.3.
99. *See, e.g.*, *id.* at 338–42.
100. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).
101. *See, e.g.*, 29 U.S.C. § 1144(b)(2)(B).

shall be deemed to be an insurance company or other insurer . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts."[102] According to the Supreme Court, "[u]nder the deemer clause, an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws 'purporting to regulate' insurance companies or insurance contracts."[103] The Supreme Court has dismissed the argument that the deemer clause applies only to "state insurance regulations that are pretexts for impinging upon core ERISA concerns."[104] Hence, a state insurance law or regulation may be preempted to the extent it operates directly on an ERISA plan, even if its intent is not pretextual.[105]

Section II. Various Judicial Standards of Review

A. Types of Judicial Standards of Review

This Section of the Article discusses the various judicial standards of review that a court *may* impose upon a decision maker's action. Differing judicial standards of review,[106] which may be required by case law or statute, emphasize the role of a trial court judge or jury over that of an appellate court judge. Such standards may also be involved in the administrative context where an agency (e.g., Social Security Administration) determines benefits.[107] Generally, trial court judges or juries resolve factual disputes and determine the credibility of witnesses who appear before the court.[108] In contrast, appellate judges generally rectify legal errors made by the lower courts, amplify the law, and set precedent to direct future cases.[109] Appellate courts generally engage panels of three or more judges, which act as a unit; panels of three judges make

102. *Id.*
103. FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990).
104. *Id.* at 63.
105. *See, e.g.*, *id.* at 61–65.
106. The judicial standard of review has been described as the "positive authority the appellate court wields in its review function." STEVEN ALAN CHILDRESS & MARTHA S. DAVIS, FEDERAL STANDARDS OF REVIEW § 1.01 (4th ed. 2023).
107. *See id.*
108. ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 2577 (3d ed. 2023).
109. *See id.*

it less likely that an error will occur, as compared to a single judge hearing the initial case.[110]

Varying degrees of judicial deference are referred to as standards of review. Courts generally recognize six different standards of review: *de novo*; clearly erroneous; reasonableness; arbitrary and capricious; abuse of discretion; and no review.[111] Which standard of review applies may also be based on the type of ruling that is being considered.[112] In the context of a benefits denial claim, the question may be purely factual (e.g., did the participant act in a certain way); it may be legal (e.g., what remedy ERISA provides for this cause of action); or it may be a mixed question of fact and law (e.g., did the participant's action violate the terms of the plan, which ERISA requires the plan administrator to follow).

The varying standards may be summarized as follows:

- ***De novo*:** This standard gives no deference to the decision maker's conclusion.[113] Such a standard is applied when an appellate court is reviewing a question of law, and not issues of pure fact.[114] Thus, the reviewing court may come to a different conclusion than that of the decision maker. The reviewing court's decision is usually based on the decision maker's fact record.[115] However, in the context of reviewing administrative fact findings *de novo*, the court may use the agency's record or, when appropriate, create its own record.[116] In situations where the court is reviewing both law and fact findings from an administrative proceeding *de novo*, the court must consult the statute providing for review of such proceeding.[117]
- **Clearly erroneous:** According to the Supreme Court, a finding is clearly erroneous when "the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed."[118] Such review generally mandates

110. *Court Role and Structure*, U.S. CTS., https://www.uscourts.gov/about-federal-courts/court-role-and-structure (last visited Feb. 20, 2024) [https://perma.cc/D33B-LWRZ].

111. *See, e.g.*, Martha S. Davis, *A Basic Guide to Standards of Judicial Review*, 33 S.D. L. REV. 468, 468 (1988).

112. *See id. See also* Kelly Kunsch, *Standard of Review (State and Federal): A Primer*, 18 SEATTLE UNIV. L. REV. 11, 24–25 (1994).

113. *Id.* at 14.

114. *Id.* at 12.

115. *Id.* at 14.

116. *Id.* at 27.

117. *Id.*

118. United States v. U. S. Gypsum Co., 333 U.S. 364, 395 (1948).

substantial, but not total, deference to the decision maker's fact findings.[119]

- **Reasonableness:** This standard asks whether reasonable minds would have come to the same conclusion as the decision maker.[120] Alternatively, it may ask whether there is substantial evidence to support the decision, in which case the decision should be affirmed.[121]
- **Arbitrary and capricious:** This standard is set forth in the Administrative Procedures Act,[122] as it applies to agency fact findings. It was intended to be deferential to such findings, but requires the agency to show the basis for its decision.[123] While scholars have equated the arbitrary and capricious review standard and the reasonableness/substantial evidence review standard (discussed above), the standards vary in regard to *what* is being reviewed.[124] Under the arbitrary and capricious review, the focus is on the agency's explanation of its decision and whether the decision is rational given the body of evidence.[125] In contrast, under the reasonableness/substantial evidence review, the review applies to the agency's assessment of the evidence in the record and the use of such evidence in making its decision.[126]
- **Abuse of discretion:** This standard generally applies in the context of discretionary decisions (e.g., the administrator in nonfactual decisions is given discretion to exercise its judgment, which, if legal, will be safeguarded).[127] Next to the no review (explained below), this standard is the most deferential.[128]
- **No review:** This standard affords complete deference to the decision maker's decision, and its use is generally constrained to administrative proceedings.[129] For example, some statutes exclude review of agency decisions, such as Veterans Administration benefits decisions[130] and Title II Social Security claims.[131]

119. *See* CHILDRESS & DAVIS, *supra* note 106, at § 2.05.
120. *See* California v. FCC., 75 F.3d 1350, 1358 (9th Cir. 1996).
121. *See* California v. FCC, 39 F.3d 919, 925 (9th Cir. 1994).
122. 5 U.S.C. § 706(2)(A).
123. *See, e.g.*, Davis, *supra* note 111, at 79–80.
124. *See* CHILDRESS & DAVIS, *supra* note 106, at § 15.7.
125. Davis, *supra* note 111, at 479–80.
126. *See* California v. FCC, 75 F.3d 1350, 1358 (9th Cir. 1996); *see also* FCC, 39 F.3d at 925.
127. Kunsch, *supra* note 112, at 34.
128. *Id.*
129. Davis, *supra* note 111, at 481.
130. 38 U.S.C. § 211(a).
131. 42 U.S.C. § 405(h).

Section III. ERISA's Judicial Standard of Review in Benefits Denial Claims

Because ERISA was silent as to the appropriate judicial standard of review in a benefits denial claim, federal courts initially looked to standards of review used in other contexts.[132] ERISA's Conference Report noted that the resolution of benefits disputes should be ". . . regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947."[133] Other portions of ERISA's legislative history indicate that "a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans."[134] In fact, the Supreme Court directed the lower courts to formulate a uniform federal common law for protecting the benefit rights of participants/beneficiaries under ERISA plans.[135] Thus, the lower courts looked to elements of labor law, trust law, contract law, insurance law, and administrative law in fashioning an ERISA common law, as all of these laws may have some relevance in the ERISA claim context.[136]

As will be discussed later in this Article, the Supreme Court determined the appropriate judicial standard of review in a benefits denial claim in the 1989 case of *Firestone Tire & Rubber Co. v. Bruch.*[137] However, prior to the Supreme Court's *Firestone* decision, virtually all of the circuit courts used labor law's arbitrary and capricious standard of review in ERISA benefit denial causes of action.[138] However, the circuit courts split on the application of this standard of review in cases where

132. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 102 (1989).

133. H.R. REP. NO. 93-1280, 327, at 488 (1974)(Conf. Rep.); B. SCHWARTZ, ADMINISTRATIVE LAW §§ 10.13–10.37 (2d ed. 1984); R. PIERCE, S. SHAPIRO & P. VERKUIL, ADMINISTRATIVE LAW AND PROCESS § 7.3.3, at 363 (1985).

134. Franchise Tax. Bd. of Cal. v. Constr. Laborers Vacation Tr., 463 U.S. 1, 24 n.26 (1983) (quoting 120 CONG. REC. 29942 (1974) (remarks of Sen. Javits)).

135. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987) (directing the lower courts to develop a "federal common law of rights and obligations under ERISA-regulated plans").

136. *See id*.

137. *Firestone*, 489 U.S. at 115.

138. *See* Kennedy, *Standard of Review*, *supra* note 54, at 1108 for a description of the various circuit court decisions pre-Firestone.

the plan administrator had a conflict of interest.[139] For example, in the case of an employer of an unfunded employer-administered employee benefit plan, an employer may be motivated to deny benefits as such payments would come from the employer's own operating funds, as opposed to trust assets administered by an independent trustee. Likewise, an insurance company which insures and administers the employee benefits plan may be motivated to deny the benefits so as to limit the payment of such claims.

A. Applicable Standard of Review Pre-ERISA in Benefit Denial Cases

Prior to the passage of ERISA, courts used an abuse of discretion standard of review in the adjudication of employee benefits under trust funds governed by the Labor Management Relations Act of 1947 (LMRA).[140] A Taft Hartley plan (otherwise known as a multiemployer plan) is a collectively-bargained employee benefits plan maintained by more than one employer (usually in the same or related industry) and a labor union.[141] Section 302 of the LMRA permits the establishment of trust funds, through collective bargaining between employers and unions, that provide pension and welfare benefits to employees.[142] Such

139. *See* Van Boxel v. J. Co. Emps.' Pension Tr., 836 F.2d 1048, 1052–53 (7th Cir. 1987) (advocating for "sliding scale of judicial review of trustees' decisions—more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is.").

140. For a discussion of the history of the arbitrary and capricious standard of review under LMRA trusts, *see* John A. McCreary, Jr., Comment, *The Arbitrary and Capricious Standard under ERISA: Its Origins and Application,* 23 DUQ. L. REV. 1033, 1038–41 (1985).

141. Labor Management Relations Act, 1947 (LMRA) (Taft-Hartley Act) §, ch. 120, 61 Stat. 136 (1947) (codified as amended in scattered sections of 29 U.S.C.) (This act was named for its congressional sponsors, Robert Taft of Ohio and Fred Hartley Jr. of New Jersey.). While § 302 of the LMRA prohibits employer contributions to unions, § 301(c)(5) permits employers to make payments into an employee benefits trust "for the sole and exclusive benefit of the employees." *See* 29 U.S.C. §§ 186(a)(2), 186(c)(5).

142. Labor Management Relations Act, § 302(c)(5), 29 U.S.C. § 186 (1947). *See* Danti v. Lewis, 312 F.2d 345, 349 (D.C. Cir. 1962) (holding that the trustee's decision was arbitrary and capricious in denying the employee's benefits); *see also* Dennard v. Richards Grp. Inc., 681 F.2d 306, 313 (5th Cir. 1982) (noting that the arbitrary and capricious standard of review traditionally has been used for review of trusts); Wardle v. Cent. States, Se. & Sw. Areas Pension Fund, 627 F.2d 820, 824 (7th Cir. 1980) (stating that a reviewing court should not resolve eligibility questions on new evidence, but should remand to the trustee for a new determination); Rehmar v.

trust funds are overseen by a board of trustees that adjudicates benefit claims.[143] Section 302 of the LMRA mandates that one-half of the board consists of trustees who are appointed by the employers who fund the plan, whereas the other one-half of the board consists of union-designated trustees.[144] A more deferential standard of review, such as the abuse of discretion standard, was applied by the courts, as the joint board of trustees (with equal representatives of management and labor) assured impartial administration under the employee benefit plan.[145] Such standard would negate the joint board's determinations as to coverage and/or eligibility for benefits "only where they are arbitrary, capricious or made in bad faith, not supported by substantial evidence, or erroneous on a question of law."[146] Even after ERISA was passed in 1974, a number of courts imposed this same abuse of discretion standard to benefit adjunctions in plans *outside* the collective bargaining process, as ERISA was silent on the issue.[147]

Smith, 555 F.2d 1362, 1371 (9th Cir. 1976) (continuing to apply the Danti standard of review in diversity cases); Pete v. UMW Welfare & Ret. Fund of 1950, 517 F.2d 1275, 1283 (D.C. Cir. 1975) (stating that the court's role is limited to determining whether the trustee actions are arbitrary and capricious); Lee v. Nesbitt, 453 F.2d 1309, 1311 (9th Cir. 1971) (stating that trustees owe fiduciary duty to the employees and may not act arbitrarily); Gomez v. Lewis, 414 F.2d 1312, 1313-14 (3d Cir. 1969) (noting the trustee's decisions are subject to review when they are arbitrary and capricious); Roark v. Lewis, 401 F.2d 425, 426 (D.C. Cir. 1968) (defining the scope of the reviewing court to determine whether the action was arbitrary and capricious); Miniard v. Lewis, 387 F.2d 864, 865 (D.C. Cir. 1967) (limiting scope of review to those actions by the trustee which are arbitrary and capricious); Kosty v. Lewis, 319 F.2d 744, 747 (D.C. Cir. 1963) (stating that trustees, like all fiduciaries, are subject to review for actions that are arbitrary and capricious).

143. Labor Management Relations Act § 302(c)(5).

144. *Id. See* Operative Plasterers Int'l Ass'n v. Paramount Plastering, Inc., 310 F.2d 179, 182 (9th Cir. 1962). There is also an impartial umpire to decide matters when the two trustee groups disagree with a benefits determination. *See* N.L.R.B. v. Amax Coal Co., 453 U.S. 322, 337 (1981).

145. *Rehmar*, 555 F.2d at 1371.

146. *Id.*

147. *Id. See Dennard*, 681 F.2d at 308 (affirming use of the arbitrary and capricious standard to avoid excessive judicial intervention); *see also* Gaydosh v. Lewis, 410 F.2d 262, 266 (D.C. Cir. 1969) ("[U]nderlying all these determinations is the awareness that the employees are not at a disadvantage vis-a-vis the trustees. The Board of Trustees is chaired by the representative of the Union. He, as well as the other two members [one of whom is neutral], is presumed to conscientiously serve the interests of all parties to the Fund.").

B. Passage of ERISA

After ERISA's passage, other courts looked to trust law and contract law in an attempt to fashion an appropriate judicial standard of review in ERISA benefit denial cases.[148] In the context of trust law, the settlor of a trust is allowed to grant broad discretionary powers to the trustee, to which the courts have historically extended deferential review.[149] As the settlor could confer discretionary powers to the trustee regarding trust administration, courts were leery to disturb the trustee's decision.[150] Thus, the court would not "second guess" a trustee's decision unless the trustee had abused his discretion (i.e., acted in bad faith, arbitrarily, capriciously, maliciously, or from some other improper motive).[151] Such standard looked very much like the Taft Hartley judicial standard of review. The abuse of discretion standard mutated into a different administrative law standard, known as the arbitrary and capricious standard.

In the context of contract law, employee benefit plans could be interpreted by the courts as contracts bargained at arms' length. In this regard, an employee's benefits claims would be reviewed similar to any other contract allegation, reviewing the terms of the plan and other manifestations of the parties' intent.[152] The court could then decide whether benefits should be paid *without* regard to either party's interpretation of the terms of the contract.[153]

148. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 102 (1989).

149. *See* AUSTIN W. SCOTT, MARK L. ASCHER, & WILLIAM F. FRATCHER, SCOTT ON TRUSTS, §§ 201, 221 (4th ed. 1988).

150. *See* In re Filzen's Est., 31 N.W.2d 520, 522 (Wis. 1948) (stating that as long as a trustee acts reasonably and in good faith, the court may not interfere); Robinson v. Elston Bank & Tr. Co., 48 N.E.2d 181, 190 (Ind. App. 1943) (discussing the deference that must be accorded to a trustee's actions); In re Sams' Est., 258 N.W. 682, 684 (Iowa 1935) (permitting trustees to use their discretion to evaluate the educational accomplishments of the beneficiary).

151. *See* Conlin v. Murdock, 43 A.2d 218, 220 (N.J. Ch. 1945) (finding an abuse of discretion where a trustee paid the plaintiff a fifty-dollar allowance on which she was to live); Stallard v. Johnson, 116 P.2d 965, 967 (Okla. 1941) (holding the allowance given by the trustee to be "so meagre as to amount to a denial of the purposes of the trust").

152. *See* Brief for the U.S. as Amicus Curiae Supporting Respondents at 5, Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) (No. 87-1054), 1988 WL 1025997 [hereinafter Firestone Amicus Curiae Brief].

153. *See id.*; *see also* Note, *Pension Plans and the Rights of the Retired Worker*, 70 COLUM. L. REV. 909, 910, 916–22 (1970).

C. The Supreme Court's Firestone Tire & Rubber Co. v. Bruch Decision

In 1989, the Supreme Court decided to settle the issue in *Firestone Tire & Rubber Co. v. Bruch*.[154] This case involved an unfunded severance pay plan, maintained and administered by the employer, which paid benefits to participants who were affected by a "reduction in work force."[155] The employer paid any benefits from the plan from its general assets.[156] Under ERISA, this plan was a welfare benefit plan and thus did not have to be pre-funded, nor did a trust or insurance policy have to be maintained.[157] Firestone Tire & Rubber Company sold five of its plants to Occidental Petroleum Corporation's Hooker Chemical Division, and most of 500 salaried employees at those plants continued in their same positions as Occidental employees without interruption and at the same rate of pay.[158] Firestone then denied severance pay to those employees who transferred to Occidental, alleging that there was no "reduction in work force."[159] Several former Firestone (now Occidental) employees filed a class action in federal court, stating that Firestone had improperly withheld their severance pay from the plan.[160]

The district court applied the arbitrary and capricious standard of review and upheld Firestone's decision to deny benefits.[161] The Third Circuit noted that the majority of circuit courts had applied the arbitrary and capricious standard of review as the appropriate judicial standard of review, but questioned its usefulness where the plan administrator had an apparent conflict of interest in determining benefits under an unfunded and self-administered plan.[162] The Third Circuit remarked that the arbitrary and capricious review standard, derived

154. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 118–20 (1989) (a unanimous decision by the court, written by Justice Sandra Day O'Connor).
155. *Id.* at 105–06.
156. *Id.* at 105.
157. *Id.* at 105–06 (quoting the termination pay plan as stating "you will be given termination pay if released because of a reduction in work force").
158. *Id.* at 105.
159. *Id.* at 105–06.
160. *Id.* at 106.
161. *See* Bruch v. Firestone Tire & Rubber Co., 640 F. Supp. 519, 526 (E.D. Pa. 1986) (concluding that Firestone's actions were not unreasonable and were supported by law).
162. *See* Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144–53 (3d Cir. 1987).

from cases involving employee benefit trusts established under Section 302(c)(5) of LMRA, followed common-law trust principles.[163] However, such trusts involved trustees' actions that did not pose any conflict of interest or improper motive.[164] This was the case because the LMRA provided for impartial administration of the trust by an equal number of labor and management trustees.[165] In contrast, the Third Circuit decided that the denial of benefits in *Firestone* should be reviewed under "the principles governing construction of contracts between parties bargaining at arms' length."[166] Thus, it should use the traditional rules of contract interpretation to determine the contracting parties' intent and, if such intent was not ascertainable, "the court should adopt the most reasonable understanding of the term."[167] Thus, the Third Circuit reversed the district court and remanded the issue for further proceedings.[168]

In reviewing the Third Circuit's decision, the Supreme Court noted that the federal courts had adopted an arbitrary and capricious standard both as a standard of review under LMRA (as the statute was silent) *and* as a means of asserting jurisdiction over suits under LMRA § 186(c) brought by beneficiaries of plans who were denied benefits by trustees.[169] As ERISA clearly provided jurisdictional basis for the federal courts over suits under 29 U.S.C. § 1132(a), use of LMRA principles did not support the adoption of the arbitrary and capricious standard of review in the context of ERISA.[170] The Court then remarked that ERISA "abounds with the language and terminology of trust law,"[171] hence principles of trust law should be used in determining the appropriate judicial standard of review.[172] Thus, the Court held that, contrary to popular belief, the default standard of review for adjudication of benefit plans is *de novo*.[173] Its interpretation of the *de novo* standard should

163. *Id.* at 140–41.
164. *Id.* at 141.
165. *Id.* at 142.
166. *Id.* at 145.
167. *Id.* at 148.
168. *Id.* at 136 (stating "that the decision by Firestone to deny benefits under the Termination Pay plan should be reviewed *de novo* by the court.").
169. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989).
170. *Id.* at 110.
171. *Id.*
172. *Id.* at 111.
173. *Id.* at 115.

then lead federal courts to "construe terms" in the plan like "contractual provisions" without "deferring to either party's interpretation."[174]

The Court rejected the argument made by Firestone and its *amici* that a *de novo* standard would result in higher administrative and litigation costs, thereby discouraging employers from establishing employee benefit plans.[175] It also remarked that the trust law *de novo* standard of review was consistent with judicial interpretation of employee benefit plans prior to ERISA—there, the courts reviewed an employer's denial of benefits under principles of contract law.[176] Thus, if the plan did not grant the employer discretionary or final authority to construe ambiguous plan language, the Court reviewed the employee's claim by looking at the terms of the plan and other manifestations of the parties' intent.[177] The Court also rejected Firestone's claim that congressional action in 1982, which sought to provide for a *de novo* standard review of review in *all* ERISA benefit denial cases, was relevant, as the bill was never enacted, indicating Congress' satisfaction with the arbitrary and capricious standard of review.[178] The Court concluded that the *de novo* standard of review applies in benefits denial cases "regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest."[179]

The Supreme Court's holding in *Firestone* did not weigh completely in favor of the plaintiff's bar. Justice O'Connor went on to say that the *de novo* standard applies *unless* the benefits plan has a reservation of discretion which gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the

174. *Id.* at 112.
175. *Id.* at 114–15.
176. *Id.* at 112 (citing Conner v. Phx. Steel Corp., 249 A.2d 866 (Del. 1969); Atlantic Steel Co. v. Kitchens, 187 S.E.2d 824 (Ga. 1972); Sigman v. Rudolph Wurlitzer Co., 11 N.E.2d 878 (Ohio Ct. App. 1937)).
177. *Id.* at 113.
178. *Id.* at 114 (referring to H.R. 6226, 97th Cong., 2d Sess. (1982), reprinted in Pension Legislation: Hearings on H.R. 1614 et al. before the Sub-committee on Labor-Management Relations of the House Committee on Education and Labor, 97th Cong., 2d Sess., 60 (1983)).
179. *Id.* at 115.

terms of the plan.[180] Here, the Court appeared to affirm the lower courts' use of the abuse of discretion standard of review when the fiduciary has discretionary authority.[181]

In *Firestone*, the Supreme Court made reference to both the arbitrary and capricious standard and the abuse of discretion standard, as if to use them interchangeably, although the abuse of discretion standard is the one generally utilized under trust law.[182] The Supreme Court would later characterize this deferential standard of review as "a feature of judicial review *highly prized by benefit plans* (emphasis added)."[183] The *Firestone* Court went on to remark that if the discretionary administrator or fiduciary was operating under a conflict of interest, such conflict "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'"[184] Such a factor is consistent with comment d to the Restatement (Second) of Trusts, where important elements as to whether or not a trustee has abused discretion include "the motives of the trustee in exercising or refraining from exercising [a power granted to the trustee]; [and] the existence of nonexistence of an interest in the trustee conflicting with that of the beneficiaries."[185]

Unfortunately, the *Firestone* decision did not specify what language would dictate a reservation of discretion to the plan administrator. In the aftermath of the *Firestone* decision, there have been hundreds of appellate cases and thousands of district court rulings opining as to

180. *Id.* Courts have interpreted the *de novo* standard of review as one in which the court extends no deference or presumption of accuracy to the administrator's decision, but instead independently "determine[s] whether the administrator properly interpreted the plan and whether the insured was entitled to benefits under the plan." Hoover v. Provident Life & Acc. Ins. Co., 290 F.3d 801, 809 (6th Cir. 2002).

181. *See* Tranbarger v. Lincoln Life & Annuity Co. N.Y., 68 F.4th 311, 323 (6th Cir. 2023), J. Nalbandian, concurrence, where he questions why the Supreme Court in *Firestone* endorsed a quasi-administrative-law review in the context of an ERISA benefits denial where the arbitrary and capricious standard is used, as it is "eschewing the Federal Rules of Civil and Appellate Procedure in favor of something like agency review." Such judge-made rules (like Firestone's judicial standard of reviews) "cannot supersede the Federal Rules of Civil Procedure," on the grounds that the Court fashioning federal common law in areas in which ERISA is silent.

182. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111 (directing the courts to the Restatement of Trusts section 187 (i.e., the abuse of discretion standard)).

183. Rush Prudential HMO v. Moran, 536 U.S. 355, 384 (2002) (emphasis added).

184. *Firestone Tire & Rubber Co.*, 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (Am. L. Inst. 1959)).

185. Restatement (Second) of Trusts § 187 (Am. Law Inst. 1959).

what language results in a reservation of discretion.[186] The *Firestone* decision also limited its discussion to the appropriate standard of review in 29 U.S.C. § 1132(a)(1)(B) actions challenging the denial of benefits based on *plan interpretation* (i.e., what constitutes a "reduction in work force" under the plan to trigger the payment of severance benefits), not based on *factual determinations* made by the plan administrator (i.e., if the employees were affected by a reduction in work force).[187]

As one would imagine, non-insured employer-drafted employee benefits plans were amended overnight to insert discretionary language into the plan document, such that the plan administrator had discretion to determine eligibility for benefits and to construe the terms of the plan.[188] Thus, such employers could avoid the *de novo* standard of review. With a reservation of discretion clause in the plan document, the majority of circuits post-*Firestone* continued to use the labor law review terminology of arbitrary and capricious as the appropriate standard of review, equating it with the trust law standard of abuse of discretion.[189] The circuits, however, varied in applying such standard when there was an apparent or actual conflict of interest on the part of the plan administrator.[190] While the *Firestone* case involved the plan administrator's interpretation of the plan terms, most courts have applied the *Firestone* standard to the plan administrator's factual findings (e.g.,

186. *See generally* Kennedy, *Standard of Review*, *supra* note 54, at 1129–46 (describing the many lower court decisions in the wake of *Firestone*).

187. *See Firestone*, 489 U.S. at 108. For an example of a factual determination, *see* Rowan v. Unum Life Ins. Co. of Am., 119 F.3d 433, 436 (6th Cir. 1997); there, the plan's definition of disability required the insured be unable to perform each of the material duties of his job and one of the issues in dispute was whether the plan participant could lift up to twenty pounds as required by her job description.

188. *See* Kennedy, *Standard of Review*, *supra* note 54, at 1116.

189. *See* DeWitt v. Penn-Del Directory Corp., 106 F.3d 514, 520 (3d Cir. 1997); *see also* Meditrust Fin. Servs. Corp. v. Sterling Chem. Inc., 168 F.3d 211, 214 (5th Cir. 1999); Wildbur v. ARCO Chem. Co., 974 F.2d 631, 635 (5th Cir. 1992); Miller v. Metro. Life Ins. Co., 925 F.2d 979, 984 (6th Cir. 1991); Ross v. Ind. State Teacher's Ass'n, 159 F.3d 1001, 1009 (7th Cir. 1998); Morton v. Smith, 91 F.3d 867, 870 (7th Cir. 1996); Cox v. Mid-Am. Dairymen, Inc., 965 F.2d 569, 571–72 (8th Cir. 1992) (Cox I), *aff'd*, 13 F.3d 272 (8th Cir. 1993) (Cox II); Snow v. Standard Ins. Co., 87 F.3d 327, 330 (9th Cir. 1996); Atwood v. Newmont Gold Co., Inc., 45 F.3d 1317, 1321 n.1 (9th Cir. 1995); Chambers v. Fam. Health Plan Corp., 100 F.3d 818, 825 (10th Cir. 1996); Jett v. Blue Cross & Blue Shield of Ala., 898 F.2d 1556 (11th Cir. 1990).

190. *See* Kennedy, *Standard of Review*, *supra* note 54, at 1130.

did the participant meet the plan's definition of disability so as to be entitled to benefits?).[191]

D. Circuit Split Regarding the Application of the Arbitrary and Capricious Standard in the Context of a Conflict of Interest

After the *Firestone* decision, the circuits were split in their application of the arbitrary and capricious standard when there was a conflict of interest.[192] The majority of the circuits used a sliding scale approach, which extended varying degrees of deference to the decision of the plan administrator relative to the conflict and the extent to which it impacted the administrator's decision.[193] In contrast, the Eleventh Circuit used a presumptively void standard whereby if the conflict of interest could be assumed or proven, the burden then shifted to the plan administrator to explain that its decision was "not tainted by self-interest."[194] As a result of the split in the circuits, the Supreme Court issued two subsequent Supreme Court decisions—*Metropolitan Life Ins. Co. v. Glenn*[195] in 2008 and *Conkright v. Frommert*[196] in 2010—that have attempted to answer the question of how the *Firestone* standard is to be applied in the context of a conflicted plan administrator.[197] However, the conclusions of the two cases render them almost inconsistent with one another and have resulted in more confusion on the part of plan sponsors and plan administrators.[198]

E. The Glenn and Conkright Decisions

The *Glenn* decision involved an employee of Sears, Roebuck and Co. that had been denied disability benefits under a long-term disability insurance policy that was administered and insured by Metropolitan Life Ins. Co. (MetLife).[199] The policy granted discretionary power to

191. *Id.* at 1164.
192. *See* Kathryn J. Kennedy, *Conkright: A Conundrum for Future Courts, An Opportunity for Congress*, 2010 NYU REV. EMP. BENEFITS & EXEC. COMP. 16.01 (2011) [hereinafter Kennedy, *Conkright*].
193. *Id.* at §§ 16.02(4)(b), 16.02(5).
194. *Id.* at § 16.02(4)(b), quoting from Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1566 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).
195. *See generally* Glenn v. Metro. Life Ins. Co. 554 U.S. 105 (2008).
196. *See generally* Conkright v. Frommert, 559 U.S. 506 (2010).
197. *See id*. at 511; s*ee also Glenn*, 554 U.S. at 112.
198. *See* Conkright, 559 U.S. at 523; *see also Glenn*, 554 U.S. at 112–15 (2008).
199. *Glenn*, 554 U.S. at 108.

MetLife to determine whether the participant was eligible to receive benefits.[200] The district court denied relief, and the Sixth Circuit reversed; while applying the arbitrary and capricious standard of review, the Sixth Circuit found that the district court's review of the administrator's denial had no analysis of the role that MetLife's conflict of interest had in its decision, nor did it appear to give any weight to such conflict.[201] As such, the Sixth Circuit found that the district court neglected to consider the following: MetLife's conflict of interest; MetLife's contradiction in encouraging Glenn to apply for Social Security benefits but then ignoring such findings; and MetLife's selective use of certain medical reports.[202] The issue posed to the Supreme Court, as MetLife was operating under a conflict of interest as insurer and plan administrator, was how such conflict should "be taken into account on judicial review of a discretionary benefit determination."[203]

The *Glenn* opinion was written by Justice Breyer and joined by Justices Alito, Ginsburg, Souter, and Stevens, and affirmed *Firestone's* use of trust law in determining the appropriate standard of review, which requires a conflict of interest to be weighed as a factor in applying the deferential standard of review.[204] In deciding how to "weigh" such factor, the Court noted that trust law and administrative law frequently ask judges to take into account a variety of factors, weighing them together.[205] It then cited two administrative law cases in which judges had considered various factors in obtaining a result,[206] and proposed a "combination-of-factors method of review" approach to weighing various factors to see if the conflict of interest tainted the plan administrator's decision.[207] It suggested that one of the factors could serve as a "tiebreaker" if the other factors balanced one another out, such as cases where the insurer as administrator had a history of bias.[208]

200. *Id.*
201. Glenn v. MetLife, 461 F.3d 660, 666 (6th Cir. 2006), aff'd 554 U.S. 105 (2008).
202. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 118 (2008).
203. *Id.* at 110 (quoting from the Brief for United States as *Amicus Curiae* on Pet. for Cert).
204. *Id.* at 110–11.
205. *Id.* at 116.
206. *Id.* (citing Citizens to Pres. Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971) and Universal Camera Corp. v. N.L.R.B., 340 U.S. 474 (1951)).
207. *Id.* at 118.
208. *Id.* at 117.

Alternatively, the conflict of interest may disprove any potential bias if the insurer "has taken active steps to reduce potential bias and to promote accuracy."[209]

In his dissent, Chief Justice Robert criticized the majority opinion by stating that the "[c]ourt leaves the law more uncertain, more unpredictable than it found it."[210] Justices Scalia and Thomas, in their dissent, called the majority's test "gobbledygook."[211]

Prior to the issuance of *Glenn*, courts rarely allowed evidence outside of the administrative record in the review of a discretionary benefit denial case.[212] However, in the wake of *Glenn,* more and more courts have permitted such evidence, as the administrative record may be deliberately void as to the issue of whether the plan administrator's conflict biased its decision.[213]

Two years later, the Supreme Court granted *certiorari* in *Conkright v. Frommert,* a case that involved plan participants of an employer self-funded defined benefit plan who were denied benefits due to the plan administrator's interpretation of an offset provision that reduced the participants' benefits.[214] As the plan administrators were employed by the sponsor of the plan, there was an inherent conflict of interest.[215] The plan granted the plan administrator discretion to construe the terms of the plan and the trust, and thus, the district court applied the arbitrary and capricious standard of review to the plan administrator's interpretation of the benefits formula, particularly the offset provision, and affirmed its interpretation.[216] The Second Circuit held such interpretation was unreasonable as it violated ERISA's anti-cutback rules, and the Second Circuit remanded the case to the district court.[217] The district court allowed both the plan administrator and participants to submit subsequent alternate interpretations of the offset provision.[218] The district court adopted the approach suggested by the participants; upon appeal, the Second Circuit affirmed that the plan administrator's

209. *Id.*
210. *Id.* at 122.
211. *Id.* at 130.
212. Kennedy, *Conkright*, supra note 192, at § 16.02(4)(c).
213. *Id.* at § 16.04(1–2).
214. Conkright v. Frommert, 559 U.S. 506, 511 (2010).
215. *Id.* at 509–10.
216. *See* Frommert v. Conkright, 328 F. Supp. 2d 420, 431 (W.D.N.Y. 2004).
217. *See* Frommert v. Conkright, 433 F.3d 254, 256–57 (2d Cir. 2006).
218. *See* Frommert v. Conkright, 472 F. Supp. 2d 452, 456–59 (W.D.N.Y. 2007).

subsequent interpretation of the same plan terms was not entitled to a deferential standard of review.[219]

The issue framed by the Supreme Court in *Conkright* was whether the district court should have shown deference to the plan administrator's *subsequent* interpretation of the plan.[220] Justices Roberts, Scalia, Kennedy, and Thomas (who had dissented from a portion of the *Glenn* ruling), joined by Justice Alito (from *Glenn*'s majority), wrote the opinion, which began with the sentences "People make mistakes. Even administrators of ERISA plans."[221] The opinion held that *Firestone's* grant of a deferential standard of review (assuming a grant of discretionary powers) was not "limited to first efforts to construe the [p]lan."[222] In fact, the majority characterized the Second Circuit's approach as devising an exception to *Firestone* deference and referred to it as the "one-strike-and-you're out" approach.[223] Hence, the court upheld the plan administrator's subsequent plan interpretation in the interest of efficiency, predictability and uniformity.[224] It concluded that the plan administration's interpretation "will not be disturbed if reasonable."[225]

The *Conkright* holding exhibited the Supreme Court's willingness to defer to the plan administrator's interpretation, not only once but multiple times. The fact that the plan administrator had made multiple and different interpretations of the plan document appeared to be of little importance to the *Conkright* court in determining its reasonableness.

In the aftermath of *Glenn* and *Conkright*, all the circuits have taken a uniform approach in applying the standard of review: if discretionary authority has not been reserved to the plan administrator, the *de novo* standard applies; if discretionary authority has been reserved and there

219. *Id*. at 457–58; Frommert v. Conkright, 535 F.3d 111, 119 (2d Cir. 2008).
220. *Conkright*, 559 U.S. at 511.
221. *Id*. at 509.
222. *Id.* at 513. Courts have also interpreted the abuse of discretion standard as one in which "the court has the definite and firm conviction the district court made a clear error of judgment in its conclusion upon weighing relevant factors" (also referred to as the clear error standard of review). *See* Shelby Cnty. Health Care Corp. v. Majestic Star Casino, 581 F.3d 355, 376 (6th Cir. 2009) (alteration in original) (quoting Gaeth v. Hartford Life Ins. Co., 538 F.3d 524, 529 (6th Cir. 2008)).
223. *Id.*
224. *Id*. at 518.
225. *Id.* at 521.

exists a structural conflict of interest, the arbitrary and capricious standard of review applies and the conflict of interest is simply a factor to be weighed in applying such standard.[226] While one may question the Supreme Court's approach to utilizing a quasi-administrative law review in a benefits denial case where the plan administrator has been granted discretion, that is not the subject of this law review article.

226. First Circuit: Cusson v. Liberty Life Assurance Co. Bos., 592 F.3d 215, 224 (1st Cir. 2010) (quoting from Denmark v. Liberty Life Assurance Co., 566 F.3d 1, 9 (1st Cir. 2009), overruled on other grounds by Montanile v. Bd. of Trs. Of Nat'l Elevator Indus. Health Benefit Plan, 136 S. Ct. 651 (2016)) ("Where the plan administrator has discretion, 'Glenn's baseline principle, consistent with this circuit's prior precedents, [is] that judicial review of such a benefit-denial decision is for abuse of discretion."); Second Circuit: McCauley v. First Unum Life Ins. Co., 551 F.3d 126, 133 (2d Cir. 2008) ("[A] plan under which an administrator both evaluates and pays benefits claims creates the kind of conflict of interest that courts must take into account and weigh as a factor in determining whether there was an abuse of discretion."); Third Circuit: Doroshow v. Hartford Life & Accidents Ins. Co., 574 F.3d 230, 234 (3d Cir. 2009) (holding that "[w]ith *Glenn*, the court aimed to elucidate its previous precedent in *Firestone* that a conflict should be weighed as a factor in determining whether there is an abuse of discretion."); Fourth Circuit: Williams v. Metro. Life Ins. Co., 609 F.3d 622, 630–31 (4th Cir. 2010) (holding that a plan administrator's conflict of interest does not alter the abuse of discretion standard, but is simply a factor to be weighed); Fifth Circuit: Holland v. Int'l Paper Co. Ret. Plan, 576 F.3d 240, 247–48 n.3 (5th Cir. 2009) (quoting from Wakkinen v. UNUM Life Ins. Co. Am., 531 F.3d 575, 581 (8th Cir. 2008) ("The existence of a conflict of interest should merely be a factor for the district court to take into account when determining whether an administrator's decision was arbitrary and capricious."); Sixth Circuit: DeLisle v. Sun Life Assurance Co. Can, 558 F.3d 440, 445 (6th Cir. 2009) (acknowledging that Glenn requires a structural conflict of interest to be a factor to be weighed in ascertaining whether the plan administrator abused its discretion); Seventh Circuit: Love v. Nat'l City Corp. Welfare Benefits Plan, 574 F.3d 392, 396 n.1 (7th Cir. 2009) (noting that the court will continue to use the arbitrary and capricious standard of review even if the plan administrator is conflicted); Eighth Circuit: Chronister v. Unum Life Ins. Co. of Am., 563 F.3d 773, 775 (8th Cir. 2009) (stating that "[u]nder *Glenn*, courts must analyze the facts of the case at issue, taking into consideration not only the conflict of interest, but also other factors that might bear on whether the administrator abused its discretion."); Ninth Circuit: Montour v. Hartford Life & Accident Ins. Co., 588 F.3d 623, 630 (9th Cir. 2009) (noting that courts "must consider numerous case-specific factors, including the administrator's conflict of interest, and reach a decision as to whether discretion has been abused by weighing and balancing those factors together."); Tenth Circuit: Holcomb v. UNUM Life Ins. Co. Am., 578 F.3d 1187, 1192–93 (10th Cir. 2009) (affirming that *Glenn* adopts a combination-of-factors approach, weighing a conflict of interest as a factor); Eleventh Circuit: Capone v. Aetna Life Ins. Co., 592 F.3d 1189, 1195–96 (11th Cir. 2010) (quoting from Doyle v. Liberty Life Assurance Co. Bos., 542 F.3d 1352, 1360 (11th Cir. 2008)) ("[T]he existence of a conflict of interest should merely be a factor for the district court to take into account when determining whether an administrator's decision was arbitrary and capricious . . . .").

Section IV. Discretionary Grants of Power in Insurance Contracts

In order to trigger the deferential standard of review, the issue arose as to what language in an insurance contract granted sufficient discretion to the plan administrator. The language that has resulted in the most judicial ink being spilt is whether insurance contract language that requires "standard proof of loss" or "satisfactory proof of loss" is sufficient to trigger a reservation of discretion for the insurance company acting as the plan administrator.[227] In order to assure payment of benefits, insurance contracts generally require the insured to submit written proof of loss or satisfactory proof of loss to the insurer in order to process the claim and pay the benefit.[228] Insurers have argued that such language should confer discretionary authority to them to determine benefits eligibility and to construe the terms of the insured plan.[229] In the aftermath of *Firestone*, the majority of the circuits have held that the typical insurance policy—using the phrases "standard proof of loss" or "satisfactory proof of loss"—is *insufficient* to overcome the *de novo* standard of review.[230]

One of the outlier circuits was the Fifth Circuit. Shortly after the Supreme Court's ruling in *Firestone*, the Fifth Circuit in the case of *Pierre v. Conn. Gen. Life Ins. Co*.[231] limited the use of *Firestone's de novo* standard to benefit denials based on interpretation of the plan terms, but not factual determinations made by the plan administrator.[232] In the latter situation, the arbitrary and capricious standard would continue to apply.[233] In that case, if the parties disputed the plan administrator's decision to pay a death benefit to a beneficiary, such an issue would be factual because the resolution turned on whether a prior beneficiary form or a more recent form was the valid and controlling document.[234]

227. Kennedy, *Standard of Review, supra* note 54, at 1123.
228. *Id.*
229. *Id.*
230. *Id.* at 1124. One reason why insurance policies were not amended overnight after the *Firestone* decision is that policy forms must be approved by insurance commissioners in each State and the review process for that is not uniform.
231. *See* Pierre v. Conn. Gen. Life Ins. Co., 932 F.2d 1552, 1556 (5th Cir. 1991).
232. *Id.* at 1555–61.
233. *Id.* at 1562.
234. *See* Luby v. Teamsters Health, Welfare, & Pension Tr. Funds, 944 F.2d 1176, 1182 (3d Cir. 1991).

The *Pierre* case was finally overruled in 2018 by the Fifth Circuit in an *en banc* review.[235] In *Ariana M. v. Humana* case, the Fifth Circuit joined *all* the other circuits in holding that the *Firestone de novo* standard applied to both benefit denials based on plan interpretation, as well as factual determinations.[236] As a result, this is no longer an issue for litigation.

Section V. Use of State Insurance Bans on the Use of Discretionary Clauses in Insurance Policies

As noted earlier, ERISA's preemption clause has a savings clause which permits state insurance laws to regulate employee benefit plans.[237] Since 2004, states have enacted bans on the use of discretionary clauses in disability insurance policies.[238] If such bans are permitted for *insured* disability benefit plans, the judicial standard of review would become the *de novo* standard.[239] With a *de novo* standard of review, there would also be the issue of whether the court could go beyond the plan administrator's administrative record in determining whether benefits should have been denied or granted under such standard.[240]

The National Association of Insurance Commissioners (NAIC) is composed of insurance commissioners from all fifty states, as well commissioners from the District of Columbia and five territories.[241] One of the goals of the NAIC is to assure that state insurance laws harmonize with one another, so as to prevent different interpretations of polices that are sold across state lines.[242]

235. Ariana M. v. Humana Health Plan Tex., 884 F.3d 246, 255 (5th Cir. 2018).

236. *Id.* at 247–48 (citing Reinking v. Phila. Am. Life Ins. Co., 910 F.2d 1210, 1213–14 (4th Cir. 1990), overruled on other grounds by Quesinberry v. Life Ins. Co. N. Am., 987 F.2d 1017 (4th Cir. 1993)) (When the Fifth Circuit decided the *Pierre* case, it created a circuit split with one other court of appeals that applied *Firestone's de novo* standard for both legal and factual determinations. Since its holding in *Pierre*, the Fifth Circuit remarked that seven other courts of appeals have held that Firestone's *de novo* standard did not depend on whether the benefits denial was based on legal or factual grounds.).

237. *See supra* Part I.

238. *See supra* Part I.

239. *See supra* Part I.

240. *See supra* Part I.

241. *See Our Story*, NAIC, https://content.naic.org/about (last visited Feb. 20, 2024) [https://perma.cc/9EDL-T6PW].

242. *See id.*; *see also* NAT'L ASS'N INS. COMM'RS, WHAT IS THE NAIC AND WHAT DOES IT DO? 1, https://content.naic.org/sites/default/files/about-naic.pdf [https://

In 2001, the NAIC began examining whether to ban discretionary clauses in health insurance policies.[243] Its ERISA Working Group of the Health Insurance and Managed Care Committee affirmed several states' conclusions that discretionary clauses in health insurance policies were "deceptive and misleading."[244] In 2002, the NAIC unanimously passed a model law to prohibit discretionary clauses in health insurance policies, known as the Prohibition on the Use of Discretionary Clauses Model Act;[245] by 2004, the NAIC unanimously agreed to amend that Act to include disability income insurance policies.[246] By 2006, NAIC noted that the Prohibition on the Use Of Discretionary Clauses Model Act was passed "to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier

perma.cc/CVY5-V346]. On its website at www.naic.org, the NAIC states that its mission is to assist state insurance regulators . . . in serving the public interest, by "setting standards and regulatory best practices, acting as a forum to exchange information, providing regulatory support functions, and educating consumers, industry, and other government stakeholders about the U.S. system of state-based insurance regulation."

243. HEALTH INSURANCE & MANAGED CARE (B) COMMITTEE, 2001 NAIC PROC. 2ND QTR. 112, 116.

244. *Id*.

245. PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT 42-1 §§ 1–6 (NAT'L ASS'N INS. COMM'RS 2006).

246. NAT'L ASS'N INS. COMM'RS, JOINT EXECUTIVE (EX) COMMITTEE/PLENARY, 2004 NAIC PROC. 4TH QTR. 56, 57 (2004). By 2004, the Consumer Protections Working Group of the Executive (EX) Committee, in conjunction with the Health Insurance and Managed Care (B) Committee, held a public hearing to opine whether the NAIC model act should be expanded to include disability income insurance. The following individuals testified at the hearing: Mary Ellen Signorille (AARP Foundation); Terri Sorota (American Council of Life Insurers); Richard E. Ramsay (America's Health Insurance Plans); Brad Wegner (Association of California Life and Health Insurance Companies); Sony Schwartz (Families USA); Mila Kofman (Georgetown University's Health Policy Institute); Teresa R. Renaker (Lewis & Feinberg, P.C.); and clients Joanna Baida, Mark Rosten, and Gregory Rowe; Ruth Silver Taube (Silver & Taube); Melvyn D. Silver (Silver & Taube); Lawrence Frank (Standard Insurance Company); Karrol Kitt (The University of Texas at Austin); and Cathey W. Steinberg (Women's Policy Group, Women's Policy Education Fund). Insurers who testified at those public hearings argued that the Supreme Court case in Aetna Health Inc. v. Davila, 542 U.S. 200 (2004) prohibited states from banning discretionary clauses in insurance policies.

responsible for providing benefits has discretionary authority to decide what benefits are due."[247]

The NAIC model law does not have the force of law in any jurisdiction unless adopted by the state. There are a variety of ways in which states can adopt NAIC model laws. For example, in New York, the superintendent of insurance can issue a circular whereby insurance policies with discretionary clauses are held to be contrary to the law of the state.[248] In Montana, the insurance commissioner has the ability to institute a model law simply by an order from the insurance director.[249] In Illinois, a model law can be adopted by notice and comment rulemaking.[250] By contrast, in Wisconsin, the model law would have to be passed into law by the legislature in order to be effective.[251] The map in Appendix A of this article indicates in black which states have adopted the NAIC model law in one form or another, thereby banning discretionary clauses in disability insurance policies.[252] It is important to note that the texts of each state's ban vary widely. The map is inaccurate, as it indicates New York has adopted a state ban on discretionary clauses. In New York, the superintendent of insurance issued a circular stating that discretionary clauses are contrary to the law of the State of New York and regulations would be forthcoming to implement such rule; however, no regulations were ever issued.[253]

The passage of the NAIC model law raises the issue of whether a state law ban is preempted by ERISA or saved under ERISA's savings

247. PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT, 42-1 § 2 (NAT'L ASS'N INS. COMM'RS 2006).

248. NY St Ins Dept 2006 Circular Letter No. 14, *Discretionary Clauses in Accident and Health (Including Disability Income) Insurance Policies, Life Insurance Policies, Annuity Contracts and Subscriber Contracts* [hereinafter NY 2006 Circular Letter No. 14].

249. MONT. CODE ANN. §33-1-502 (West 2024). Requires the commissioner of insurance to "disapprove any [insurance] form . . . if the form . . . contains . . . any inconsistent, ambiguous, or misleading clauses or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract . . . ." Montanan Insurance Commissioner Morrison rejected Standard Insurance Company's challenge to his disapproval of any employee benefit plan that contains a "discretionary clause." The district court affirmed the Commissioner's practice and held that it was not preempted under ERISA's savings clause. *See* Standard Ins. Co. v. Morrison, 537 F. Supp. 2d 1142 (D. Mont. 2008), *aff'm* Standard Ins. Co. v. Morrison, 584 F.3d 837, 545 (9th Cir. 2009), *cert. denied sub nom*. Standard Ins. Co. v. Lindeen 560 U.S. 904, 904 (2010).

250. 5 ILL. COMP. STAT. 100/5-40 (2023).

251. WIS. STAT. § 227.11 (2024).

252. *See infra* app. A.

253. NY St Ins Dept 2006 Circular Letter No. 8, *RE: Discretionary Clauses in Health Insurance Policies including Disability Income Insurance*.

clause, which protects state insurance laws from being preempted by ERISA. Thus far, three circuit courts of appeal (the Sixth, Seventh, and Ninth Circuits) have held that such model laws are saved under ERISA's preemption savings clause.[254]

In Michigan, the Commissioner of the Office of Financial and Insurance Services has the authority to regulate insurance and issued a ruling prohibiting insurers from "issuing, delivering, or advertising" insurance policies that contain discretionary clauses (i.e., a clause that would grant deference in a court proceeding to a plan administrator's decision to deny benefits or to interpret the plan).[255] The American Council of Life Insurers, America's Health Insurance Plans, and Life Insurance Association of Michigan filed suit, seeking declaratory and injunctive relief to prohibit the enforcement of such ruling.[256] In *American Council of Life Insurers v. Ross*, the Sixth Circuit upheld the district court's ruling that Insurance Commissioner Ross' ruling was saved under ERISA's savings clause.[257]

The court began its opinion with the two prong analysis from the Supreme Court's *Miller* case: The first prong requires the state law in question to regulate insurance and be "specifically directed toward" the insurance industry.[258] The Sixth Circuit noted that state laws are "directed toward entities engaged in insurance" if they regulate insurers through the use of their insurance practices.[259] It then quickly affirmed that this test was met, as the state rule in question regulated only insurance companies by dictating the terms of the policies that they may issue.[260] The fact that plan fiduciaries of employee benefit plans were also impacted by the rule was inconsequential, as the Supreme Court has held that the fact that other entities are impacted by the state rule does not remove it from ERISA's savings clause.[261]

254. *See, e.g.*, Am. Council Life Insurers v. Ross, 558 F.3d 600, 609 (6th Cir. 2009); Fontaine v. Metro. Life Ins. Co., 800 F.3d 883, 887–88 (7th Cir. 2015); Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, Plan No. 625, 856 F.3d 686 695–96 (9th Cir. 2017).
255. MICH. ADMIN. CODE r. 500.2201-02, 550.111-12 (2024).
256. *Am. Council Life Insurers*, 558 F.3d at 601.
257. *Id.* at 602.
258. Ky. Ass'n Health Plans, Inc. v. Miller, 538 U.S. 329, 334 (2003).
259. *Am. Council Life Insurers,* 558 F.3d at 605.
260. *Id.*
261. *Id.* at 606 (citing *Ky. Ass'n Health Plans, Inc.*, 538 U.S. at 335–36).

The second *Miller* prong requires the state law in question to substantially affect the risk pooling arrangement between the insurer and the insured.[262] The Sixth Circuit quickly affirmed that this prong was met, as the state rule in question "dictates to the insurance company the conditions under which it must pay for the risk it has assumed," which substantially affected the risk pooling agreement between the insurer and the insured.[263] Hence, it altered the choice of the permissible bargain between the insurer and the insured.

The Sixth Circuit rejected the conflict preemption argument. Under that theory, if the Michigan ruling conflicted with ERISA's civil enforcement provisions by attempting to "create, duplicate, supplant, or supplement any of the causes of action that may be alleged under ERISA," it would be preempted.[264] However, the court noted that the Michigan rule did not authorize more or different reliefs in state courts, nor did it alter ERISA's cause of action for the recovery of benefits.[265] Finally, the Sixth Circuit dismissed a more subtle conflict preemption argument that the Michigan law was preempted, as it attempted to defeat ERISA's goal of having a uniform set of rules for adjudicating cases.[266] As *Firestone* made the *de novo* standard of review the default standard and the Michigan ruling applied the *de novo* standard to insures, there was not conflict with ERISA. The court then cited to the *Moran* decision, which held that an Illinois statute mandating certain benefit denials to a *de novo* review did not collide with ERISA.[267]

Similarly, the Ninth Circuit in *Standard Ins. Co. v. Morrison* upheld the commissioner's interpretation of a Montana statute to prohibit discretionary clauses in its insurance policies.[268] Montana's statute required its commissioner of insurance to disapprove of insurance policies with "inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purposed to be assumed in the general coverage of the contract," which the commissioner interpreted to prohibit discretionary clauses.[269] The court

262. *Ky. Ass'n Health Plans, Inc.*, 538 U.S. at 341.
263. *Am. Council Life Insurers*, 558 F.3d at 607 (quoting *Ky. Ass'n Health Plans, Inc.*, 538 U.S. at 339 n. 3).
264. *Id.* at 607–08.
265. *Id.*
266. *Id.* at 608.
267. *Id.* at 606–08 (citing Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 384 (2002)).
268. Standard Ins. Co. v. Morrison, 584 F.3d 837, 849 (9th Cir. 2009).
269. *Id.* at 840.

rejected the argument that the first prong of the *Miller* test was not met, as the prohibition against discretionary clauses was not directed at insurance companies, but instead directed at ERISA plans and procedures.[270] Quoting from *Miller*, it affirmed that a state law which regulates the terms of insurance policies clearly regulated insurers.[271] As to the second prong of the *Miller* test, the Ninth Circuit found that the commissioner's interpretation narrowed the scope of the bargain between insurers and insureds, as it changed the terms by which an insurer could determine whether the insured contingency existed, thereby satisfying the test.[272]

The Ninth Circuit also rejected the argument that the state law conflicted with ERISA's civil enforcement provisions, as it provided no additional remedy outside of ERISA and simply allowed causes of action for benefits with the default standard of review.[273] Finally, the court rejected the argument that the state's ban on discretionary clauses was inconsistent with the goals of ERISA's remedial system, which is to promote the adoption of employer-provided plans and employees' rights to benefits.[274] The court read the *Firestone* and *Glenn* cases to infer that the arbitrary and capricious standard of review was not a "cornerstone of the ERISA system," as the Supreme Court accepted the use of the *de novo* standard in certain circumstances.[275] More recently in *Orzechowski v. The Boeing Company Non-Union Long-Term Disability Plan, Plan Number 625*, the Ninth Circuit upheld a California law which voided discretionary clauses in insurance policies, on the same grounds that were used in *Morrison*.[276]

The Seventh Circuit, in *Fontaine v. Metropolitan Life Ins. Co*., agreed to follow the Sixth and Ninth Circuits' reasoning, holding that an

270. *Id*. at 842–44.

271. *Id*. at 842 (citing Ky. Ass'n Health Plans, Inc. v. Miller, 538 U.S. 329, 337 (2003)). The Ninth Circuit also noted that it affirmed the Sixth Circuit's interpretation in American Council of Life Insurers v. Ross, that such discretionary bans clearly were directed towards entities engaged in the business of insurance, Am. Council Life Insurers v. Ross 558 F.3d 600, 605 (6th Cir. 2009).

272. *Id*. at 845.

273. *Id*. at 846–47.

274. *Id*. at 847.

275. *Id*. at 847–48.

276. *See* Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, Plan No. 625, 856 F.3d. 686, 693–94 (9th Cir. 2017).

Illinois insurance law that prohibits provisions that reserve discretion to insurers to interpret health and disability insurance policies was not preempted by ERISA.[277] It held that the Illinois law regulates insurance, as it subjects insurers to certain insurance practices.[278] The issue of whether the clause for discretionary interpretation was in the insurance policy or plan document was irrelevant to the court.[279] As to the second prong of the *Miller* test, the court held that the ban on discretionary clauses clearly impacted the scope of the bargain between the insurer and insured, as it dictated the parameters under which risk is to be assumed under the policy.[280] Similarly, the court rejected the argument that the State law interferes with ERISA's civil enforcement remedy, as the *de novo* standard of review is already the default standard in ERISA cases.[281]

While the Fourth Circuit has not opined directly on this issue, one district court in the Fourth Circuit has affirmed that Maryland's ban on discretionary clauses in disability insurance policies is not preempted.[282]

The Tenth Circuit in *Hancock v. Metropolitan Life Insurance Co*. was not faced with a state law that banned reservation of discretion clauses in insurance policies, but instead a Utah rule that allowed discretionary clauses in ERISA employee benefit plans if the plan language followed the state law's safe-harbor language and was highlighted by a bold font not less than 12 point.[283] As the plan that MetLife administered had a discretionary clause, Ms. Hancock argued such clause to be invalid as it did not satisfy the terms of the Utah rule.[284] MetLife countered that such Utah rule was preempted by ERISA.[285] The Tenth Circuit invoked the Supreme Court's *Miller* decision to determine whether the Utah rule

277. Fontaine v. Metro. Life Ins. Co., 800 F.3d 883, 885 (7th Cir. 2015).
278. *Id.* at 887.
279. *Id.* at 888–89.
280. *Id.* at 888.
281. *Id.* at 889–90.
282. Weisner v. Liberty Life Assurance Co. Bos., 192 F. Supp. 3d 601, 610 (D. Md. 2016).
283. Hancock v. Metro. Life Ins. Co., 590 F.3d 1141, 1146–47 (10th Cir. 2009) (explaining that Utah's Rule 590-218-5(1) banned reservation of discretion clauses in insurance policies, but Rule 590-218-5(2) provided an exception for employee benefit plans if the plan language met certain safe-harbor language and was highlighted in bold with font not less than 12 point). *See* UTAH ADMIN. CODE r. 590-218 (LexisNexis 2003)).
284. *Id.* at 1146.
285. *Id.*

was preempted by ERISA or saved under its saving clause. MetLife did not contest that the Utah rule satisfied Miller's first prong.[286] The court held that the second *Miller* prong (i.e., the risk pooling prong) was not satisfied, as the rule did "not remove the option of insurer discretion from the scope of permissible insurance bargains in ERISA plans."[287] The rule "authorizes discretion-granting clauses so long as they disclose certain matters and conform with the rule's font requirement," and thus, "relates to the form, not the substance of ERISA plans."[288] Hence, it had no impact on risk pooling, as required by *Miller*.[289] The court was quick to note that the result would have been different if the rule had a "blanket prohibition" on the use of discretionary clauses.[290]

In the context of a *non-insured* short-term disability plan that was administered by an insurer, the Ninth Circuit invoked ERISA's deemer clause when examining whether such plan was subject to a California ban on discretionary clauses.[291] In that case, the Boeing Company offered a non-insured disability plan which was administered by Aetna and contained the necessary reservation of discretion clause for Aetna when interpretating the plan or making factual determinations.[292] The district court reviewed Aetna's benefits denial *de novo* on the grounds that the California Insurance Code § 10110.6 invalidated the plan's discretionary clause.[293] The Ninth Circuit reversed.[294] It reviewed ERISA's savings clause, which creates a "carve-out" from its preemption clause for state insurance laws, as well as its deemer clause, which prevents an ERISA employee benefit plan from being "deemed" to be an insurance company or other insurer for purposes of any State insurance laws.[295] The court noted that the Supreme Court held that the deemer clause's scope "turns on the presence or absence of traditional

286. *Id.* at 1148.
287. *Id.* at 1149.
288. *Id.*
289. *Id.*
290. *Id.*
291. Williby v. Aetna Life Ins. Co., 867 F.3d 1129, 1136 (9th Cir. 2017).
292. *Id.* at 1131.
293. Williby v. Aetna Life Ins. Co., No. 2:14-cv-04203 CBM, 2015 WL 5145499, at *1 (C. D. Cal. Aug. 31, 2015).
294. *Williby*, 867 F.3d at 1137.
295. *Id.* at 1135–36.

insurance."[296] Thus, the court concluded that under ERISA's deemer clause, the savings clause did not apply to self-funded plans, such as Boeing's short-term disability plan, and that state insurance regulations operating on such a self-funded plan were preempted.[297] Thus, Boeing's self-funded plan was not subject to the California insurance ban on discretionary clauses.[298]

Since ERISA's passage in 1974, Congress has not amended ERISA to provide for a standard of review.[299] But Congress' House of Representatives in September of 2022 passed a law referred to as the Mental Health Matters Act, H.R. 7780.[300] Sections 702 and 703 of that bill prohibit the use of discretionary clauses in *all* (not just insured) ERISA-covered employee benefit plans, other than multi-employer plans.[301] The rationale of the proposal is to "enhance access" to employer-provided employee benefits by banning discretionary clauses "that unfairly advantage plan administrators."[302] The reason for the multi-employer plan exclusion is likely that organized labor and insurance lobbies have banded together to support the bill, making it more likely that it could be passed.[303] But whether the House bill will pass through the Senate remains to be seen.

296. *Id.* at 1136 (quoting FMC Corp. v. Holliday, 498 U.S. 52, 64 (1990), which issued a bright-line rule: "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it.").

297. *Id.* at 1136.

298. *Id.* at 1137.

299. Kennedy, *Standard of Review*, *supra* note 54, at 1084.

300. *See* H.R. REP. NO. 117-484, at 38–40 (2022). In its legislative history, the Committee on Education and Labor stated that it "strongly believes a general prohibition on discretionary clauses in ERISA-covered plans would significantly enhance participants' and beneficiaries' ability to prevail when they challenge a wrongful denial of mental health benefits." Hence, the Committee believes the use of a *de novo* standard of review would be an "important step" in overturning the unbalance of power and improving access to benefits for plan participants.

301. *Id.* at 18–19.

302. *Id.* at 40. The legislative history indicates that the committee believes that without a *de novo* standard of review, "individuals are unfairly disadvantaged when they challenge a benefit denial in court."

303. *Id.* at 124–25.

Section VI. Circuit-by-Circuit Review of ERISA's Judicial Standard of Review in Benefit Denial Cases

The following is a circuit-by-circuit review of ERISA's judicial standard of review of the following issues:

- what insurance language (i.e., "proof satisfactory to us") is insufficient to confer discretionary authority;
- whether the insurer or plan administrator has the burden of proving whether the deferential review standard applies;
- what constitutes an arbitrary and capricious or abuse of discretion review; and
- whether the court's review of the benefits denial is limited to the plan administrator's administrative record that was created during the claims adjudication process in either the *de novo* review context or the arbitrary and capricious review context. The Sixth Circuit framed this issue as follows: *de novo* could mean "to review of the decision below based only on the record below [or] to review based on the record below plus any additional evidence received by the reviewing court."[304] Some courts also refer to this additional evidence as "extrinsic evidence," which can mean evidence that was not available to the claimant or was not a part of the administrator's administrative record. As will be explained, the answer to this question varies by the type of judicial standard of review used by the court (i.e., *de novo* or arbitrary and capricious) and by jurisdiction.

Such analysis is critical because an ERISA practitioner accustomed to practicing before a given district court or within a specific circuit should not presume that the district courts and the circuit courts have a uniform interpretation of ERISA in these contexts. Such practitioner must familiarize himself with the jurisdiction that he is litigating in, so as to prevail either for the plaintiff pursuing a benefits claim or for the defendant relying upon a deferential standard of review. As witnessed by the split within the circuits as to how these issues are resolved, the Supreme Court's guidance could prove to be very useful.

304. *See* Perry v. Simplicity Eng'g, 900 F.2d 963, 966 (6th Cir. 1990). The Supreme Court in *Firestone* did not consider this issue.

First Circuit [Maine, Massachusetts, New Hampshire, Puerto Rico, and Rhode Island]

Maine,[305] New Hampshire,[306] and Rhode Island[307] ban discretionary clauses in insurance contracts.

In the case of *Gross v. Sun Life Assur. Co*., an employee, Gross, was covered by her employer's long term disability plan that was insured under group policies obtained through Medical Group Insurance Service, Inc. (MGIS) since 2003, with the policies originally written by The Hartford Life (Accident Insurance Company) and, beginning in 2006, by Sun Life Assurance Company of Canada.[308] After Sun Life dismissed Gross' claim for benefits on the grounds that she provided "insufficient objective evidence to substantiate" her disability, Gross sued in federal court and requested the court to apply the Firestone *de novo* standard of review.[309] The district court granted summary judgment for Sun Life, applying the arbitrary and capricious standard to Sun Life's benefits denial.[310]

Under the terms of the insurance policy, the insurer required that "proof [of claim] must be satisfactory to Sun Life" (referred to by the courts as the "satisfactory to us" language) and that "[b]enefits are payable when Sun Life receives satisfactory Proof of Claim."[311] The First Circuit held that such "satisfactory to us" language was insufficient to confer discretion, as the plan was required to "reflect a *clear* grant of discretionary authority to determine eligibility for benefits."[312] Such "satisfactory to us" language referred to Sun Life's right to require certain forms of proof (e.g., required information and types of evidence to prove a claim), but did not confer upon it discretionary authority over benefit claims.[313] The court inferred that Sun Life bore the burden of proving the deferential standard of review, as it noted that Sun Life

305. ME. STAT. tit. 24-A, §§ 2847-V, 4303, 2770 (2023).
306. N.H. CODE ADMIN. R. ANN. INS. § 401.04 (2023).
307. 27 R.I. GEN. LAWS §§ 27-18-79, 27-34.2-22 (2024).
308. Gross v. Sun Life Assur. Co. of Canada, 734 F.3d 1, 4 (1st Cir. 2013).
309. *Id.* at 4–5.
310. *Id.* at 5.
311. *Id.* at 11–12.
312. *Id.* at 13 (quoting from Leahy v. Raytheon Co., 315 F.3d 11, 15 (1st Cir. 2002)) (emphasis added).
313. *Id.* at 15.

could have avoided this adverse ruling by inserting more explicit language into its policy or summary policy booklet.[314]

In applying the Firestone *de novo* standard, the issue facing the court was the ability of the claimant to obtain discovery and the scope of the court's review of that discovery. The First Circuit noted that it was to "weigh the facts and opinions in the administrative record to determine whether the claimant has met [her] burden of showing that [she] is disabled within the meaning of the policy."[315] Hence, the presumption was that the evidence the court examined would be limited to the "administrative record" that was created during the claims process.[316] This approach was consistent with an earlier First Circuit opinion in *Orndorf v. Paul Revere Life Insurance Company*, where the court held that the presumption in an arbitrary and capricious review was to limit its review to the administrative record, unless there was "some very good reason . . . to overcome that preference."[317] The court then decided to extend this rule even when the benefits denial was subject to a *de novo* review.[318] It explained its rationale as follows:

> It would offend interests in finality and exhaustion of administrative procedures reacquired by ERISA to shift the focus from [the administrative] decision to a moving target by presenting extra-administrative record evidence going to the substance of the decision . . . the final administrative decision acts as a temporal cut off point. The claimant may not come to a court and ask it to consider post-denial medical evidence in an effort to reopen the administrative decision . . . extrinsic evidence may be relevant if there was an "attack on the *process* of decision making," such as personal bias or procedural irregularity by the plan administrator.[319]

As remarked earlier, the term "administrative record," used by the courts, is not an administrative record at all, as there is no administrative process used in fashioning such a record.[320] Such term makes the

314. *Id.* at 15–16 (noting the Seventh Circuit's decision in Herzberger v. Standard Ins. Co., 205 F.3d 327, 332 (7th Cir. 2000) in which the court proposed specific language to be used to invoke the deferential standard of review).

315. *Id.* at 17 (quoting Scibelli v. Prudential Ins. Co. of Am., 666 F.3d 32, 40 (1st Cir. 2012), which in turn quoted from Richards v. Hewlett-Packard Corp., 592 F.3d 232, 239 (1st Cir. 2012)).

316. *Id.*

317. Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 519 (1st Cir. 2005).

318. *Id.* at 519–20.

319. *Id.* at 519–20.

320. *Supra* text accompanying notes 43–47.

plan administrator's decision sound more like a review of an administrative agency decision, when in fact, the benefits denial is a dispute between two private parties.[321] The term "claim file" may be more relevant, but the courts use the phrase "administrative record."[322]

Other First Circuit opinions affirm the majority rule that the court is limited to the administrative record in the context of a deferential review.[323] A more recent First Circuit decision, *Troiano v. Aetna Life Ins. Co.*, affirmed the rule that extrinsic evidence may be admitted, but only in the court's discretion.[324] In the context of a structural conflict of interest on the part of the plan administrator, the claimant had the burden of showing that such conflict influenced its decision.[325]

In *Winters v. Liberty Life Assurance Co. of Boston*, a recent district court case within the First Circuit, the District Court of Massachusetts reiterated that evidence outside of the administrative record may be considered if there is "some very good reason."[326] Such information includes the "nature or timing" of the claim[327] or information that a party has a "colorable claim of bias."[328] In *Winters*, the insurer sought to supplement the administrative record before the court.[329] The court permitted such evidence.[330] The first piece of evidence was a medical chronology which provided a summary of information found in the record.[331] As the chronology was in an exhibit and provided a useful summary of

321. *Supra* text accompanying notes 43-47.

322. *See supra* Section I.

323. Niebauer v. Crane & Co., 783 F.3d 914, 930 (1st Cir. 2015) (stating that the question before the court was whether the administrator's action "on the record before him" was unreasonable, quoting from Liston v. Unum Corp. Officer Severance Plan, 330 F.3d 19, 24 (1st Cir. 2003)); Leahy v. Raytheon Co., 315 F.3d 11, 18 n.6 (1st Cir. 2002) (acknowledging that there could be special circumstances in which the court may consider additional evidence); *Liston*, 330 F.3d at 23–24.

324. *See* Troiano v. Aetna Life Ins. Co., 844 F.3d 35, 45 (1st Cir. 2016) (stating that the "party seeking discovery must provide 'some very good reason . . . to overcome the strong presumption' against discovery," citing *Liston*, 330 F.3d at 23 (requiring a "very good reason" to rebut the presumption that review is limited to the administrative record)).

325. *Id.*

326. Winters v. Liberty Life Assurance Co. of Bos., C.A. No. 20-11937-MLW, 2022 WL 6170588, at *5 (D. Mass. Oct. 6, 2022).

327. *Id.* (quoting *Liston*, 330 F.3d at 23).

328. *Id.* at 5. (quoting Denmark v. Liberty Life Assurance Co. of Bos., 566 F.3d 1, 10 (1st Cir. 2009)).

329. *Id.* at 1.

330. *Id.*

331. *Id.* at 5.

the information already contained in the record, the court allowed it.[332] The second piece of evidence was the Tom Declaration; although it contained information not in the administrative record, it was useful to the court as it explained how claims and appeals were processed by the insurer.[333]

Second Circuit [Connecticut, New York, Vermont, District of Columbia]

Connecticut,[334] New York,[335] and Vermont[336] ban discretionary clauses in insurance contracts.

In *Kinstler v. First Reliance Std. Life Ins. Co.*, the Second Circuit affirmed that "the party claiming deferential review should prove the predicate that justifies it."[337] It then ruled that the insurance language which required "satisfactory proof . . . to us" was insufficient to preclude *de novo* review.[338] According to the court, the policy should have made it explicit that the required proof "must be satisfactory to the decision-maker."[339]

In *Donlick v. Standard Ins. Co.*, the Second Circuit held that, while the district court had discretion to consider evidence outside of the administrative record, "the presumption is that judicial review 'is limited to the record in front of the claims administrator unless the district court finds good cause to consider additional evidence.'"[340] As the case

332. *Id.* at 6.

333. *Id.* at 5–6, 20 (such information discussed the insurer's procedural processes which were relevant in ascertaining whether the insurer had a structural conflict of interest and if so, whether there were meaningful safeguards to reduce the risk that such conflict would result in a biased decision).

334. State of Conn. Ins. Dep't, HC-67, Bulletin on Use of Discretionary Clauses (Mar. 19, 2008).

335. NY 2006 Circular Letter No. 14, *supra* note 248.

336. VT. STAT. ANN. tit. 8, § 4062f (2024).

337. Kinstler v. First Reliance Standard. Life Ins. Co., 181 F.3d 243, 249 (2d Cir. 1999) (quoting from Sharkey v. Ultramar Energy Ltd., 70 F.3d 226, 230 (2d Cir. 1995)).

338. *Id.* at 251.

339. *Id.* at 252.

340. Donlick v. Standard Ins. Co., 726 F. App'x 12, 16 (2d Cir. 2018) (citing Muller v. First Unum Life Ins. Co., 341 F.3d 119, 125 (2d Cir. 2003)), which in turn quoted from DeFelice v. Am. Int'l Life Assurance Co. of N.Y., 112 F.3d 61, 67 (2d Cir. 1997). *See* Krizek v. CIGNA Grp. Ins., 345 F.3d 91, 98 (2d Cir. 2003) (affirming that the

involved a claim for long-term disability benefits in which the employer insured such plan through Standard Insurance Co., the plaintiff alleged the insurer's conflict of interest, as it acted as administrator and insurer of benefits, and argued for a *de novo* standard of review. The Second Circuit rejected that argument, as the policy granted appropriate discretionary authority to the insurer as plan administrator, and a conflicted administrator did not constitute good cause for the court to consider additional evidence.[341] Under the Second Circuit's prior ruling, the court is limited to the administrative record unless there is "good cause" for it to consider additional evidence.[342]

In *DeFelice v. American Int'l Life Assurance Co. of N.Y.*, the Second Circuit affirmed that the district court has discretion to admit additional evidence in a *de novo* review context, but noted such discretion should not be extended in the absence of a showing of good cause.[343] While the court had earlier permitted additional evidence upon *de novo* review on the issue of plan interpretation, the *DeFelice* court now extended that holding in determining factual issues, as the case involved a conflicted administrator.[344] Under those facts, the court noted that the claim was decided by a committee consisting entirely of employees of the plan administrator, that there had been no guidelines for determining an appeal, and that the committee had a practice of destroying all records within minutes of the appeal.[345] As such, the court held "[i]n such circumstances, [district] courts *must* exercise fully their power to review de novo and to *be* substitute administrators."[346]

In allowing additional evidence, the Second Circuit later elaborated what constituted "good cause" to include flawed internal claim procedures or situations in which the insurer's reason for denial was not given to the claimant.[347] However, in the former context, the court

district court did not abuse its discretion in limiting itself to the administrative record); *see also* Zervos v. Verizon N.Y., Inc., 277 F.3d 635, 646 (2d Cir. 2002) (requiring "good cause" to consider evidence outside of the administrative record, even in a de novo review).

341. *Donlick*, 726 F. App'x at 15–16.

342. *Zervos*, 277 F.3d at 646.

343. *DeFelice*, 112. F.3d at 66.

344. *Id.* at 65–66 (referring to Masella v. Blue Cross & Blue Shield of Conn., Inc., 936 F.2d 98, 103–05 (2d Cir. 1991)).

345. *Id.* at 66.

346. *Id.*

347. Locher v. UNUM Life Ins. Co. of Am., 389 F.3d 288, 295 (2d Cir. 2004).

ruled that the mere existence of the plan administrator's structural conflict of interest (i.e., a *per se* rule) was not reason for "good cause."[348]

In the case of *Daniel v. Unum Provident Corp*., the Second Circuit permitted the district court to consider evidence outside of the administrative record in determining the applicable judicial standard of review.[349] At question in the case was whether a General Services Agreement (which was not in the administrative record) actually conferred discretionary authority on the entity that denied the benefits, thereby allowing a deferential standard of review upon the entity.[350] As the district court had not considered the General Services Agreement, the appropriate judicial standard of review was not known.[351] Hence, extrinsic evidence was necessary to determine the standard of review.

Third Circuit [Pennsylvania, New Jersey, Delaware, the Virgin Islands]

New Jersey[352] bans discretionary clauses in insurance contracts.

The Third Circuit has adopted the Second Circuit's *Kinstler* approach, requiring the party seeking deferential review have the burden of proving that such standard applies.[353] It also affirmed the insurance language relying on its provision that the claimant submit proof "satisfactory to us" was insufficient to trigger discretionary review of the insurer's decision.[354]

The Third Circuit in the case of *Noga v. Fulton Fin. Corp. Emp. Benefit Plan* opined as to the court's scope of review in the abuse of discretion context.[355] In the case where the courts are reviewing an ERISA fiduciary's discretionary adverse benefit decision, the Third Circuit confines the courts to the information contained in the administrative

348. *Id.* at 295–96.
349. Daniel. v. Unum Provident Corp., 261 F. App'x 316, 318 (2d Cir. 2008).
350. *Id.* at 318–19.
351. *Id.* at 318.
352. N.J. ADMIN. CODE § 11:4-58.3 (2024).
353. Viera v. Life Ins. Co. of N. Am., 642 F.3d 407, 413 (3d Cir. 2011) (citing Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 249 (2d Cir. 1999)).
354. *Id.* at 416–17.
355. Noga v. Fulton Fin. Corp. Emp. Benefit Plan, 19 F.4th 264, 272–73 (3d Cir. 2021).

record.[356] The Court defined the administrative record as the materials before the fiduciary when it decides the benefit decision on internal review, as well as relevant plan documents, the claim file, and the fiduciary's final determination with respect to the claim.[357] The court traced the history of relying on the "whole record" before the benefits decision maker (referred to by the court as the ERISA record rule) in the context where the plan administrator had discretionary authority to make the benefits determination.[358] Drawing on administrative law principles to fashion ERISA's common law, the Third Circuit had in the past linked the arbitrary and capricious standard to record review, referring to the *Mitchell v. Eastman Kodak Co.* decision, which applied Social Security's whole-record rule to arbitrary and capricious reviews under ERISA.[359] In contrast, the Third Circuit noted that it did not apply the ERISA record rule to adverse benefit determinations subject to the *de novo* review.[360] In those cases, the court is not limited to the evidence before the plan administrator.[361]

The Third Circuit continued its analysis of the ERISA record rule in the case of an arbitrary and capricious standard of review, noting that the rule did not extend to information regarding the fiduciary's "potential biases and conflicts of interest."[362] The rationale was that the decision-maker, if affected by a conflict of interest, would not be likely to divulge such information.[363] However, this exception to the ERISA record rule for structural conflicts is narrow, as it does not permit supplemental of the record with information relating to the claim or review process.[364]

356. *Id.* at 271 (citing Howley v. Mellon Fin. Corp., 625 F.3d 788, 793 (3d Cir. 2010)). *See* Abnathya v. Hoffmann-La Roche, Inc., 2 F.3d 40, 48 (3d Cir. 1993), *abrogated in part on other grounds as recognized by* Miller v. Am. Airlines, Inc., 632 F.3d 837 (3d Cir. 2011) (affirming that the district court need not consider additional evidence submitted by the claimant long after her appeal was decided, under a deferential review).

357. *Noga*, 19 F.4th at 272 (citing *Howley*, 625 F.3d at 793 and Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440 (3d Cir. 1997)).

358. *Id.*

359. *Id.* (citing *Mitchell*, 113 F.3d at 440).

360. *Id.* at 273 (citing Luby v. Teamsters Health, Welfare, & Pension Tr. Funds, 944 F.2d 1176, 1185 (3d Cir. 1991)).

361. *Id.*

362. *Id.* at 271–72 (citing Kosiba v. Merck & Co., 384 F.3d 58, 67 n.5 (3d Cir. 2004) and *Howley*, 625 F.3d at 794 (3d Cir. 2010)).

363. *Id.* at 273 (citing Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 111 (2008)).

364. *Id.* at 274 (citing Post v. Hartford Ins. Co., 501 F.3d 154, 168–69 (3d Cir. 2007)).

When exercising *de novo* review in a benefits denial case, the Third Circuit held that the court was not limited to the administrative record.[365] While the court did not require the district court to conduct a *de novo* evidentiary hearing or a full trial *de novo* to resolve the case, the district court has the discretion to conduct a *de novo* review of the administrative record to make its own independent conclusions.[366] The court then cited the *McMahan v. New England Mut. Life Ins. Co.* case, in which the record was insufficient, thereby prompting the district court to "supplement the record" in order to make a *de novo* benefit determination.[367] Later, in the *Viera v. Life Insurance Co. of North America* case, the Third Circuit held that the district court's *de novo* review "may be based on any information before the administrator initially, as well as any supplemental evidence."[368] However, the court did not set forth guidelines as to how district courts should exercise their discretion.[369]

In a recent district court case within the Third Circuit, *Dwyer v. Unum Life Ins. Co. of Am.*, Judge McHugh echoed the view of Justice Easterbrook in the *Krolnik* decision that a *de novo* review requires the district court to determine *for itself* whether the benefits denial was accurate and that "[e]vidence is essential if the court is to fulfill its fact-finding function."[370] Thus, the court needs to determine the weight and credibility of the medical consultants and recognizes that certain evidence may not always be in the record, because it was known to the insurer but not the claimant.[371] Thus, district judges should utilize the Federal Rules of Civil Procedure to "make case-specific determinations of whether discovery is warranted, rather than rely[ing] upon indiscriminate generalizations."[372] This district court took a very expansive view of the role of discovery in the *de novo* context.

365. *Luby*, 944 F.2d at 1184.
366. *Id.* at 1185.
367. *Id.* at 1185 (citing McMahan v. New England Mut. Life Ins. Co., 888 F.2d 426, 431 (6th Cir. 1989)).
368. Viera v. Life Ins. Co. of N. Am., 642 F.3d 407, 418 (3d Cir. 2011).
369. *See id.*
370. Dwyer v. Unum Life Ins. Co. of Am. 470 F. Supp. 3d 434, 437–38 (E.D. Pa. 2020) (quoting Krolnik v. Prudential Ins. Co. of Am., 570 F.3d 841, 843 (7th Cir. 2009)).
371. *See id.* at 438.
372. *Id.*

Fourth Circuit [Maryland, North Carolina, South Carolina, Virginia, West Virginia]

Maryland[373] bans discretionary clauses in insurance contracts.

In *Cosey v. Prudential Ins. Co. of Am*., the Fourth Circuit joined five of its sister circuits in holding that insurance language requiring the claimant to submit "proof satisfactory" to the insurer was insufficient to confer deferential review.[374]

The Fourth Circuit has affirmed the general rule that consideration of evidence outside of the administrative record is inappropriate when the decision maker's decision is being reviewed for abuse of discretion.[375] Such rule promotes ERISA's goals of "expeditiously, efficiently, and inexpensively resolving coverage disputes."[376] But it takes "a more nuanced approach" to considering extrinsic evidence on deferential review, focusing instead on whether the evidence was known to the plan administrator at the time of the decision, not whether it was contained in the administrative record.[377] To do otherwise would permit plan administrator to eliminate any evidence in the administrative record that could imply that their decision was unreasonable.[378] In its earlier decision of *Booth v. Wal-Mart Stores, Inc. Associates Health & Welfare Plan*, the Fourth Circuit determined eight factors to be used in ascertaining whether the plan administrator abused its discretion in denying the claim.[379] One such factor requires the court to consider

373. MD. CODE ANN., INS. § 12-211 (West 2023).

374. Cosey v. Prudential Ins. Co. of Am., 735 F.3d 161, 166 (4th Cir. 2013) (citing Gross v. Sun Life Assurance Co. of Can., 734 F.3d 1, 11–17 (1st Cir. 2013); Diaz v. Prudential Ins. Co. of Am., 424 F.3d 635, 639–40 (7th Cir. 2005); Viera v. Life Ins. Co. of N. Am., 642 F.3d 407, 417 (3d Cir. 2011); Feibusch v. Integrated Device Tech., Inc. Emp. Benefit Plan, 463 F.3d 880, 883–84 (9th Cir. 2006); Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 252 (2d Cir. 1999)).

375. Helton v. AT & T Inc., 709 F.3d 343, 352 (4th Cir. 2013).

376. *Id.* (citing Perry v. Simplicity Eng'g, 900 F.2d 963, 967 (6th Cir. 1990)); *see* Sheppard & Enoch Pratt Hosp. v. Travelers Ins. Co., 32 F.3d 120, 125 (4th Cir. 1994) (in which the court takes a different approach to considering additional evidence in *de novo* cases as compared to deferential cases, as the latter should not consider such evidence).

377. *Helton*, 709 F.3d at 352–53 (citing Jett v. Blue Cross & Blue Shield of Ala., 890 F.2d 1137, 1139 (11th Cir. 1989)). The court also cites Hess v. Hartford Life Accident Ins. Co., 274 F.3d 456, 462–63 (7th Cir. 2001) (allowing the court to consider the beneficiary's employment contract which was not in the administrative record) and Brooking v. Hartford Life & Accident Ins. Co., 167 F. App'x 544, 547 n.4 (6th Cir. 2006) (allowing the court to consider plan documents which were not in the administrative record).

378. *See id*. at 353.

379. Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, 201 F.3d 335, 342–43 (4th Cir. 2000).

whether the plan administrator's interpretation of the plan in question was consistent with prior interpretations, which may require the court to look to extrinsic evidence.[380] As noted earlier, the court may also consider evidence outside of the administrative record, but known to the administrator, on abuse of discretion review in the context of a conflicted plan administrator.[381] As a result, this circuit does not have an absolute bar on the use of extrinsic evidence on abuse of discretion review.[382]

In contrast, the Fourth Circuit, in *Quesinberry v. Life Ins. Co. of N. Am*., permits the district court to use its discretion in admitting evidence that was not before the plan administrator if the benefits denial is being reviewed under a *de novo* standard.[383] Such is required "when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision."[384] To do otherwise extends fewer rights to participants than they enjoyed prior to ERISA's passage.[385]

The court in *Quesinberry* noted that flexibility in a *de novo* review is required, as some ERISA plans have extensive administrative procedures and lengthy records, while others have limited administrative procedures and meager records.[386] For example, some plans have the payor and the administrator as the same entity, while others have different entities for both roles; some cases involve complex medical issues critical to the interpretation and application of the plan terms, while others involve limited factual determinations.[387] The Fourth Circuit recently affirmed this approach, stating that a *de novo* review of the ERISA benefits claim is not limited to the evidentiary record in *Shupe v. Hartford Life & Accident Ins. Co.,* as the courts may wish to know "why the evidence proffered was not submitted to the plan administrator."[388] For example, if there was information known to the plan administrator but

380. *Id.* at 342.
381. Helton v. AT&T, Inc., 709 F.3d 343, 355 (4th Cir. 2013).
382. *Id.* at 356.
383. Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1026–27 (4th Cir. 1993).
384. *Id.* at 1025.
385. See *id*.
386. *Id.* at 1025–26.
387. *Id.*
388. Shupe v. Hartford Life & Accident Ins. Co., 19 F.4th 697, 705 (4th Cir. 2021).

not contained in the administrative record, the court may wish to know why that was the case.

Fifth Circuit [Mississippi, Louisiana, Texas, Canal Zone]

Texas[389] bans discretionary clauses in insurance contracts.

As noted earlier in the Article, the Fifth Circuit has been on a longer journey than the other circuits on the issue of whether the *de novo* standard of review applies only to legal determinations or whether it should apply to both legal and factual determinations.[390] In 2018, the Fifth Circuit in *Ariana M. v. Humana Health Plan of Texas, Inc*. noted that it had been an outlier in limiting the *de novo* standard of review to denials based on interpretations of plan terms, and not applying it to factual determinations since the *Pierre v. Conn. Gen. Life Ins. Co*. case in 1991.[391] However, its view did not affect the vast number of ERISA cases, because the employers inserted the necessary language reserving discretionary authority to the plan administrator, thereby avoiding the *de novo* default standard.[392] However, the Fifth Circuit indicated that the importance of whether the *Firestone* standard should apply to factual determinations has now changed.[393] As Texas recently enacted a law banning an insurer's use of such delegation clauses,[394] if such statute is held not to be preempted by ERISA, many more ERISA cases will become subject to the *de novo* standard.[395] Thus, in *Ariana*, the Fifth Circuit concurred with all of the other circuits and overruled *Pierre*, now holding that Firestone's *de novo* standard also applies when the benefits denial is based on a factual determination.[396] Note: the Fifth Circuit has yet to rule whether the Texas law would be saved under ERISA's preemption clause.

In the case of *Foster v. Principal Life Ins. Co*.,[397] an attorney alleged intractable headaches prevented her from working for her employer and took disability leave under the employer's long-term disability

389. TEX. INS. CODE ANN. § 1271.057 (West 2023); 28 TEX. ADMIN. CODE § 3.1201 (2024).
390. *See supra* Section V.
391. Ariana M. v. Humana Health Plan of Tex., 884 F.3d. 246, 248 (5th Cir. 2018).
392. *Id.* at 255.
393. *Id.* at 248.
394. TEX. INS. CODE ANN. § 1701.062(a) (2023).
395. *Ariana M*., 884 F.3d at 248.
396. *Id.* at 255–56.
397. Foster v. Principal Life Ins. Co. 920 F.3d 298, 300 (5th Cir. 2019).

plan, insured by Principal.[398] The plan stated that a member was "disabled" if she could not "perform one or more of the Substantial and Material Duties of his or her Own Occupation."[399] As the insurance policy conferred discretion on Principal to construe the policy provisions and determine eligibility, it ruled that Foster was not disabled, as she was capable of working a full-time sedentary position and able to function at the level needed as an attorney on a regular basis (as opposed to whether she could perform the substantial and material duties of her occupation).[400] The Fifth Circuit ruled that "[w]here a benefits plan 'gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan,'. . . the reviewing court applies an abuse of discretion standard to the plan administrator's decision to deny benefits."[401] As the plan administrator's decision was supported by substantial evidence and was not arbitrary and capricious, it must prevail.[402] As to the substantial evidence criteria, such evidence is more than a scintilla, less than a preponderance, and supports the conclusion that a reasonable mind might accept as appropriate.[403] As to the arbitrary criteria, a decision is arbitrary "only if made without a rational connection between the known facts and the decision or between the found fact and the evidence."[404] This view of the abuse of discretion standard is similar to that seen in the other circuits.[405]

As to the scope of review, the seminal case in the Fifth Circuit is *Crosby v. Louisiana Health Service and Indemnity Co*, which involved a deferential review of the benefits denial.[406] The Fifth Circuit affirmed its prior rulings, particularly its ruling in *Vega v. National Life Insurance*

398. *Id.*
399. *Id.* at 301.
400. *Id.* at 303.
401. *Id.* at 303 (quoting Anderson v. Cytec Indus., Inc., 619 F.3d 505, 511–12 (5th Cir. 2010), in which the 5th Circuit, in turn, quoted Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)).
402. *Id.* at 304 (citing Corry v. Liberty Life Assurance Co. of Bos., 499 F.3d 389, 397–98 (5th Cir. 2007)).
403. *Id.* (citing *Anderson*, 619 F.3d at 512).
404. *Id.* (quoting Holland v. Int'l Paper Co. Ret. Plan, 576 F.3d 240, 246–47 (5th Cir. 2009)).
405. *Id.* at 305
406. Crosby v. La. Health Servs. & Indem. Co., 647 F.3d 258, 264 (5th Cir. 2011).

Services, Inc.,[407] that, in terms of resolving *factual* determinations relating to the merits of the claim, the court may not consider evidence apart from the administrative record unless such evidence relates to how the administrator had interpreted the plan in the past or would assist the court in understanding medical terms and procedures.[408] A ruling to the contrary would allow claimants to circumvent the administrative process by delaying the submission of evidence until they filed suit.[409] The court also stated that a "participant is not entitled to a second chance to produce evidence demonstrating that coverage should be afforded," which in effect would be a second bite of the apple.[410]

However, the Fifth Circuit went on to write that it does not prohibit the use of extrinsic evidence to answer *other questions* raised in a benefits denial case.[411] It outlines the following situations in which extrinsic evidence may be considered because such information may not be set forth in the administrative record: (1) when the claimant questions the completeness of the administrative record; (2) when ascertaining whether the plan administrator complied with ERISA's procedural requirements; and (3) when determining the existence and extent of any conflict of interest on the part of the plan administrator.[412] In *Vega*, the claimant sought evidence to determine whether the record was complete, whether Blue Cross observed ERISA's procedural rules, and whether Blue Cross previously extended coverage related to the jaw, teeth, or mouth.[413]

After so ruling, the Fifth Circuit remarked that review of an ERISA benefits denial "is essentially analogous to a review of an administrative agency decision," and thus, district courts need to oversee

407. Vega v. Nat'l Life Ins. Servs., Inc., 188 F.3d 287, 299–300 (5th Cir. 1999) (en banc), *abrogated on other grounds by* Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 114–16 (2008), as recognized in Holland v. Int'l Paper Co. Ret. Plan, 576 F.3d 240, 247 n.3 (5th Cir. 2009).

408. *Crosby*, 647 F.3d at 262–63 (quoting *Vega*, 188 F.3d at 299–300 (en banc), *abrogated on other grounds by Glenn*, 554 U.S. at 114–16, *as recognized in Holland*, 576 F.3d at 247 n.3); *see* Wilbur v. Arco Chem. Co., 974 F.2d 631, 638 (5th Cir. 1992) (allowing some evidence outside of the administrative record regarding the administrator's interpretation of the plan for uniformity).

409. *Crosby*, 647 F.3d at 263.

410. *Id.*

411. *Id.*

412. *Id.*

413. *Id.* at 263–64.

discovery carefully.[414] Hence, district courts should curtail otherwise permissible discovery if it ascertains that "the burden or expense of the proposed discovery outweighs its likely benefit, considering the needs of the case, the amount in controversy, the parties' resources, the importance of the issues at stake in the action, and the importance of discovery in resolving the issues."[415]

In the case of *Ariana v. Humana Health Plan of Texas, Inc*., the Fifth Circuit considered whether this same rule regarding extrinsic evidence should apply in the context of a *de novo* review.[416] While it noted that the Third, Fourth, Eighth, and Ninth Circuits provided different scope of record reviews in the *de novo* context, the Fifth Circuit saw no reason why the applicable judicial standard of review should change the scope of the record review.[417] It then reviewed its prior decision in *Vega v. National Life insurance Services, Inc*. which limited the court to the administrative record except in "very limited circumstances."[418] One exception permitted extrinsic evidence to ascertain how the administrator had interpreted the plan in previous instances; the other allowed such evidence, including expert opinions, to aid the court in understanding medical terminology that related to the claim.[419] It then affirmed applying this same scope of record in the *de novo* context in order to promote a quicker resolution of the claim at the administrative stage.[420]

414. *Id*. at 264 (quoting Doe v. Blue Cross & Blue Shield United of Wis., 112 F.3d 869, 875 (7th Cir. 1997) ("Like a suit to challenge an administrative decision, a suit under ERISA is a review proceeding, not an evidentiary proceeding.")).

415. *Id*. (citing FED. R. CIV. P. 26(b)(2)(C)(iii)).

416. Ariana M. v. Humana Health Plan of. Tex., Inc., 884 F.3d 246, 256–57 (5th Cir. 2018).

417. *Id*. at 256.

418. *Id.*

419. *Id.* (citing Wildbur v. ARCO Chem. Co., 974 F.2d 631, 639 n.15 (5th Cir. 1992)).

420. *Id*. Note how, in the *Wildbur* decision, the Fifth Circuit cites earlier decisions in which the court "accepted without discussion" the district court's use of extrinsic evidence upon a de novo review. *Wildbur*, 974 F.2d at 641.

Sixth Circuit [Kentucky, Michigan, Ohio, Tennessee]

Kentucky[421] and Michigan[422] ban discretionary clauses in insurance contracts.

In the case of *Perez v. Aetna*, the Sixth Circuit was called upon to determine whether the following insurance policy language was sufficient to grant discretionary authority to Aetna: "[s]ubsequent written proof . . . must be furnished to [Aetna] at such intervals as [Aetna] may reasonably require . . . [Aetna] shall have the right to require as part of the proof of claim satisfactory evidence . . . that [the claimant] has furnished all required proofs of such benefits . . . ."[423] The court affirmed that such language was sufficient, looking back to its prior Sixth Circuit decisions, which addressed similar plan language.[424] As noted in other circuits above, this holding in the Sixth Circuit is clearly different than other circuits.[425]

In the case of *Davis v. Hartford Life & Accidence Ins. Co*., Davis, a plan participant, challenged the plan administrator's decision to terminate long-term disability benefits, which were insured under a policy issued by Hartford Life.[426] The parties to the case agreed that the policy granted discretionary authority to Hartford Life, but they disputed whether Hartford Life exercised its discretionary authority in making that determination, as a related employer (Hartford Fire) was involved in the adjudication of the case.[427] As the court dismissed that argument, it applied the arbitrary and capricious standard of review, which it described as "extremely deferential" standard and one of the "least demanding form[s] of judicial review."[428] Such standard requires the court to affirm the plan administrator's decision if "it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence."[429]

The Sixth Circuit in *Cooper v. Life Ins. Co. of N. Am.* affirmed its prior holding in *Wilkins* that the court is to review a discretionary

421. KY. REV. STAT. ANN. § 304.14-130 (West 2024).
422. MICH. ADMIN. CODE r. 500.2202, 550.302 (2024).
423. Perez v. Aetna Life Ins., 150 F.3d 550, 555 (6th Cir. 1998).
424. *Id.* at 557 (citing Miller v. Metro. Life Ins. Co., 925 F.2d 979, 983 (6th Cir. 1991) and Yeager v. Reliance Standard Life Ins. Co., 88 F.3d 376, 380 (6th Cir. 1996)).
425. *Id.*
426. Davis v. Hartford Life & Accident Ins. Co., 980 F.3d 541, 543 (6th Cir. 2020).
427. *Id.* at 545–56.
428. *Id.* at 547.
429. *Id.* (quoting Jackson v. Blue Cross Blue Shield of Mich. Long Term Disability Prog., 761 F. App'x 539, 543 (6th Cir. 2019)).

benefits denial solely based on the administrative record.[430] An exception applies "only if that evidence is offered in support of a procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part."[431]

Immediately after *Firestone*, the Sixth Circuit in *Perry v. Simplicity Engineering* considered the scope of review by the district court under a *de novo* standard of review.[432] It held that the *de novo* standard required the court to decide whether or not it agreed with the plan administrator's decision based only the administrative record and not based on any additional evidence received by the court.[433] To do otherwise would turn the federal district courts into "substitute plan administrators," a result that would frustrate ERISA's goal of prompt disposition of claims.[434] In the court's words:

> "[T]he Supreme Court differentiated between *de novo* determination, in which the judge gives fresh consideration to issues determined by the magistrate, and a *de novo* hearing, at which the judge hears new or additional evidence. In our view *Bruch* does not contemplate a *de novo* hearing, but rather a *de novo* consideration of the proper interpretation of the plan and whether an employee is entitled to benefits under it. . . . A primary goal of ERISA was to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously. . . . Permitting or requiring district courts to consider evidence from both parties that was not presented to the plan administrator would seriously impair the achievement of that goal. If district courts heard evidence not presented to plan administrators, employees and their beneficiaries would receive less protection than Congress intended."[435]

The reader should take note of Judge Nalbandian's concurrence in *Tranbarger v. Lincoln Life & Annuity Co. of New* (as discussed in the Seventh Circuit opinions below), as he calls for a more expansive view of the record, especially in the *de novo* context.

The Sixth Circuit appeared to soften its view in the *Wilkins v. Baptist Healthcare Sys. Inc*. case.[436] The court in *Wilkins* affirmed that when

430. Cooper v. Life Ins. Co. of N. Am., 486 F.3d 157, 171 (6th Cir. 2007) (citing Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 618–19 (6th Cir. 1998)).
431. *Id*. at 171 (citing *Wilkins*, 150 F.3d at 619).
432. Perry v. Simplicity Eng'g, 900 F.2d 963, 966 (6th Cir. 1990).
433. *Id.*
434. *Id.*
435. *Id.* at 966–67.
436. *Wilkins*, 150 F.3d at 616.

conducting a *de novo* review of the case, the district court may take a "fresh look" at the administrative record, but may not consider new evidence or look beyond the administrative record.[437] However, the Sixth Circuit then permitted an exception to this rule if there is an allegation of lack of due process afforded by the plan administrator or alleged bias on its part.[438] This is the same standard that the court used in a deferential review of the benefits denial, as seen in *Coopers*.[439] For example, when the plan administrator failed to provide the specific reasons for the benefits denial and its denial letter contained insufficient information regarding the next steps to be taken for obtaining a review, the Sixth Circuit believes that such procedural errors are sufficient to overturn the plan administrator's decision to deny benefits.[440] In addition, if the claimant is alleging that the plan administrator was conflicted, the court may consider evidence as to whether the plan administrator's bias affected its decision.[441]

Seventh Circuit [Illinois, Indiana, Wisconsin]

Illinois[442] and Indiana[443] ban discretionary clauses in insurance contracts.

In *Herzberger v. Standard Insurance Co.*, the Seventh Circuit consolidated two appeals raising the same issue—does plan language requiring benefits to be paid when the plan administrator upon proof (or, as some plan documents state, satisfactory proof) determines that the applicant is entitled to such benefits confer upon the plan administrator a power of discretionary judgment to set aside the *de novo* standard of review? In deciding this issue, the court held that it would not assume a conferral of discretion because the outcome of the case may be

437. *Id.*

438. *Id.* at 618 (citing VanderKlok v. Provident Life & Accident Ins. Co., Inc., 956 F.2d 610, 617 (6th Cir. 1992), which permitted the insured to present new evidence as the plan administrator did not provide him with proper notice as required by the administrative hearing procedures); *see also* Weiner v. Aetna Health Plans of Ohio, No. 97-3136, 1998 WL 381642, at *3 (6th Cir. June 23, 1998).

439. Cooper v. Life Ins. Co. of N. Am., 486 F.3d 157, 171 (6th Cir. 2007).

440. *VanderKlok*, 956 F.2d at 617.

441. *Wilkins*, 150 F.3d at 618 (Gilman, J., concurring). But the *Cooper* court noted that the mere existence of a conflict of interest was insufficient as the claimant needed to provide "significant evidence" that the conflict actually affected or provoked the benefits denial. *See Cooper*, 486 F.3d at 165 (citing Peruzzi v. Summa Med. Plan, 137 F.3d 431, 433 (6th Cir. 1998)).

442. ILL. ADMIN. CODE tit. 50, § 2001.3 (2024).

443. Meridian Mut. Ins. Co. v. Cox, 541 N.E.2d 959, 961–62 (Ind. App. 1989); IND. CODE § 27-8-5-1 (2023).

determined by the standard of review that is used.[444] It described the discretionary review standard as one "largely insulated from judicial review."[445] Thus, it held language requiring benefits be paid upon submission of proof "satisfactory to us" to be insufficient to confer discretion.[446] The court then provided the following "safe harbor" language for inclusions in ERISA plans which use the word "discretion": "Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them."[447]

In surmising why some courts have been misled, the Seventh Circuit in *Herzberger* distinguished between the judicial review of a plan administrator's decision to deny disability benefits and the judicial review of the denial of such benefits by the Social Security Administration.[448] In *Herzberger*, one of the appellants applied for and received Social Security disability benefits, but was denied disability benefits under her employer-provided plan.[449] Judicial review of an agency's decision is to be based on a reasonableness or substantial evidence standard.[450] The court reasoned that a deferential standard of review is justified because the public agency denying benefits did so only after affording the applicant a full adjudicative hearing before a judicial officer.[451] Procedural safeguards are afforded to such an applicant to assure a full and fair hearing.[452] In contrast, the default judicial standard of review in an ERISA benefits denial case is the plenary review, as stated by *Firestone*.[453] However, if the plan wishes to stipulate for a more

444. Herzberger v. Standard Ins. Co., 205 F.3d 327, 329–31 (7th Cir. 2000); *see* Fessenden v. Reliance Standard Life Ins. Co., No. 3:15CV370-PPS, 2018 WL 461105, at *13 (N.D. Ind. Jan. 17, 2018), *vacated and remanded*, Fessenden v. Reliance Standard Life Ins. Co., 927 F.3d 998 (7th Cir. 2019), where the court stated that the *die was essentially cast* against the participant's claim in the context of the court's use of the deferential standard of review.

445. *Herzberger*, 205 F.3d at 332.

446. *Id.* at 331–32.

447. *Id.* at 331.

448. *Id.* at 332. (In this case, the participant Herzberger did apply and received social security disability benefits).

449. *Id.* at 332–33.

450. *Id.* at 332.

451. *Id.*

452. *Id.*

453. *Id.*

deferential review, the Seventh Circuit requires it to do explicitly so that the employees understand how benefit denials will be handled.[454]

As to the scope of the administrative record, Judge Easterbrook in the *Perlman v. Swiss Bank Corp*. case affirmed that the arbitrary and capricious standard of review, applicable when discretion has been granted, is limited to the court's review of the administrative record.[455] The court cited six other courts of appeal cases which affirmed that same rule.[456]

In the context of a *de novo* review, the Seventh Circuit in *Patton v. MFS/Sun Life Financial Distributors, Inc.* held that the district court has discretion to consider additional evidence in order for it to make "an informed and independent judgment."[457] But it then cautioned that such additional evidence should be considered "only where the benefits of increased accuracy exceeds the costs, a balance familiar to the district court."[458] Examples of cases where additional evidence should be considered include evidence concerning plan terms or historical facts concerning the claimant; whether the plan administrator is operating under a conflict of interest; whether the parties had an opportunity to present evidence during the claims process; and cases in which there is an "unusually glaring gap" in the record.[459]

Later, the Seventh Circuit clarified in *Krolnik v. Prudential Insurance Co. of America*, that a court's "*de novo* review" in a nondiscretionary benefits denial requires an "independent decision" by the court, and not a "review" of the plan administrator's decision.[460] Thus, Chief Judge Easterbook admonished the courts to read *Firestone's de novo* review as requiring independent analysis, and not a review of "someone else's

454. *Id*. at 332–33.

455. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989); Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan, 195 F.3d 975, 981–82 (7th Cir. 1999).

456. *Perlman*, 195 F.3d at 982 (citing Wilkins v. Baptist Healthcare System, Inc., 150 F.3d 609, 617–20 (6th Cir. 1998)); DeFelice v. Am. Int'l Life Assurance Co., 112 F.3d 61, 65 (2d Cir. 1997); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993); Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1021–27 (4th Cir. 1993); Sandoval v. Aetna Life & Casualty Ins. Co., 967 F.2d 377, 380 (10th Cir. 1992); Luby v. Teamsters Health, Welfare, & Pension Tr. Funds, 944 F.2d 1176, 1184–85 (3d Cir. 1991)).

457. Patton v. MFS/Sun Life Fin. Distribs., Inc., 480 F.3d 478, 490 (7th Cir. 2007) (citing Casey v. Uddeholm Corp., 32 F.3d 1094, 1099 (7th Cir. 1994), which cited *Quesinberry*, 987 F.2d at 1025).

458. *Id*. at 492.

459. *Id*. at 492–93.

460. Krolnik v. Prudential Ins. Co. of Am., 570 F.3d 841, 843 (7th Cir. 2009).

action."[461] He stated that *Firestone* stood for the proposition that benefit denial cases should be resolved similarly to contract litigation.[462] With contract litigation, the judge does not "review" each side's position; "[i]nstead the court takes evidence (if there is a dispute about a material fact) and makes an independent decision about how the language of the contract applies to those facts."[463] Hence, unlike deferential review where the review is limited to the administrative record, here the court "decides on the record made in the litigation," and if the evidence conflicts, "then there must be a trial."[464]

Thus, the Seventh Circuit is unique in being the only circuit that affords a trial to the claimant in the *de novo* context, *i.e.*, the court takes in evidence (if there is a dispute as to a material fact) and makes an independent decision about how the plan language applies to those facts.[465] In contrast, the other circuits, even under the *de novo* standard of review, will review the administrative record without affording deference to either side, and then make their own decisions as to whether the claimant is entitled to benefits.

In his concurrence, Judge Nalbandian in the Sixth Circuit decision of *Tranbarger v. Lincoln Life & Annuity Co. of New York*, appears to agree with Judge Easterbrook's analysis in *Krolnick*.[466] As ERISA provides a civil action under 29 U.S.C. § 1132(a)(1)(B) for a participant or beneficiary to recover benefits due to him under the terms of the plan, the Federal Rules of Civil Procedure should then govern such civil actions, which include discovery.[467] The only exception is when an explicit statutory provision prevails, which does not exist under ERISA. As a result, the parties to the civil action should "build up a record with discovery under Rule 26, move for summary judgment under Rule 56, and conduct a bench trial under Rule 52."[468] However, Judge Nalbandian

461. *Id.* at 844.
462. *Id.* at 843 (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 112–13 (1989)).
463. *Id.*
464. *Id.*
465. *Id.*
466. Tranbarger v. Lincoln Life & Annuity Co. of N.Y., 68 F.4th 311, 316 (6th Cir. 2023).
467. *Id.* at 320.
468. *Id.*

laments that the Sixth Circuit in *Perry v. Simplicity Eng'g*[469] limited the district court in its *de novo* review to the administrative record, as allowing additional evidence would "frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme."[470] This result rejects the traditional litigation rules under Federal Civil Procedure. In addition, Judge Nalbandian asserts that the Sixth Circuit's approach to ERISA claims conflicts with a recent Supreme Court decision in *United States v. Tsarnaev*,[471] where the Court stated that the federal courts' supervisory rules are not to conflict with a federal statute or federal rules, such as the Federal Rules of Civil Procedure.[472] Thus, he concludes that *Firestone* and *Tsarnaev* are in "tension," as the *Firestone* Court endorses a "quasi-administrative-law" review in discretionary cases despite the fact ERISA calls for a civil action in a benefits denial case, which should be governed by the Federal Rules of Civil Procedure.[473] Thus, if he were "writing on a blank slate," Judge Nalbandian would be nudging the Sixth Circuit in the direction of the Seventh Circuit.[474]

Eighth Circuit: [Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, South Dakota]

Arkansas,[475] Minnesota,[476] and South Dakota[477] ban discretionary clauses in insurance contracts.

In *McKeehan v. Cigna Life Ins. Co*. the Eighth Circuit required "explicit discretion-granting language" in the plan or the insurance policy to trigger ERISA's deferential standard of review.[478] In that case, the plan sponsor retained discretionary authority under the plan to administer claims and to interpret the plan, including questions that arose about the plan's administration, interpretation and application, as well as conferring upon it the ability to delegate the sponsor's discretionary authority.[479] However, the record was silent as to whether the plan

469. *Id.* (citing Perry v. Simplicity Eng'g, 900 F.2d 963, 966 (6th Cir. 1990)).
470. *Tranbarger*, 68 F.4th at 321 (Nalbandian, J., concurring) (quoting *Perry*, 900 F.2d at 967).
471. *Id.* at 322 (citing United States v. Tsarnaev, 595 U.S. 302, 313–17 (2022)).
472. *Tsarnaev*, 595 U.S. at 315–16.
473. *Tranbarger*, 68 F.4th at 321.
474. *Id.* at 316.
475. 054-00-101 ARK. CODE R. § 4 (LexisNexis 2023).
476. MINN. STAT. § 60A.42 (2024).
477. S.D. ADMIN. R. 20:06:52:02 (2024).
478. McKeehan v. Cigna Life Ins. Co., 344 Fd.3 789, 793 (8th Cir. 2003).
479. *Id.*

administrator, who was the insurer under the plan, had such discretionary authority delegated to it. Hence, the court decided to conduct a *de novo* review of the benefits claim.[480]

The Eighth Circuit in *Brown v. Seitz Foods, Inc., Disability Ben. Plan* affirmed that plan language which required that "written proof of loss must be furnished to us" was insufficient to confer discretionary authority to decide claims.[481] While the district court had affirmed such ruling and thus reviewed the plan administrator's decision *de novo*, it allowed evidence outside of the plan administrator's record (i.e., a statement of the claimant's rehabilitation consultant saying that the claimant was unable to perform his job duties).[482] The Eighth Circuit stated that such additional evidence gathering is to be "discouraged" on a *de novo* review to "ensure expeditious judicial review of ERISA benefit decisions and to keep district courts from being substitute plan administrators."[483] But the court went on to say that additional evidence may be permitted if the plaintiff shows *good cause* for the district court to do so.[484] Absent a finding on Brown's part of any showing of good cause, the court concluded that the district court abused its discretion when it reviewed the insurer's decision on an expanded administrative record.[485]

However, the Eighth Circuit in *Sloan v. Hartford Life and Accident Insurance Co.* permitted the use of extrinsic evidence in a *de novo* review case, largely focusing on whether the claimant had the opportunity to present the additional evidence at the time of the original benefits denial.[486] As the claimant did not have the chance to present a favorable Social Security decision (whose definition of disability was similar to the plan's definition) during the original benefits denial because the

480. *Id.*
481. Brown v. Seitz Foods, Inc. Disability Benefit Plan, 140 F.3d 1198, 1200 (8th Cir. 1998).
482. *Id.*
483. *Id.* (quoting Cash v. Wal-Mart Grp. Health Plan, 107 F.3d 637, 641–42 (8th Cir. 1997) (quoting Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993)).
484. *Id.* (citing Davidson v. Prudential Ins. Co. of Am., 953 F.2d 1093, 1095 (8th Cir. 1992) (demonstrating factors relevant to a showing of good cause).
485. *Id.* at 1201.
486. Sloan v. Hartford Life & Accident Ins. Co., 475 F.3d 999, 1004 (8th Cir. 2007).

Social Security hearing occurred much later, such evidence would have been relevant when the district court made its determination.[487]

The Eighth Circuit in *Cooper v. Metropolitan Life Ins. Co*. affirmed its holding that when a benefits determination is reviewed for abuse of discretion, the scope of review is limited to the administrative record.[488] It suggests that such rule may be relaxed in determining the proper standard of review.[489]

Ninth Circuit [Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington, Guam, and the Northern Marianna Islands]

Alaska,[490] California,[491] Hawaii,[492] Idaho,[493] Montana,[494] Oregon,[495] and Washington[496] ban discretionary clauses in insurance contracts.

As far back as the *Kearney v. Standard Ins. Co*. case, the Ninth Circuit has held that the plan administrator has the burden of showing a grant of unambiguous discretion in order to shift from the *de novo* standard of review.[497] That case involved disability benefits insured through an insurance policy that stated that the insurer would pay benefits "upon receipt of satisfactory written proof that you have become disabled."[498] The Ninth Circuit found such language ambiguous in conferring discretion, as there were three possible interpretations of the policy:

487. *Id*. at 1004–05.

488. Cooper v. Metro. Life Ins. Co., 862 F.3d 654, 661 (8th Cir. 2017); *see Brown*, 140 F.3d at 1200 (quoting *Cash*, 107 F.3d at 641–42, quoting *Donatelli*, 992 F.2d at 765) (affirming that "additional evidence gathering is ruled out on deferential review . . . to 'ensure expeditious judicial review of ERISA benefit decisions and to keep district courts from becoming substitute plan administrators.'").

489. *Cooper*, 862 F.3d at 661.

490. ALASKA STAT. § 21.42.130 (2023).

491. CAL. INS. CODE § 10110.6 (West 2024).

492. J. P. SCHMIDT, HAW. INS. DIV., 2004-13H, Memorandum on Discretionary Clauses In HMSA's Agreement for Group Health Plan and Guide to Benefits 3 (2004).

493. IDAHO ADMIN. CODE r. 18.04.07.011 (2024).

494. MONT. CODE ANN. § 33-1-502 (2024); Standard Ins. Co. v. Morrison, 584 F.3d 837, 849 (9th Cir. 2009).

495. OR. ADMIN. R. 836-010-0026 (2024).

496. WASH. ADMIN. CODE § 284-46-015 (2023).

497. Kearney v. Standard Ins. Co., 175 F.3d 1084, 1089–90 (9th Cir. 1999) (en banc).

498. *Id*. at 1088.

- such language could have conferred discretion on the insurer to decide if the "quantum of proof is sufficient" such that the insurer could not reject proof that would be satisfactory to a reasonable person;
- such language could have required proof be established to cover the disability, as well as whether there was a sufficient amount of such proof; or
- such language could have implied a fiduciary duty such that if the plan administrator was not satisfied with such proof, it would not have to pay the claim.[499]

As the three interpretations had different consequences to the outcome, the court concluded that the conferral of discretion and its scope were ambiguous, and thus, did not confer discretion "because it does not say that it does."[500] The court then harkened back to the case of *Bogue v. Ampex Corp*.,[501] in which it held that discretion must be "unambiguously retained" by the plan administrator in order to hold a grant of discretion.[502]

Due to its holding, the *Kearney* court then reviewed the plan administrator's decision *de novo*, but queried whether the plan administrator's record should be the primary basis for its review.[503] Following the Fourth Circuit's lead in *Quesinberry v. Life Insurance Company*,[504] it allowed evidence to be presented that was not before the plan administrator, but "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review."[505] In its earlier case of *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, the Ninth Circuit followed the Third, Fourth, Seventh, Eighth, and Eleventh Circuits in allowing new evidence that was not part of the administrative record to be considered by the court, but only under

499. *Id.* at 1089–90.
500. *Id.* at 1090.
501. *Id.*
502. Bogue v. Ampex Corp., 976 F.2d 1319, 1325 (9th Cir. 1992).
503. *Kearney*, 175 F.3d at 1090.
504. Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1025 (4th Cir. 1993) (en banc).
505. *Kearney*, 175 F.3d at 1090–91 (quoting Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 942 (9th Cir. 1995)).

"carefully circumscribed conditions."[506] In contrast, the *Kearney* court rejected the participant's claim that additional evidence be considered regarding their medical condition, as the participant's brief did not elaborate what new evidence was needed, nor was any new evidence being proposed to the district court.[507] The court didn't allow such evidence, as it was simply "a suggestion that the door be opened to whatever new evidence might be developed."[508]

However, the Ninth Circuit in *Kearney* concluded that there was a genuine question of fact as to whether Kearney was disabled as defined by the insurance policy, and that it must be resolved by a trial, not by summary judgment.[509] During such trial, the court should determine the facts based on the record that was before the plan administrator, subject to the discretion outlined in *Mongeluzo*.[510] Such result is consistent with ERISA's goals of upholding the fiduciary's review procedures, minimizing costs and premiums, and reducing any rerouting of benefits money to litigation money.[511]

In a later decision, *Opeta v. Northwest Airlines Pension Plan for Contract Employees*, the Ninth Circuit affirmed that the grant of discretion must be "unambiguously retained" in order to avoid the *de novo* standard of review, and thus plan terms making the administrator "solely . . . . responsible" for paying benefits, deciding all claims, and running the operation and administration of the plan, did not confer the power in interpret the terms of the plan.[512] The court then reaffirmed its ruling in *Kearney* regarding this issue.[513] But it rejected that new evidence needs to be considered simply because the plaintiff later comes up with new evidence, as "[i]n most cases" the only evidence that needs to be considered is that which was before the plan administrator when

506. *Mongeluzo*, 46 F.3d at 943–44 (citing Casey v. Uddeholm Corp., 32 F.3d. 1094, 1098–99 & n.4 (7th Cir. 1994); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993); Quesinberry, 987 F.2d at 1025 (en banc); Luby v. Teamsters Health, Welfare & Pension Tr. Funds, 944 F.2d 1176, 1184–85 (3d Cir. 1991); Moon v. Am. Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989)).

507. *Kearney*, 175 F.3d at 1091.

508. *Id.*

509. *Id.* at 1094.

510. *Id.*

511. *Id.*

512. Opeta v. Nw. Airlines Pension Plan for Cont. Emps., 484 F.3d 1211, 1216 (9th Cir. 2007) (quoting Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 964 (9th Cir. 2006)).

513. *Id.* at 1217 (quoting Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1025 (4th Cir. 1993) (en banc) (emphasis added)).

it determined the claim.[514] The court then reiterated the *Quesinberry* list of exceptional circumstances where evidence beyond the administrative record could be considered: "claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability to very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process."[515]

If sufficient discretionary powers have been conferred, the Ninth Circuit applies an abuse of discretion standard of review.[516] Under such standard, the plan administrator's decision is to be affirmed if it is "grounded on *any* reasonable basis."[517] For example, unless conflicted, the plan administrator may support its decision based on a "single persuasive medical opinion," provided it did not construe the plan language unreasonably or issue its decision without explanation.[518]

Normally, the Ninth Circuit follows the majority rule that additional evidence outside of the record is not to be considered under the abuse of discretion standard.[519] But the Ninth Circuit, in *Abatie v. Alta Health & Life Insurance Company*, permitted the district court to consider evidence outside of the administrative record in a deferential review, on the issues of how much weight should be given in conflict of interest situations.[520] Such evidence may assist the court in determining the "nature, extent, and effect on the decision-making process of any conflict of interest; the decision on the merits, though, must rest on the

514. *Id.* (quoting *Quesinberry*, 987 F.2d at 1025).
515. *Id.*
516. Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan, 572 F.3d 727, 733 (9th Cir. 2009).
517. *Id.* at 734–35.
518. Montour v. Hartford Life & Acc. Ins. Co., 588 F.3d 623, 630 (9th Cir. 2009).
519. Nicula v. First Unum Life Ins. Co. 23 F. App'x 805, 808 (9th Cir. 2001) ("[j]udicial review of a plan administrator's denial of benefits ordinarily is limited to what was presented to the plan administrator").
520. Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 970 (9th Cir. 2006) (en banc).

administrative record once the conflict (if any) has been established, by extrinsic evidence or otherwise."[521] The *Abatie* court also noted that additional evidence outside of the record may be contemplated if there were procedural irregularities that resulted in an incomplete record, as the court may have to recreate the record that would have existed had the irregularities not occurred.[522]

In addition, in a context where egregious or flagrant procedural violations have occurred on the part of the plan administrator, such actions do not fit within the administrator's discretionary authority, and thus, the administrator fails to exercise discretion.[523] In such case, the court reviews the claim *de novo*.[524] But even if the procedural irregularities are minor and the abuse of discretion review applies, the Ninth Circuit permits courts to look at additional evidence when the irregularities prevented the full development of the administrative record, so that the court may recreate the administrative record that would have existed had the procedure been followed.[525] For example, if the insurer poses a new reason for denying the claim without providing the claimant the chance to respond to that rationale, the court may provide the claimant to offer new evidence to make such a response.

In the case of *Montour v. Harford Life & Acc. Ins. Co.*,[526] the Ninth Circuit noted that if the conflict of interest tainted the decision-making process, the courts should review the administrator's decision with "enhanced skepticism" (i.e., allowing greater weight to the conflict of interest as a factor in assessing whether an abuse of discretion occurred).[527] In that case, the insurance company failed to provide extrinsic evidence of its part to "assure accurate claims assessment" (e.g., utilizing procedures that could safeguard a non-bias review process), so as to rebut its inherent conflict of interest.[528]

521. *Id.*
522. *Id.* at 973–74.
523. *Id.* at 972.
524. *Id.*
525. *Id.*
526. Montour v. Hartford Life Ins. Co. 588 F.3d 623, 631 (9th Cir. 2009).
527. *Id.*
528. *Id.* at 634.

Tenth Circuit [Colorado, Kansas, New Mexico, Oklahoma, Utah, and Wyoming]

Colorado,[529] Wyoming,[530] and Utah[531] ban discretionary clauses in insurance contracts.

In the case where discretionary powers have been granted to the plan administrator, the Tenth Circuit applies the abuse of discretion standard,[532] but it describes such standard as interchangeable with the arbitrary and capricious standard.[533] In *Adamson v. Unum Life Ins. Co. of America*, the Tenth Circuit described the arbitrary and capricious standard of review as one in which the court must uphold the plan administrator's decision if it were predicated on a "reasoned basis," (i.e., one that does not require the basis to be the only "logical one or even the superlative one").[534] In applying such standard, the court was limited to the evidence before the plan administrator at the time of the benefits denial.[535] The Tenth Circuit described its rationale as follows:

> ERISA was designed to promote internal resolution of claims, . . . and to encourage informal and non-adversarial proceedings, and these related aims are promoted by early and full development of the factual record before the administrator, rather than the federal district court[536] . . . a fully developed administrative record facilitates the goal of prompt resolution of claims by the fiduciary under the ERISA scheme.[537]

The Tenth Circuit later altered this approach in *Murphy v. Deloitte & Touche Grp. Ins. Plan* in light of the Supreme Court's decision in

529. COLO. REV. STAT. § 10-3-1116 (2024).
530. WYO. STAT. ANN. § 26-13-304 (2024).
531. UTAH CODE ANN. § 31A-21-314 (West 2023).
532. Holcomb v. Unum Life Ins. Co. of Am., 578 F3d 1187, 1192 (10th Cir. 2009).
533. *See* Fought v. UNUM Life Ins. Co. of Am., 379 F.3d 997, 1002–03 (10th Cir. 2004), *abrogated on other grounds by* Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 116 (2008).
534. Adamson v. Unum Life Ins. Co. of Am., 455 F.3d 1209, 1214 (10th Cir. 2006); *see* Chamber v. Fam. Health Plan Corp., 100 F.3d 818, 823 (10th Cir. 1996) (quoting Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 380 (10th Cir. 1992)) (stating that under the deferential review, the district court "generally may consider only the arguments and evidence before the administrator at the time it made that decision").
535. *Adamson*, 455 F.3d at 1214.
536. Jewell v. Life Ins. Co. of N. Am., 508 F.3d 1303, 1308 (10th Cir. 2007), (quoting Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1022 (4th Cir. 19093) (internal quotation marks and citations omitted)).
537. *Id.* (quoting Hall v. UNUM Life Ins. Co. of Am., 300 F.3d 1197, (10th Cir. 2002) (internal quotation marks and citations omitted)).

Glenn.[538] The court noted that its instruction to the district court to confine itself to the administrative record did not allow the court to weigh the plan administrator's conflict of interest in its abuse of discretion analysis.[539] Hence, the district court may go beyond the administrative record to assure itself that the plan administrator "has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances."[540] The possibility of extra-record discovery may also extend to cases involving procedural irregularities on the part of the plan administrator.[541]

In the context where the *de novo* standard of review applies, the Tenth Circuit in *Hall v. UNUM Life Ins. Co. of America* acknowledged that it had not yet considered the evidentiary scope of review in such cases.[542] In that opinion, the court detailed the split within the circuits on this issue.[543] On the one hand, the Sixth Circuit in *Perry v. Simplicity Eng'g* rejected the introduction of new evidence, not wanting the courts to function as substitute plan administrators.[544] However, the Eleventh Circuit in *Moon v. Am. Home Assurance Co*. allowed additional evidence

538. Murphy v. Deloitte & Touche Grp. Ins. Plan, 619 F.3d 1151, 1161 (10th Cir. 2010).

539. *Id*. at 1157.

540. *Id*. at 1158 (quoting from Metro Life Ins. Co. v. Glenn, 554 U.S. 105, 118 (2008)).

541. *Id*. at 1161.

542. *Hall*, 300 F.3d at 1201.

543. *See* DeFelice v. Am. Int'l Life Assurance Co. of N.Y., 112 F.3d 61, 65–67 (2d Cir. 1997) (permitting additional evidence in the context of a conflict of interest); Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 943–44 (9th Cir. 1995) (allowing additional evidence where the plan administrator improperly interpreted the plan); Casey v. Uddeholm Corp., 32 F.3d 1094, 1098–99 (7th Cir. 1994) (approving additional evidence where the plan administrator made no factfinding himself); Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 101 (5th Cir. 1993) (letting additional evidence in the context of the plan administrator's plan interpretation, but not with respect to his finding of historical facts); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993) (enabling additional evidence at the discretion of the court where "good cause" must be proven in order to guarantee "adequate" review); Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1021–27 (4th Cir. 1993) (en banc) (agreeing to additional evidence but only at the discretion of the court under exceptional circumstances); Luby v. Teamsters Health, Welfare & Pension Tr. Funds, 944 F.2d 1176, 1184–85 (3d Cir. 1991) (consenting to additional evidence at the court's discretion as there was no evidentiary record in this case).

544. Perry v. Simplicity Eng'g, 900 F.2d 963, 966–67 (6th Cir. 1996). *But see* VanderKlok v. Provident Life & Accident Ins. Co., 956 F.2d 610, 617 (6th Cir. 1992) (allowing additional evidence where the plan administrator failed to follow proper procedures in ceasing benefits).

outside of the administrative record as the parties could have submitted such evidence pre-ERISA and thus, to restrict the use of additional evidence, would provide less protection to participants and beneficiaries than existed before ERISA.[545] The court then cited the other circuits' approaches.[546]

The Tenth Circuit concluded that in *de novo* ERISA cases, the district court could, in exceptional circumstances, consider evidence outside the administrative record.[547] Such exceptional circumstances would include:

- Consideration of detailed medical questions/issues regarding the credibility of medical experts;
- Very limited or no administrative review procedures resulting in little or no evidentiary record;
- The need for evidence regarding plan interpretation (e.g., prior plan interpretations inconsistent with the current plan interpretation);
- The existence of a conflict of interest on the part of the plan administrator;
- The existence of new evidence the claimant could not have submitted during the administrative process.[548]

The Tenth Circuit then noted that the party seeking to enhance the administrative record has the burden of proving why the district court should use its discretion to allow it.[549] A few years later, in *Jewell v. Life Insurance Co. of N. Am*., the Tenth Circuit further articulated that "exceptional circumstances" allowing additional evidence to be consider must satisfy the following standards:

> (1) the evidence must be 'necessary to the district court's de novo review' (2) the party offering the extra-record evidence must 'demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision was made;' (3) the evidence must not be '[c]umulative or repetitive;' nor (4) may it be 'evidence that 'is simply better evidence than the claimant mustered for the claim review.'[550]

545. Moon v. Am. Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989).
546. Hall v. Unum Life Ins. Co. of Am., 300 F.3d 1197, 1201–02 (10th Cir. 2002).
547. *Id.* at 1203.
548. *Id.*
549. *Id.*
550. Jewell v. Life Ins. Co. of N. Am., 508 F.3d 1303, 1309 (10th Cir. 2007) (quoting *Hall*, 300 F.3d at 1203).

Eleventh Circuit [Alabama, Florida, and Georgia]

None of these states ban discretionary clauses in insurance contracts.

As far back as 1994, the Eleventh Circuit in *Kirwan* requires an express grant of discretionary authority to trigger the arbitrary and capricious standard of review.[551] Thus, plan language giving the plan administrator the "authority to control and manage the operation and administration of the [p]lan," is merely a grant of administrative powers; it does not give the administration the authority to construe the terms of the plan.[552] The Eleventh Circuit specifically mentioned the case of *Michael Reese Hospital and Medical Center v. Solo Cup Employee Health Benefit Plan*[553] from the Seventh Circuit and the *Baxter v. Lynn*[554] case from the Eighth Circuit as those circuits, faced with almost identical language, affirmed that such language did not confer discretionary powers.[555] It also noted the Third Circuit rejected similar plan language that permits the plan administrator to "interpret and administer" the plan as a grant of discretionary powers.[556] Thus, the Eleventh Circuit concluded that a *de novo* review is the standard to apply to the administrator's decision and that the district court is not limited to the administrative record before the plan administrator at the time of the denial.[557]

In deciding the applicable judicial standard of review, the Eleventh Circuit in *Blankenship v. Metropolitan Life Ins. Co*.[558] developed a six-step test (the first five elements which were developed under the *Williams v. BellSouth Telecomms*[559] case and the sixth element developed under this case):

- Apply the *de novo* standard to the plan administrator's decision to ascertain whether it is wrong (i.e., the court disagrees with it). If it is not wrong, then affirm the decision.

551. Kirwan v. Marriott Corp., 10 F.3d 784, 788–89 (11th Cir. 1994).
552. *Id.* at 788.
553 Michael Reese Hosp. & Med. Ctr. v. Solo Cup Emp. Health Benefit Pan, 899 F.2d 639, 641 (7th Cir. 1990).
554. Baxter v. Lynn, 886 F.2d 182, 188 (8th Cir. 1989).
555. *Kirwan*, 10 F.3d at 789.
556. *Id.* at 789.
557. *Id.*
558. Blankenship v. Metro Life Ins. Co., 644 F.3d 1350, 1354–55 (11th Cir. 2011) (citing to the first five steps from Williams v. BellSouth Telecomms., Inc., 373 F.3d 1132, 1137–38 (11th Cir. 2004), *overruled on other grounds* by Doyle v. Liberty Life Assurance Co. of Bos., 542 F.3d 1352 (11th Cir. 2008)).
559. *Id.* at 1354; *Williams*, 373 F.3d at 1137–38.

- If the decision was *de novo* wrong, determine whether the administrator had discretion. If he did not have discretion, then reverse the decision.
- If the administrator's decision is "*de novo* wrong," but he had discretion, establish whether he had "reasonable grounds" to support it, which is the arbitrary and capricious standard.
- If no reasonable grounds exist to support the decision, then reverse it. If reasonable grounds do exist, then determine if the administrator was operating under a conflict of interest.
- If reasonable grounds exist and there is no conflict, then affirm the decision.
- If reasonable grounds exist and there exists a conflict, then take the conflict into account in determining whether the decision was arbitrary and capricious.[560]

Basically, if the plan administrator has discretionary authority, the court should skip steps one and two and move to step three. The Eleventh Circuit equated this arbitrary and capricious standard with a reasonableness standard, requiring that it be supported by some "reliable evidence" in the record.[561] The Eleventh Circuit noted that if a conflict exists, the burden stays with the plaintiff to show that the decision was arbitrary;[562] it rejects the premise that the defendant has the burden to provide that its decision was not tainted.[563]

As to the scope of review, if the court is reviewing the plan administrator's decision *de novo*, the Eleventh Circuit held in *Moon v. American Home Assur. Co*. that a reviewing court is not limited to the facts available to the administrator at the time of the benefits denial.[564] In so holding, the Eleventh Circuit held that the alternative was "contrary to the concept of a de novo review,"[565] as such holding would extend less protection to employees and beneficiaries than they had prior to ERISA's passage. The Eleventh Circuit in *Kirwan v. Marriott Corp*. affirmed its earlier position that the district court is not limited to the facts

560. *Id.* at 1354–55.
561. Jean Baptiste v. Securian Fin. Grp., Inc., 557 F. Supp. 3d 1271, 1281–82 (S.D. Fla. 2021).
562. *Blankenship*, 644 F.3d at 1355.
563. *See id*.
564. Moon v. Am. Home Assur. Co., 888 F.2d 86, 89 (11th Cir. 1989); Kirwan v. Marriott Corp., 10 F.3d 784, 789 (11th Cir. 1994).
565. *Moon*, 888 F.2d at 89.

available to the plan administrator at the time of its decision in the *de novo* review context.[566]

In the recent 2022 case of *Harris v. Lincoln Nat'l Life Ins*., the Eleventh Circuit took up the question again as to whether evidence outside of the administrative record may be considered in the *de novo* review context.[567] It began with a review of the positions of the other circuits. It noted that the Fifth and Sixth Circuits limit the scope of the review to the administrative record in both the *de novo* and arbitrary and capricious contexts.[568] It commented that the Fourth, Seventh, Eighth, Ninth, and Tenth Circuits allow new evidence under "certain circumstances."[569] It further noted that the Third and the District of Columbia Circuit permit the district courts to consider all relevant evidence, regardless of whether it was in the administrative record.[570] It then cited *Moon* and *Kirwan* as prior precedent in the circuit, which has not been "abrogated by the Supreme Court."[571] Finally, the Eleventh Circuit affirmed its holding that *all* relevant evidence must be considered, even subsequently available evidence after the administrator's decision, as the district court, in a *de novo* context, must make its own decision as to the benefits denial.[572]

566. *Kirwan*, 10 F.3d at 789.

567. Harris v. Lincoln Nat'l Life Ins. Co., 42 F.4th 1292, 1294 (11th Cir. 2022).

568. *Id.* at 1294–95 (citing Perry v. Simplicity Eng'g, 900 F.2d 963, 966 (6th Cir. 1990) and Ariana M. v. Humana Health Plan of Tex., Inc., 884 F.3d 246, 256 (5th Cir. 2018) (en banc)).

569. *Id.* at 1295 (citing Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1026–27 (4th Cir. 1993) (en banc) (allowing such evidence when "necessary for resolution of the benefit claim"); Dorris v. Unum Life Ins. Co. of Am., 949 F.3d 297, 304 (7th Cir. 2020) (freely permitting "the parties to introduce relevant extra-record evidence and seek appropriate discovery"); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993) (requiring "good cause" in order to permit such evidence); Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 944 (9th Cir. 1995) (allowing such evidence in "certain circumstances . . . [in order] 'to conduct an adequate de novo review of the benefit decision'"); Jewell v. Life Ins. Co. of Am., 508 F.3d 1303, 1308–09 (10th Cir. 2007) (allowing new evidence in limited circumstances)).

570. *Id.* (citing Luby v. Teamsters Health, Welfare & Pension Tr. Funds, 944 F.2d 1176, 1184 (3d Cir. 1991)) (stating that "[l]imiting the review of an ERISA benefit decision to evidence before the administrator . . . makes little sense . . . when a plan administrator's decision is reviewed de novo") and Doe v. United States, 821 F.2d 694, 697–98 (D.C. Cir. 1987) ("De novo means . . . a fresh, independent determination of 'the matter' at stake; the court's inquiry is not limited to or constricted by the administrative record, nor is any deference due to the agency's conclusion.")).

571. *Id.* at 1296.

572. *Id.* at 1296–97 (citing Shannon v. Jack Eckerd Corp., 113 F.3d 208, 210 (11th Cir. 1997); *Doe*, 821 F.2d at 698).

However, if the court is reviewing the plan administrator's decision under the arbitrary and capricious standard, the Eleventh Circuit follows the majority rule of limiting review to the administrative record.[573] Further, some district courts within the circuit have expanded the scope of review for conflict of interest claims.[574]

District of Columbia Circuit

As the District of Columbia is a small jurisdiction, ERISA cases are rare, as most employee benefit claims relate to governmental employers, whose plans are not subject to ERISA.[575] But early on, the District of Columbia Court affirmed the rule that the administrator or insurer had the burden of proving the deferential standard of review applied, as *Firestone* made *de novo* the default standard.[576]

As to the scope of review, the District of Columbia Court has permitted limited discovery of evidence outside of the administrative record for a deferential review in determining whether such record was complete or if there is evidence of a conflict of interest.[577] In the context

573. *See* Crowder v. Delta Air Lines, Inc. 963 F.3d 1197, 1203 (11th Cir. 2020) (quoting Blankenship v. Metro Life Ins. Co., 644 F.3d 1350, 1354 (11th Cir. 2011); *see also* Kaviani v. Reliance Standard Life Ins. Co., 799 F. App'x 753, 757 (11th Cir. 2020)) ("Whether the administrator had a reasonable basis for its denial of benefits is 'based upon the facts as known to the administrator at the time the decision was made.'") (quoting Jett v. Blue Cross & Blue Shield of Ala., Inc., 890 F.2d 1137, 1139 (11th Cir. 1989)); *see also* Lee v. Blue Cross & Blue Shield of Ala., 10 F.3d 1547, 1550 (11th Cir. 1994) ("Application of the arbitrary and capricious standard requires us to look only to the facts known to the administrator at the time the decision was made.").

574. Martin v. Sun Life Assurance Co. of Can., No. 12-61009-CIV-WILLIAMS/HUNT, 2013 WL 12384050, at *1 (S.D. Fla. Oct. 7, 2013); Jean Baptiste v. Securian Fin. Grp., Inc., 557 F. Supp. 3d 1271, 1283 (S.D. Fla. 2021).

575. 29 U.S.C. § 1003(b)(1). *But see generally* Doley v. Prudential Ins. Co. of Am., No. 05-0277(JR), 2008 WL 131192 (D.D.C. 2008).

576. *Doley*, 2008 WL 131192 at *1–2.

577. Doe v. MAMSI Life & Health Ins. Co., 448 F. Supp. 2d 179, 183–84 (D.D.C. 2006) (citing to Nagele v. Elec. Data Sys. Corp., 193 F.R.D. 94, 103, 105–07 (W.D.N.Y. 2000), which stated that "judicial review without a complete and accurate record is in no one's interest . . . and . . . does not comport with the meaningful judicial review Congress undoubtedly had in mind"). *Cf.* Block v. Pitney Bowes Inc., 952 F.2d 1450, 1455 (D.C. Cir. 1992) ("Courts review ERISA-plan benefit decisions on the evidence presented to the plan administrators, not on a record later made in another forum").

of a *de novo* review of a benefits denial claim, this Circuit has declined to opine directly on the issue.[578]

Overview of Circuits' Split on the Issue #1: Who has the Burden of Proof?

As to the issue of who has the burden of proving which judicial standard of review applies, the First Circuit suggests that the insurer or plan administrator has the burden.[579] In the Second,[580] Third,[581] District of Columbia,[582] Ninth[583] Circuits, the courts hold that the party wanting the use of the deferential standard of review has the burden. As the insurer or plan administrator invariably wants the courts to use the deferential standard of review, the First Circuit is in agreement with these other circuits.[584]

This rule is consistent with *Firestone*, as the default standard of review is the *de novo* standard; only if the plan extends discretionary powers to the plan administrator does it shift to the arbitrary and capricious or the abuse of discretion standard.[585] The Second Circuit adequately justifies placing this burden on the plan administrator, since "the party claiming deferential review should prove the predicate that justifies it."[586] The author asserts that the burden of proof should fall upon the party claiming the deferential standard of review, as *Firestone* made *de novo* review the default standard.

578. Kemathe v. Reliance Ins. Co., 801 F. App'x. 793, 795 (D.C. Cir. 2020) (noting that "[o]ur circuit has not addressed whether courts may consider such extra-record evidence when reviewing an administrator's decision *de novo*"). *But see* Doe v. United States, 821 F.2d 694, 697–98 (D.C. Cir. 1987) (holding in the context of an agency proceeding being reviewed *de novo*, the court holds that *de novo* means "a fresh, independent determination" which is "not limited to or constricted by the administrative record, nor is any deference due the agency's conclusion").

579. Gross v. Sun Life Assurance Co. of Can., 734 F.3d 1, 11 (1st Cir. 2013).

580. Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 249 (2d Cir. 1999).

581. Viera v. Life Ins. Co. of N. Am., 642 F.3d 407, 413 (3d Cir. 2011).

582. Doley v. Prudential Ins. Co. of Am., No. 05-0277(JR), 2008 WL 131192, at *1 (D.D.C. Jan. 8, 2008).

583. Kearney v. Standard Ins. Co., 175 F.3d 1084, 1089–90 (9th Cir. 1999) (en banc).

584. *Gross*, 734 F.3d at 16 (faulting Sun Life for failing to insert "more explicit language" to avoid the *de novo* standard of review).

585. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989).

586. *See* Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 249 (2d Cir. 1999) (quoting Sharkey v. Ultramar Energy Ltd., 70 F.3d 226, 230 (2d Cir. 1995)).

Overview of Circuits' Split on the Issue #2: What Insurance Language is Sufficient to Grant Discretion?

As to the issue of whether the insurance language "satisfactory proof to us" is sufficient to confer discretionary authority to the insurer, the overwhelming majority of the circuits reject such language on the grounds that the grant of discretionary powers must be explicit.[587] Only the Sixth Circuit in the *Perez* decision finds such language sufficient.[588] The author agrees that "satisfactory proof to us" language should be insufficient to grant discretionary authority to plan administrators, as one of the hallmark fiduciary standards of ERISA is for the plan administrator to abide by the terms of the plan; such standard is meaningless if the term of the plan is ambiguous or nebulous. Thus, insurance companies should continue to face an uphill battle in providing such language is sufficient. And of course, if the state in which the insurance policy is issued bans the use of discretionary clauses, the issue becomes moot.

Overview of Circuits Issue #3: Is a State Ban on Discretionary Clauses Saved under ERISA's Savings Clause?

As discussed in Section V above, the Sixth, Ninth, and Seventh Circuits have held that states' bans on discretionary clauses in insurance policies are saved under ERISA's savings clause.[589]

The Sixth Circuit held in *American Council of Life Insurers v. Ross* that a Michigan ban on insurance policies with discretionary clauses was saved under ERISA's savings clause.[590] Under *Miller's* first prong test, the court held that the statute was directed at insurance companies, as it dictated what terms of policies they could issue.[591] As to *Miller*'s second prong test, the court affirmed that the statute clearly substantially impacted the risk being assumed by the insurer, as it altered the condition under which the insurer must pay for the claim.[592] The court rejected the conflicted preemption argument, as no new causes of

587. *Id.* at 251.
588. *Id.* at 252.
589. *See supra* Section V.
590. Am. Council of Life Insurers v. Ross, 558 F.3d 600, 602 (6th Cir. 2009).
591. *Id.* at 605.
592. *Id.* at 606–07.

action were being created.[593] It also rejected the argument that ERISA's goal of a uniform set of rules for adjudicating claims would be defeated, as *Firestone* had affirmed *de novo* as the default standard.[594]

Months later, the Ninth Circuit upheld Montana's ban on discretionary clauses with similar reasoning in the case of *Standard Ins. Co. v. Morrison*.[595] Like the Sixth Circuit, it affirmed that *Miller*'s first prong was met, as the clause was directed at insurers, not just ERISA plans, and that is regulated the terms of an insurance policy.[596] Likewise, it agreed with the Sixth Circuit in *Ross* that the interpretation to ban discretionary clauses narrowed the scope of the bargains between the insurer and insureds, thereby substantially affecting their risk pooling arrangement.[597]

Six years later, the Seventh Circuit in *Fontaine v. Metropolitan Life Ins. Co*. also upheld an Illinois insurance law prohibiting discretionary clauses in health and disability insurance policies as being saved by ERISA's savings clause, citing to the *Ross* decision in the Sixth Circuit and the *Morrison* decision in the Ninth Circuit.[598]

While there is case law from only three circuits thus far as to whether states' bans on discretionary clauses are saved under ERISA's savings clause, their message is clear that state bans clearly satisfy the two tests of *Miller* and thus, are enforceable.[599] The author agrees that state bans on discretionary clauses unmistakably satisfy the two prongs of the *Miller* test. As state bans direct insurance companies to exclude discretionary clauses from their insurance policies, they are clearly directed at insurance companies, as they regulate the terms of the contracts that an insurer can issue.

In the case of *UNUM Life Ins. Co. v. Ward*, the Supreme Court held that California's notice prejudice rule (requiring the insurer to prove prejudice before enforcing its proof of claim rule) clearly "'regulates insurance' as a matter of common sense."[600] The fact that a state ban on discretionary clauses also has an impact on plan administrators of

593. *Id.* at 607–08.
594. *Id*. at 608–09.
595. Standard Ins. Co. v. Morrison, 584 F.3d 837, 845 (9th Cir. 2009).
596. *Id.* at 842.
597. *Id.* at 845 (quoting *Ross*, 558 F. 3d at 606).
598. Fontaine v. Metro. Life Ins. Co., 800 F.3d 883, 885 (7th Cir. 2015) (citing *Ross*, 558 F.3d at 606; *Morrison*, 584 F.3d at 837; Fontaine v. Metro. Life Ins. Co., No. 12 C 87368, 2014 WL 1258353, at *11–12 (N.D. Ill. Mar. 27, 2014)).
599. *See id.*
600. Unum Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 368 (1999).

insured employee benefit plans "does not disqualify it from being a regulation of insurance."[601]

As to *Miller's* second prong, a state ban on discretionary clauses obviously "dictates to the insurance company the conditions under which it must pay for the risk it has assumed," thereby satisfying the risk-pooling requirement between the insured and insurer.[602] By regulating the terms of the insurance policy to ban *de novo* judicial review, such state laws plainly alter the risk being assumed by the insurer, as its decision to deny a benefit will be subject to a more scrutinized review. That review will then require the insurer to demonstrate that all ERISA procedural requirements have been satisfied, that its benefits denial was made pursuant to a thoughtful and thorough review of the entire claimant's record, and that any inherent conflict of interest on the part of the insurer was tempered by its proactive steps to reduce bias and boost accuracy.[603]

Any argument that a state ban on discretionary clauses conflicts with ERISA's enforcement regime (i.e., the conflict preemption doctrine) should be dismissed, as *Firestone* made the default standard of review *de novo.* Hence, there is no additional cause of action or remedy being sought with a state ban on discretionary clauses. Similarly, any argument that a state ban on discretionary clauses is inconsistent with the goals of ERISA's remedial system should be rejected. In the *Glenn* decision, the Supreme Court rejected a rule that would have made *de novo* the default standard of review in cases where there is a conflict of interest on the part of the plan administrator, as Congress would have so noted.[604] However, the Supreme Court's rejection of a universal *de novo* scheme did not infer that the states would be prohibited from passing insurance laws and regulations with such effect.

As such, the question then becomes, under a *de novo* standard of review, is the reviewing court confined to the administrative record?

601. *Morrison*, 584 F.3d at 842, *cert. denied sub nom.* Standard Ins. Co. v. Lindeen, 560 U.S. 904, 904 (2010) (citing Ky. Ass'n Health Plans, Inc. v. Miller, 538 U.S. 329, 334 (2003)).

602. *Morrison*, 584 F.3d at 845 (quoting Standard Ins. Co. v. Morrison, 537 F. Supp. 2d 1142, 1151 (D. Mont. 2008), which quoted *Miller*, 538 U.S. at 339 n.3).

603. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 117 (2008).

604. *Id.* at 116, which had been advocated in the Brief for America's Health Insurance Plans as *AmiciCuriae* 3–4.

Before summarizing the circuits' approach to this issue, the Article will document whether courts can go beyond the administrative record in deferential review cases, as this would be the floor with which courts may judge whether they can go beyond in a *de novo* review case.

Overview of Circuits' Split on Issue #4: If the Deferential Standard of Review Applies, Can the Court Go Beyond the Administrative Record?

In the context where discretionary authority has been reserved to the plan administrator, thus invoking the arbitrary and capricious or the abuse of discretion standard, the majority rule in all the circuits generally confines the district courts to the administrative record before the plan administrator.[605] The Third Circuit, in *Noga v. Fulton Financial*

605. First Circuit: Niebauer v. Crane & Co., 783 F.3d 914, 923 (1st Cir. 2015) (confining the court "in light of the record as a whole," (quoting Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan, 705 F.3d 58, 61 (1st Cir. 2013)); Second Circuit: Krizek v. Cigna Grp. Ins., 345 F.3d 91, 95 (2d Cir. 2003) (affirming that the district court is "to restrict its review of the record before the plan administrator" unless the claimant shows "good cause" to expand the record); Third Circuit: Carney v. Int'l Bhd. of Electric Workers Loc. Union 98 Pension Fund, 66 F. App'x 381, 385 (3d Cir. 2003) (limiting the reviewing court only to the evidence contained in the administrative record); Fourth Circuit: Webster v. Black & Decker (U.S.) Inc., 33 F. App'x 69, 74 (4th Cir. 2002) (assessing the reasonableness of the plan administrator's decision using the evidence available when the decision was rendered); District of Columbia: Doe v. Mamsi Life & Health Ins. Co., 448 F. Supp. 2d 179, 183 (D.C., 2006) (refusing to consider evidence outside of the administrative record); Fifth Circuit: Bellaire Gen. Hosp. v. Blue Cross Blue Shield of Mich., 97 F.3d 822, 827 (5th Cir. 1996) (limiting the district court to the evidence before the plan administrator); Sixth Circuit: Recker v. Newcourt Credit Grp., Inc., 126 F. App'x 226, 230 (6th Cir. 2005) (reviewing "only those materials known to the administrator at the time the decision was made"); Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 619 (6th Cir. 1998) (Gilman, J., concurring) (limiting the court's review "based solely upon the administrative record"); Seventh Circuit: Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan, 195 F.3d 975, 981–82 (7th Cir. 1999) ("[d]eferential review of an administrative decision means review on the administrative record"); Eighth Circuit: Cooper v. Metro. Life Ins. Co., 862 F.3d 654, 661 (8th Cir. 2017); Rittenhouse v. UnitedHealth Grp. Long Term Disability Ins. Plan, 476 F.3d 626, 630 (8th Cir. 2007) (denying the district court to consider evidence not in the administrative record unless the claimant can show "good cause" for its omission); Ninth Circuit: Nicula v. First Unum Life Ins. Co. 23 F. App'x 805, 808 (9th Cir. 2001) (affirming that "[j]udicial review of a plan administrator's denial of benefits ordinarily is limited to what was presented to the plan administrator"); Tenth Circuit: Chambers v. Fam. Health Plan Corp., 100 F.3d 818, 823 (10th Cir. 1996) (holding that the reviewing court "generally may consider only the arguments and evidence before the administrator at the time it made that decision," quoting Sandoval v. Aetna Life & Casualty Ins. Co., 967 F.2d 377, 380 (10th Cir. 1991)); Eleventh

Corporation Employee Benefit Plan, explained the rationale for this view.[606] It noted that the federal courts have adopted administrative law principles into ERISA litigation, as they develop a federal common law for ERISA plans.[607] Administrative law equates the arbitrary and capricious standard of review with a record review requirement.[608] Thus, when a court reviews a discretionary adverse benefit determination by a plan administration under the arbitrary and capricious standard of review, it is bound to limit itself to the administrative record assembled by the plan administrator.[609] Conversely, if the court reviews the adverse benefits determination under a *de novo* standard of review, it should not limited to the administrative record.[610]

The Sixth Circuit in *Perry v. Simplicity Eng'g* explained that the *de novo* review that *Bruch* envisions is a review of the plan administrator's decision, "without deference to the decision or any presumption of correctness," using only the administrative record before the administrator.[611] It rejects the argument that district courts are to "function as substitute plan administrators," as such role would "frustrate the goal of prompt resolution of claims by the fiduciary."[612] But in the case of *Vanderklok v. Provident Life and Accident Ins. Co*., the Sixth Circuit allowed additional evidence, as the claimant had not been offered the opportunity to present such evidence because the insurer failed to comply with ERISA's notice requirement, distinguishing it from *Perry*.[613]

The Third Circuit in its *Noga* decision continued its analysis to carve out an exception for the ERISA record rule in the context of a

Circuit: Blankenship v. Metr. Life Ins. Co., 644 F.3d 1350, 1354 (11th Cir. 2011) (limiting review of the benefits denial to the "material available to the administrator at the time it made its decision").

606. Noga v. Fulton Fin. Corp. Emp. Benefit Plan, 19 F.4th 264, 272–73 (3d Cir. 2021).

607. *See id*.

608. *Id*. at 273 (referencing 5 U.S.C. § 706 (which permits that agency actions to be disregarded is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" based on its review of the "whole record or those parts of it cited by a party)).

609. Kennedy, *Standard of* Review, *supra* note 54, at 166–67.

610. *Id.* at 1167–68.

611. Perry v. Simplicity Eng'g, 900 F.2d 963, 966 (6th Cir. 1990).

612. *Id.*

613. VanderKlok v. Provident Life & Accident Ins. Co., 956 F.2d 610, 617 (6th Cir. 1992).

conflicted plan administrator, as such person is not likely to volunteer such information.[614] Quoting from the Ninth Circuit, the court wrote that "courts plainly must be willing to consider evidence relating to 'the nature, extent, and effect on the decision-making process of any conflict of interest' revealed during the litigation process."[615] However, such exception does not permit the claimant to supplement the record with information relating to the claim process or the internal review process.[616] Similarly, the First,[617] District of Columbia,[618] Fifth,[619] Sixth,[620] Ninth,[621] and Tenth[622] Circuits permit the reviewing court to go outside the administrative record, although sparingly, in the context where the plan administrator is acting under a conflict of interest, as the record may not reflect his bias nor steps taken by the plan administrator to

614. Noga v. Fulton Fin. Corp. Emp. Benefit Plan, 19 F.4th 264, 273–74 (3d Cir. 2021).

615. *Id.* at 274 (quoting Burke v. Pitney Bowes Inc. Long-Term Disability Plan, 544 F.3d 1016, 1028 (9th Cir. 2008)).

616. *Id.*

617. Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 520 (1st Cir. 2005), allowing new evidence if the procedure used by the plan administrator in making its decision is being challenged; if there is a claim of bias on the part of the administrator or a claim of prejudicial procedural irregularity. The First Circuit was lenient is allowing new evidence when there was a challenge on the "process of decision making."

618. Doe v. MAMSI Life & Health Ins. Co., 448 F. Supp. 2d 179, 183–84 (D.D.C. 2006) (also allowing extrinsic evidence in determining whether the administrative record was complete).

619. Crosby v. La. Health Serv. & Indem. Co., 647 F.3d 258, 263 (5th Cir. 2011) (allowing extrinsic evidence when the claimant questions the completeness of the administrative record; in deciding whether the plan administrator adhered with ERISA's procedural guidelines; in ascertaining the existence of extent of the conflict of interest).

620. Coopers v. Life Ins. Co. of N. Am., 486 F.3d 157, 171 (6th Cir. 2007) (citing Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 618–19 (6th Cir. 1998)).

621. Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 970 (9th Cir. 2006) (allowing the district court to have discretion in permitting extrinsic evidence "to decide the nature, extent, and effect on the decision-making process of any conflict of interest").

622. Murphy v. Deloitte & Touche Grp. Ins. Plan, 619 F.3d 1151, 1158 (10th Cir. 2010).

minimize the effect of this bias.[623] But the Eleventh Circuit[624] has rejected such exception.

Some circuits have fashioned exceptions to the majority rule to consider additional evidence to ascertain "how an administrator interpreted certain policy provisions and . . . assist[ing] the district court in

623. First Circuit: Winters v. Liberty Life Assurance Co. of Bos., No. 20-11937-MLW, 2022 WL 6170588, at *7 (D. Mass Oct. 7, 2022); Troiano v. Aetna Life Ins. Co., 844 F.3d 35, 45 (1st Cir. 2016) (stating that the "party seeking discovery must provide 'some very good reason . . . to overcome the strong presumption' against discovery" in the context of Aetna's structural conflict); Denmark v. Liberty Life Assurance Co. of Bos., 566 F.3d 1, 10 (1st Cir. 2009) (allowing some discovery as to whether "a structural conflict has morphed into an actual conflict . . . [b]ut any such discovery must be allowed sparingly, and if allowed at all, must be narrowly tailored so as to leave the substantive record essentially undisturbed"); Second Circuit: Chau v. Hartford Life Ins. Co., No. 1:14-cv-8484-GHW, 2016 WL 7238956, at * 2 (S.D.N.Y. Dec. 13, 2016) (noting that the court has discretion to go outside the administrative record upon a showing of "good cause" to do so and "[a] demonstrated conflict of interest in the administrative reviewing body is an example of 'good cause' that may, under certain circumstances, warrant the introduction of additional evidence," quoting Biomed Pharms., Inc. v. Oxford Health Plans (N.Y.), Inc., 831 F. Supp. 2d 651, 658 (S.D.N.Y. 2011)). *But see* Donlick v. Standard Ins. Co., 726 F. App'x 12, 16 (2d Cir. 2018) (allowing the district court to go outside the administrative record upon a showing of good cause, but "[a] conflicted administrator does not necessitate a finding of good cause," as the claimant must demonstrate good cause, not simply imply such conflict); Fourth Circuit: Chughtai v. Metro. Life Ins. Co., No. PWG-19-cv-848, 2019 WL 4199036, at *2 (D. Md. Sept. 5, 2019) (noting other district court cases within the circuit that permit the court to go beyond the administrative record in order to assess the defendant's conflict of interest); Helton v. AT & T Inc., 709 F.3d 343, 355 (4th Cir. 2013); Sixth Circuit: Likas v. Life Ins. Co. of N. Am., 222 F. App'x 481, 486 (6th Cir. 2007) (allowing limited prehearing discovery for the plan administrator's failure to provide or due process or his bias); Seventh Circuit: Dennison v. MONY Life Ret. Income Sec. Plan for Emps., 710 F.3d 741, 747 (7th Cir. 2013) (allowing the district court discretion to allow discovery as to the conflict of interest); Ninth Circuit: Wilcox v. Wells Fargo & Co. Long Term Disability Plan, 287 F. App'x 602, 603–04 (9th Cir. 2008) (permitting the district court to consider evidence outside of the administrative record to determine the appropriate weight to extend to defendant's conflict of interest); *Abatie*, 458 F.3d at 970; Tenth Circuit: *Murphy*, 619 F.3d at 1161 (allowing limited discovery for the purpose of determining the scope of the conflict of interest) and Chambers v. Fam. Health Plan Corp., 100 F.3d 818, 826–27 (10th Cir. 1996).

624. Blair v. Metro. Life Ins. Co., 569 F. App'x 827, 832 (11th Cir. 2014) (affirming the district court's denial of discovery on the conflict of interest issue in deciding the case do novo as the existence of a conflict of interest is just one of the many factors for the court to weigh in reviewing the plan administrator's denial). *But see* Martin v. Sun Life Assurance Co. of Can., No. 12-61009-CIV-WILLIAMS/HUNT, 2013 WL 12384050, at *2–13 (S.D. Fla. Oct. 7, 2013); Jean Baptiste v. Securian Fin. Grp., Inc., 557 F. Supp. 3d 1271, 1283, fn.9 (S.D. Fla. 2021).

understanding medical terminology."[625] Others permit additional evidence concerning the consistency of the administrator's plan interpretation in the case where the plan language is ambiguous.[626] Others permit additional evidence if the plan administrator engaged in procedural irregularities that affected the review process, as the participant should be given the opportunity to introduce new evidence.[627] The Fifth Circuit allows several exceptions to the majority rule.[628] The Fourth and the Eleventh Circuits have created an exception to allow extrinsic evidence regarding evidence "known to the administrator at the time the decision was made,"[629] as the abuse of discretion standard dictates that the decision must be reasonable "based on the facts known to it at the time."[630]

The Second[631] and Eighth[632] Circuits permit this majority rule to be "relaxed" when determining the proper standard of review to use.

625. Williams v. Hartford Life Ins. Co., 243 F. App'x 795, 798 (5th Cir. 2007) (noting limited exceptions to the majority rule as to "evidence related to how an administrator interpreted certain policy provisions and for evidence that assists the district court in understanding medical terminology"); *see Helton*, 709 F.3d at 354 (creating an exception for the court to consider additional evidence to determine if the administrator's coverage determination was "consistent with earlier interpretations of the plan"); Crosby v. La. Heath Serv. & Indem. Co., 647 F.3d 258, 262–63 (5th Cir. 2011); Willcox v. Liberty Life Assurance Co. of Bos., 552 F.3d 693, 700–02 (8th Cir. 2009) (dicta).

626. Gannon v. NYSA-ILA Pension Tr. Fund & Plan, 523 F. App'x 752, 755 (2d Cir. 2003); Wulf v. Quantum Chem. Corp., 26 F.3d 1368, 1376 (7th Cir. 1994); Brutvan v. CIGNA Life Ins. Co. of N.Y., No. 5:12-cv-590 (MAP/DEP), 2013 WL 5439151, at *7 (N.D.N.Y. Sept. 27, 2013) (declining to consider extrinsic evidence as the plan language in question was unambiguous).

627. Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 520 (1st Cir. 2005); *Crosby*, 647 F.3d at 263; *Abatie*, 458 F.3d at 973–74; VanderKlok v. Provident Life & Accident Ins. Co., 956 F.2d 610, 617 (6th Cir. 1992); *Murphy*, 619 F.3d at 1161.

628. *Crosby*, 647 F.3d at 263 (allowing extrinsic evidence: (1) when the claimant questions the completeness of the administrative record; (2) when ascertaining whether the plan administrator complied with ERISA's procedural requirements; and (3) when determining the existence and extent of any conflict of interest on the part of the plan administrator).

629. *Helton*, 709 F.3d at 352 (quoting from Jett v. Blue Cross & Blue Shield of Ala., 890 F.2d 1137, 1139 (11th Cir. 1989)); *see* Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan, 201 F.3d 355, 342–43 (allowing extrinsic evidence as to whether the plan administrator's interpretation of the plan was consistent with prior interpretations and in the context of a conflicted plan administrator).

630. Helton v. AT & T Inc., 709 F.3d 343, 352 (4th Cir. 2013) (citing Sheppard & Enoch Pratt Hosp. v. Travelers Ins. Co., 32 F.3d 120, 125 (4th Cir. 1994)).

631. Daniel v. UnumProvident Corp., 261 F. App'x 316, 318 (2d Cir. 2008).

632. Cooper v. Metro. Life Ins. Co., 862 F.3d 654, 661 (8th Cir. 2017); Waldoch v. Medtronic, Inc., 757 F.3d 822, 830 (8th Cir. 2014).

In the author's opinion, when a court may be operating under an arbitrary and capricious or abuse of discretion standard, at minimum, the reviewing court should go beyond the administrative record in three contexts: (1) when the plan administrator is operating under a conflict of interest, as the plan administrator has every incentive to ignore that issue within the administrative record and minimize its impact on the decision-making process, unless the administrative record indicates that the administrator analyzed the decision based on the whole record and that significant safeguards existed to reduce his bias; (2) when there are procedural irregularities such that the participant has not been given the opportunity to have a full and complete administrative record, as is required by ERISA's procedural rules and (3) when there was evidence known and material to the administrator at the time it rendered its decision but was not made a part of the administrative record. The exceptions should be permitted by the district court because their existence alone should demonstrate an abuse of discretion on the part of the plan administrator.

Overview of Circuits' Split on the Issue #4: If the De Novo Standard Applies, Can the Court Go Beyond the Administrative Record?[633]

If the *de novo* standard applies, the next issue is whether the courts are bound by the administrative record or can introduce extrinsic evidence. The Seventh Circuit takes a unique approach in the context of a *de novo* standard of review in the contexts of all the other circuits. In *Krolnick v. The Prudential Ins. Co. of America*, Chief Judge Easterbrook remarked that when review is deferential, the court's review is limited to the administrative record, but in the context of a *de novo* review, "the court decides on the record made in the litigation.[634] And, if material evidence conflicts, then there must be a trial."[635] Judge Easterbrook took the position that *de novo* review cases call for federal civil procedure

633. Casey v. Uddeholm Corp., 32 F.3d 1094, 1098–99, n.4 (7th Cir. 1994); Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993); Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1025 (4th Cir. 1993) (en banc); Luby v. Teamsters Health, Welfare & Pension Trs. Funds, 944 F.2d 1176, 1184–85 (3d Cir. 1991); Moon v. Am. Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989).

634. Krolnik v. Prudential Ins. Co. of Am., 570 F.3d 841, 843 (7th Cir. 2009).

635. *Id.*

guidelines, which call for a plenary hearing in civil actions.[636] This view is consistent with Supreme Court decisions that have held that record review proceedings are the exception and not the rule, unless a statute dictates to the contrary; otherwise, the court should conduct a plenary hearing.[637]

The Eighth and Eleventh Circuits take an expansive view as to the scope of discovery in *de novo* cases.[638] The Eight Circuit in *Sloan* allowed additional evidence concerning Social Security's determination of the claimant's disability, as the plan's definition resembled that of Social Security and the claimant had not been given the opportunity to present such evidence at the internal hearing.[639] The Eleventh Circuit in *Moon*, and more recently in *Harris*, rejected the notion that a *de novo* review should be limited only to the facts known to the plan administrator at the time of the denial and thus, permit all relevant evidence, even evidence presented after the plan administrator's decision.[640]

The majority of the other circuits extend discretion to the district court, under carefully defined conditions, in going beyond the administrative record in the context of *de novo* review cases.[641] The First,[642]

636. *See id.*

637. United States v. First City Nat'l Bank of Hous., 386 U.S. 361, 368 (1967); Chandler v. Roudebush, 425 U.S. 840, 846 (1976); Kappos v. Hyatt, 566 U.S. 431, 444–45 (2012).

638. *See* Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993); *see also* Moon v. Am. Home Assurance Co., 888 F.2d 86, 89 (11th Cir. 1989).

639. Sloan v. Hartford Life & Accident Ins. Co., 475 F.3d 999, 1004–05 (8th Cir. 2007).

640. *Moon*, 888 F.2d at 89.

641. *See* sources cited *supra* note 607.

642. Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 520 (1st Cir. 2005) (allowing additional evidence in determining personal bias on the part of the plan administrator or if there was prejudicial procedural irregularity during the claims process).

Third,[643] Fourth,[644] Sixth,[645] Ninth,[646] and Tenth[647] Circuits permit additional evidence to be reviewed during a *de novo* review, under "carefully circumscribed conditions."[648] The Second[649] and Eighth[650] Circuits

643. Viera v. Life Ins. Co. of N. Am., 642 F.3d 407, 418 (3d Cir. 2011); Luby v. Teamsters, Health, Welfare & Pension Tr. Funds, 944 F.2d 1176, 1184–85 (3d Cir. 1991).

644. Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1025 (4th Cir. 1993) (en banc) (stating that the district court has the discretion to consider additional evidence "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision"); Shupe v. Hartford Life & Accident Ins. Co., 19 F.4th 697, 705 (4th Cir. 2021) (allowing extrinsic evidence for the court to know "why the evidence proffered was not submitted to the plan administrator").

645. Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 618 (6th Cir. 1998) (Gilman, J., concurring) (allowing additional evidence only if that evidence is offered in support of a "procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part," citing to VanderKlok v. Provident Life & Accident Ins. Co., Inc., 956 F.2d 610, 617 (6th Cir. 1992)).

646. Opeta v. Nw. Airlines Pension Plan for Cont. Emps., 484 F.3d 1211, 1217 (reiterating the *Quesinberry* list of exceptional circumstances where evidence beyond the administrative record could be considered: "claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability to very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process"); Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan, 46 F.3d 938, 943 (9th Cir. 1995); Kearney v. Standard Ins. Co., 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc).

647. Hall v. UNUM Life Ins. Co. of Am., 300 F.3d 1197, 1203 (10th Cir. 2002) (allowing extrinsic evidence in the following contexts: consideration of detailed medical questions; where there was very limited or no administrative review procedures resulting in little or no evidentiary record; the need for evidence regarding plan interpretation; and the existence of a conflict of interest on the plan of the plan administrator; or the existence of new evidence that the claimant could not have submitted during the administrative process).

648. *Mongeluzo*, 46 F.3d at 943; *see* Jewell v. Life Ins. Co. of N. Am., 508 F.3d 1303, 1309 (10th Cir. 2007) (requiring "exceptional circumstance [to] warrant the admission of additional evidence," quoting from *Hall*, 300 F.3d at 1203).

649. *DeFelice*, 112. F.3d at 66 (where good cause included a flawed internal claims procedure or a situation in which the insurer's reason for denial was not given to the claimant).

650. Sloan v. Hartford Life Acc. Ins. Co., 475 F.3d 999, 1004 (8th Cir. 2007) (stating that the district court has discretion pending "good cause" to consider

require a showing of "good cause" in order for additional evidence to be considered. But the circuits are quick to hold that "[s]upplemental evidence should not be used to take a second bite at the apple, but only when necessary to enable the court to understand and evaluate the decision under review."[651] The First,[652] Fifth,[653] and Sixth[654] Circuits extend the same rule used in arbitrary and capricious review to *de novo* review. The District of Columbia Circuit has yet to directly opine on this fourth issue.

In the author's opinion, the *Firestone de novo* standard envisioned a new trial by the district court, consistent with the arguments posed by Chief Judge Easterbrook in the *Krolnick's* Seventh Circuit opinion and Judge Nalbandian in his concurrence in *Tranbarger v. Lincoln Life & Annuity Co. of New York*.

Conclusion

The purpose of this Article was to highlight the inconsistencies within the various circuits on the issues highlighted in the Introduction Section and to propose solutions to attain uniformity within them. While only twenty-five States have bans on insured discretionary clauses for disability plans, all the circuits, save the District of Columbia and the Eleventh Circuit, will be facing the following issues: are such state bans on discretionary clauses valid and saved under ERISA's preemption clause; if so, the judicial standard of review becomes *de novo* and thus, the court must define the scope of the review in its benefits determination. While three of the circuits have held that state bans on discretionary clauses are valid and saved under ERISA's preemption clause, other circuits will need to weigh in. If other circuits confirm such result, there will be a wide divergence on the scope of review that district courts take in their *de novo* review, due to the inconsistencies within the circuits. Both such issues are ripe for Supreme Court review.

additional evidence (quoting Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993)).

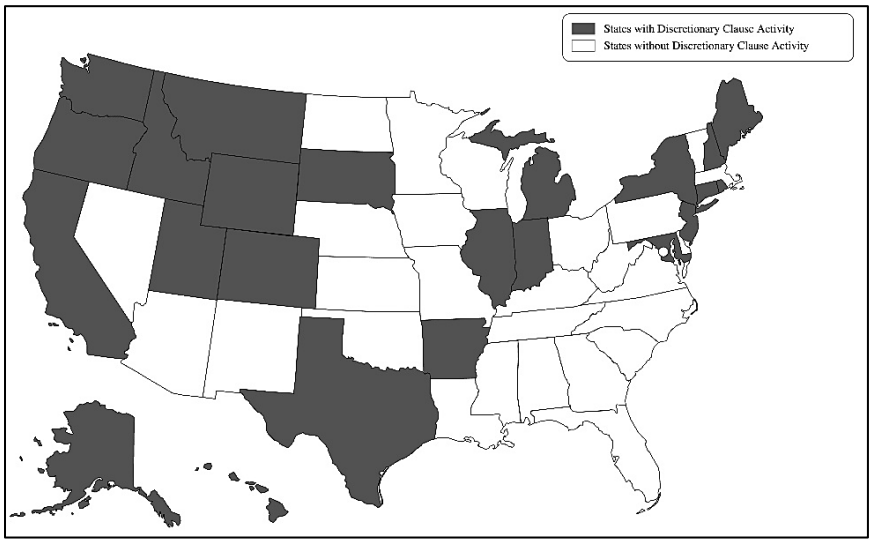
651. *Jewell*, 508 F.3d at 1309.

652. Gross v. Sun Life Assurance Co. of Can., 734 F.3d 1, 11 (1st Cir. 2013); Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 519–20 (1st Cir. 2005).

653. Ariana M. v. Humana Health Plan of Tex., Inc., 884 F.3d 246, 256 (5th Cir. 2018).

654. Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609, 618 (6th Cir. 1998).

Appendix A[655]



655. Debofsky et al., *supra* note 12. Please note that the map is inaccurate because it indicates that New York has banned discretionary clauses. In New York, the superintendent of insurance issued a circular stating that discretionary clauses are contrary to the law of the State of New York and regulations would be forthcoming to implement such rule; however, no regulations were ever issued. *See* source cited *supra* note 253.