No. 06-923

In the Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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BRIEF OF THE NATIONAL EMPLOYMENT LAWYERS ASSOCIATION AND OF UNITED POLICYHOLDERS, AS *AMICUS CURIAE*, IN SUPPORT OF THE RESPONDENT

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INTEREST OF AMICI CURIAE[1]

The National Employment Lawyers Association (NELA) is the largest professional membership organization in the country comprised of lawyers who represent workers in labor, employment and civil rights disputes. NELA advances employee rights and serves lawyers who advocate for equality and justice in the American workplace. NELA and its 68 state and local affiliates have a membership of over 3,000 attorneys who are committed to working on behalf of those who have been illegally treated in the workplace. NELA strives to protect the rights of its members' clients, and regularly supports precedent-setting litigation affecting the rights of individuals in the workplace. Accordingly, NELA has filed amicus briefs to protect the rights of workers and their beneficiaries under the Employee Retirement Income Security Act ("ERISA"). *See, e.g.*, *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101 (1989).

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no person or entity other than the *amici curiae,* and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. Written consent to the filing of this brief has been obtained from the parties in accordance with Supreme Court rule 37.3(a). Copies of the consent letters have been filed with the Clerk.

NELA members have particular expertise in the issues raised in this action not only because they have represented tens of thousands of employees in ERISA actions in the lower courts, but also in a number of ERISA cases before this Court. *LaRue v. DeWolff, Boberg & Assoc.*, _U.S. _, 128 S. Ct. 1020 (2008); *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739 (2004); *Rush Prudential HMO, Inc. v. Moran,* 532 U.S. 141 (2002); *Egelhoff v. Egelhoff,* 532 U.S. 141 (2001); and *UNUM Life Ins. Co. of Amer. v. Ward,* 526 U.S. 358 (1999).

United Policyholders ("UPH") is a single-issue, nonprofit organization founded in 1991. The organization's mission is to educate the public, legislators and courts on insurance issues and consumer rights and to help policyholders secure fair, prompt claim settlements. UPH is a recognized charity with tax exempt status under Internal Revenue Code § 501(c)(3), funded by donations and grants from individuals, businesses and foundations. An average of 20,000 monthly visitors read articles and tips at UPH's website, www.unitedpolicyholders.org.

UPH participates in proceedings of the National Association of Insurance Commissioners and receives frequent invitations to speak to trade and civic associations and to testify at public hearings on insurance issues. It also protects the interests and presents the positions of policyholders through participation as *amicus*

curiae in insurance cases throughout the country.

UPH's reputation as a reliable friend of the court was enhanced when its *amicus curiae* brief was cited in this Court's opinion in *Humana v. Forsyth*, 525 U.S. 299 (1999), and its arguments were adopted by the Texas Supreme Court in *Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc.*, 2008 Tex. LEXIS 92, 51 Tex. Sup. J. (Tex. Feb. 1, 2008), as well as by the California Supreme Court in *Vandenberg v. Superior Court*, 88 Cal. Rptr.2d 366 (Cal. 1999) and in *TRB Investments, Inc. v. Fireman's Fund Ins. Co.*, 145 P.3d 472 (Cal. 2006).

The resolution of the issue in this case is of great importance to both NELA and UPH because of its potential application to millions of employees enrolled in ERISA plans.

SUMMARY OF ARGUMENT

This brief will address only the first question certified for review: "Whether an administrator that both evaluates and pays claims under a plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq., is operating under a conflict of interest that must be weighed on judicial review of a benefit determination." *Amici* specifically address Petitioners' contentions that principles of economics dictate that insurers typically will not be impermissibly

influenced by their self-interest and, that in any event, considering a conflict of interest would upset contractual expectations.

When employee benefit programs are funded through insurance rather than established through trusts, hard reality shows that insurers left to their own devices will consistently place profits over consumer satisfaction. Even a passing familiarity with the history of insurance law in the United States underscores that regulation was instituted to protect consumers from the potential for misconduct by insurers. *See* National Association of Insurance Commissioners, "State Insurance Regulation: History, Purpose and Structure," *available at* http://www.naic.org/documents/consumer_state_reg_brief.pdf (visited on March 21, 2008).

Petitioners and their *amici* argue that "business incentives" nullify any instinct of dual-role administrators to act in their own self-interest. *See* Brief of Petitioners at 29-32; Brief of America's Health Insurance Plans as Amicus Curiae at 8-14. However, the real world experiences described below starkly demonstrate how this is not so and, in turn, illustrate how an unchecked arbitrary-and-capricious standard of review has fostered significant mischief and misbehavior. This bias is not deterred by countervailing interests such as the dollar value of an individual claim or an insurer's long-term reputational interests. Moreover, experience

has shown that employees can be given incentives, either by offers of rewards or threats of punishment, to behave improperly. Further, the threat of increased costs offers no legitimate justification for insurers to be accorded deference. Finally, given the nature of insurance and the goals and purposes of ERISA, granting deference under principles of freedom of contract is neither supportable nor desirable.

Accordingly, none of Petitioners' economic arguments provide a sufficient rationale to justify unfettered deference to insurers' findings. Hence, this Court must find MetLife's conflicted role in both administering and paying claims presents a conflict of interest.

ARGUMENT

I. METLIFE ACTED UNDER A CONFLICT OF INTEREST IN ADMINISTERING WANDA GLENN'S CLAIM FOR BENEFITS

The question before the Court as to "[w]hether an administrator that both evaluates and pays [ERISA benefit] claims . . . is operating under a conflict of interest" must be answered in the affirmative, especially with respect to insurance companies with whom employers contract to insure employee benefit plans.

While it is no doubt true that insurers must be wary of paying benefits to undeserving claimants, insurers also profit by withholding payments to those who deserve them. The Court need look no further than the text of ERISA to see where the conflict arises. ERISA imposes fiduciary obligations on insurers such as MetLife to act "solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries." 29 U.S.C. § 1104(a)(1)(A)(i). That fiduciary duty is in perpetual conflict, though, with the fiduciary duties MetLife owes its shareholders to return maximal profits. Thus, as the Eleventh Circuit has pointed out,

> when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs direct, immediate expense as a result of benefit determinations favorable to plan participants.

Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F.2d 1556, 1561 (11th Cir. 1990) (citations omitted). Consequently, neither the financial arguments advanced by Petitioners and their *amici*, nor the reputational interests claimed to act as a sufficient deterrent against misconduct, obviate the plain and palpable conflict of interest under which an insurer operates. Nor

are such arguments supported by sound economic principles.

A. There Is an Economic Incentive to Deny Employee Benefit Claims

One of Petitioners' main arguments is that the size of any individual claim is "trivial" when compared with the net assets of the insurer (Brief of Petitioners at 30), thus negating any motivation to wrongfully deny claims. Although the size of an individual benefit claim may pale in comparison to the overall revenues of the company administering benefits, there is irony in the fact that the Circuit that has most frequently advanced that rationale, *see, e.g.*, *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999), sits in a building named for the political figure who remarked, "A billion here, a billion there, and pretty soon you're talking real money."[2] Internal insurance company documentation as well as several publicized incidents have shown how insurers recognize the aggregate savings that can be gained from rejecting multiple claims. For example, an internal memorandum from a leading disability insurer noted:

The advantages of ERISA coverage in litigious

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[2] *See* "Senator McKinley Dirksen Dies," http://www.senate.gov/artandhistory/history/minute/ Senator_Everett_Mckinley_Dirksen_Dies.htm (viewed on February 17, 2008).

> situations are enormous . . . . [There] are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit[s] in question, and *claims administrators may receive a deferential standard of review*. The economic impact on Provident from having policies covered by ERISA could be significant . . . . *While our objective is to pay all valid claims and deny invalid claims, there are some gray areas, and ERISA applicability may influence our course of action.*

See John H. Langbein, *Trust Law As Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1321 (2007) (emphasis added). The memorandum further remarked that the insurer "identified 12 claim situations where we settled for $7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million." *Id.*

It is no secret that UnumProvident and its employees acted on the type of advice contained in the above memorandum in terminating ERISA-governed benefits for scores of its beneficiaries. Petitioners even acknowledge in their Opening Brief (at 37-38) that in 2003 and 2004 Unum entered into regulatory settlement agreements that grew out of a "Targeted Multis-

tate Market Conduct Examination" conducted by 52 participating jurisdictions.[3] The report identified the following areas of concern in its review of UnumProvident's claim practices:

- Excessive reliance upon in-house medical professionals;
- Unfair construction of attending physician or IME reports;
- Failure to evaluate the totality of the claimant's medical condition; and
- Inappropriate burden placed on claimants to justify eligibility for benefits.

As a result of the investigation, Unum was required to reassess more than 200,000 claims that had been denied since January 1, 1997.[4]

That only tells part of the story, though. Testimony and documentary evidence showed:

UnumProvident has a company-wide practice

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[3] *See* "Report of the Targeted Multistate Market Conduct Examination," http://maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm (viewed on March 21, 2008).

[4] *See id.*

> of denying claims based on UnumProvident's current profits. Claims managers and handlers are given a quota of how many claims need to be "closed," *i.e.* denied, in a given period for the company to remain at a certain level of profitability. Medical advisors such as McSharry are offered bonuses at a level of 25% base pay determined, in part, on company earnings. . . . Claims handlers, his supervisor, and even other doctors employed by UnumProvident pressured McSharry to agree with claims handlers to deny claims. When he did not agree with the claims handlers, his supervisor told him he was not part of the team and he was falling off the career path. . . . Dr. McSharry also testified that there were occasions in which he gave an opinion that the claims handler did not like so the claims handler would ignore his opinion and find another doctor who would provide an opinion more supportive of the claims handler's decision to deny benefits.[5]

The consequences of UnumProvident's behavior show that the value of claim denials was anything but trivial. UNUM estimated the cost to it of paying the

[5] *Bennett v. Unum*, 321 F. Supp.2d 925, 935 (E.D. Tenn. 2004); *see also Radford Trust v. First Unum Life Ins Co.*, 321 F. Supp.2d 226, 247 n.20 (D. Mass. 2004) (collecting citations to multiple cases that the judge described as "reveal[ing] a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics").

additional benefits after reassessing claims was a sum in excess of $200 million.[6] The empirical evidence thus shows the "triviality" argument carries no weight. There is no actuarial evidence submitted by any of its proponents to support it – only conjecture about financial motivation, which is thoroughly discredited by evidence proving that wrongful denial of individual claims can *and do* add up.

Nor is it correct, as Petitioners have argued, that states' regulation of insurance companies prevents misbehavior (Pet'rs Br. at 37-39). In making that argument, Petitioners have tacitly agreed that misbehavior has occurred and that it enabled UnumProvident to earn significant profits in the aggregate until it was caught and punished. However, as Professor Langbein points out:

> Broadly speaking, there are two plausible interpretations of the Unum/Provident scandal. Unum could be such an outlier that the saga

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[6] *See* "UnumProvident Announces Settlement of Multistate Market Conduct Examination," *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-newsArticle&ID=645732&highlight= (viewed on March 8, 2008); "UnumProvident Reaches Settlement with California Department of Insurance; 'Changing Landscape' May Impact Cost, Availability of Disability Insurance in State," *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-newsArticle&ID=763320&highlight= (viewed on March 8, 2008) (describing charges taken by UnumProvident to fund the Regulatory Settlement Agreement and California Settlement Agreement).

> lacks legal policy implications. On this view, a rogue insurance company behaved exceptionally badly, it got caught and was sanctioned, and its fate should deter others. The other reading of these events is less sanguine: For reasons discussed below in Part III, conflicted plan decisionmaking is a structural feature of ERISA plan administration. The danger pervades the ERISA-plan world that a self-interested plan decisionmaker will take advantage of its license under *[Firestone Tire v.] Bruch* to line its own pockets by denying meritorious claims. Cases of abusive benefit denials involving other disability insurers abound. Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect.

Langbein, *supr*a, at 1321; *see also Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206 (9th Cir. 2008).

Petitioners have not presented the Court with any empirical evidence that the UnumProvident Settlement Agreements have changed anything. The Court of Appeals below observed that MetLife was engaging in precisely the same misbehavior that was described in the Multistate Examination. Thus, MetLife's own conduct belies the argument that insurance companies won't bother wrongfully denying the small claim.

Focusing on the individual claim therefore entirely misses the point. The UnumProvident example starkly demonstrates that profit motive is powerful – there is a large profit to be gained from aggregating a substantial number of small claim denials. Thus, the UnumProvident situation offers a concrete example refuting the broad assertions of MetLife that insurance companies with high revenues and significant assets are above influence.

MetLife would have this Court believe that the UnumProvident experience had its intended effect on the insurance industry and this Court need not worry that the profit motive will further interfere with objective decision-making. Unfortunately, events have proven otherwise. For example, in January 2008, the California Department of Insurance fined UnitedHealth Group, Inc. (PacifiCare) $30 million for violations of state insurance laws. UnitedHealth is the nation's biggest provider of health care insurance. The Commissioner is also seeking to impose penalties of another $1.33 billion for 133,000 additional violations of law. The Commissioner conducted an audit of UnitedHealth's claims practices and concluded that fully 30% of all claims had been wrongfully denied – a total of 133,000 claims. This audit was conducted in June 2007, well after the UnumProvident settlement in 2004.[7]

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[7] *See* California Department of Insurance R*eport, available at*

A wrongful denial rate of thirty percent cannot be ascribed to anything other than a system-wide failure. The investigation did not reveal any correlation between the size of the claim and whether it would be wrongfully denied, but it did describe failures in how claims were processed and how evidence was viewed.

Another example occurred in February 2008, when New York's Attorney General announced its own industry-wide investigation based on its findings that UnitedHealth Group, Inc., created a "convoluted and dishonest system" for reimbursing for out-of-network services.[8]

The list goes on:

- In December, 2004, United Healthcare agreed to pay the federal government $3.5 million to settle allegations the company defrauded the Medicare program.[9]

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http://www.dmhc.ca.gov/library/reports/hp_exam/exams/126nonroutine011608.pdf (visited February 26, 2008).

[8] *See* "Cuomo Announces Industry-wide Investigation into Health Insurers' Fraudulent Reimbursement Scheme," *available at* http://www.oag.state.ny.us/press/2008/feb/feb13a_08.html (viewed on February 26, 2008).

[9] *See* "United Healthcare Insurance Agrees to Pay U.S. $3.5 million to Settle Fraud Charges," *available at* http://www.usdoj.gov/opa/pr/2004/December/04_civ_788.htm (viewed on March 28, 2008).

- Health Net, another major player in the health insurance market, faces problems of its own. Making the headlines recently was a $9 million arbitration verdict after a finding of wrongful cancellation of Patsy Bates's health insurance.[10] Based on the evidence presented at trial, Retired Judge Cianchetti concluded that the persons in charge of policy rescissions were given concrete rescission goals and were paid bonuses based on whether they achieved those goals. The employee who terminated Ms. Bates's policy was described by her supervisor as having had a "banner year" for exceeding her goals in the number of rescissions and the amount saved by the company because of the rescissions ($6 million).[11]

In yet another example of improper financial motivations affecting a disability insurer administering

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[10] *See* "Health Net ordered to pay $9 million after canceling cancer patient's policy," *available at* http://www.latimes.com/features/health/la-fi-insure23feb23,1,2680255.story; *see also* "Health insurer tied bonuses to dropping sick policyholders," *available at* http://www.latimes.com/business/la-fi-insure9nov09,1,5093427.story.

[11] *In the Matter of Arbitration between Bates v. Health Net*, Case No. BC321432 (Feb. 21, 2001) (Cianchetti, J., Ret.), *available at* http://uniset.ca/other/cs5/healthnet_arbitr.html.

ERISA benefits, *Wilkerson v. Riffage.Com*, Case No. CV 03-4926 RMW (N.D. Cal.), *available at* PACER, Document 61, Part 3, Exhibit A, revealed how Sun Life maintained a "white board" in the claims department showing how the claims staff were meeting their "goals." One such goal was to meet an anticipated number of benefit denials and terminations. To encourage his employees to meet the stated "goals," a manager sent a memo to his staff urging them to produce more denials and terminations (pp. 590-591) so that the month's goals could be met. It worked. Before the memo went out, his staff were producing an average of five denials or terminations a day. After the memo was issued, terminations increased to an average of sixteen per day (p. 595). In June of that year, when projected profits were down by $1 million for the month, the Manager of Claims issued a memo offering cash prizes for denials. For each denial of a claim performed on a weekday, a claims person would receive three chances to win a cash prize. If additional motivation was shown and a termination was processed on a weekend, the chance of winning the prize was doubled. The prize? Two-hundred and fifty dollars. Although the Vice President of claims called a halt to the raffle, he expressed no objection to encouraging claims people to generate more denials in order to meet goals (p. 582).

In each of these cases, the structure of the claims department, the motivations given to employees and

the work product that resulted shows that denials were encouraged, promoted, and praised irrespective of the value of each claim. In each of these examples, either a whistleblower or simply pure happenstance allowed an outsider a glimpse into an insurer's workings. Thus, Petitioners' triviality argument must fail when the hard reality shows that insurers' prevailing custom is to focus on aggregate savings which, as demonstrated above, can ultimately be quite significant.

B. Reputational Incentives Are Not a Sufficient Basis to Ignore Insurers' Conflicts of Interest

Petitioners and their *amici* place great weight on insurers' reputational interest as a safeguard against conflicts of interest (Brief of Petitioners at 29-30). However, as pointed out by the Third Circuit in *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000), these interests are hardly sufficient to prevent misbehavior:

> To amplify, while in a perfect world, employees might pressure their companies to switch from self-dealing insurers, there are likely to be problems of imperfect information and information flow. Employees typically do not have access to information about claim-denying by insurance companies, and the relationship between employees and insurance companies is

> quite attenuated; so long as obviously meritorious claims are well-handled, it is unlikely that an insurance company's business will suffer because of its client's employees' dissatisfaction. Additionally, many claims for benefits are made after individuals have left active employment and are seeking pension or disability benefits. Details about the handling of those claims, whether responsible or irresponsible, are unlikely to seep into the collective knowledge of the still-active employees.

Mers, 144 F.3d at 1020.

Without a doubt, all businesses would prefer to enjoy a good reputation. However, the counter-incentives of achieving significant profits or savings often provide an even stronger motive. For example, in *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996), a case in which $125 million was at stake dependent on how employees' pensions were calculated, the Seventh Circuit acknowledged, "a loss of reputation might be a price worth paying to avoid $125 million in unanticipated expense." Of course, $125 million can also be a "price worth paying" when aggregated across many cases involving "small" claims. And in a pre-*Firestone* case, *V*an *Boxel v. Journal Co. Employees' Pension Trust,* 836 F.2d 1048, 1052 (7th Cir. 1987), the Seventh Circuit aptly remarked that employee benefits "are too important these days for most employees to want to

place them at the mercy of a biased tribunal subject only to a narrow form of 'arbitrary and capricious' review, relying on the company's interest in its reputation to prevent it from acting on its bias." 836 F.2d at 1052.

Empirical evidence further undermines Petitioners' theoretical argument. If reputational injury were indeed a factor, insurers could expect to see their stock prices quickly decline and revenues plummet in the face of reputation-damaging news. UnumProvident's experience shows just the opposite, however. The Targeted Multistate Market Conduct Examination was made public on November 18, 2004. On November 12 of that year, Unum's stock was selling at $13.45 per share. The day after the report, Unum's stock was up to $15.35 per share; and Unum's share price has continued to climb. In May 2007 it reached a high of $27.57 and currently sells around $23 per share. Unum has not missed paying its regular dividend since the Multistate report.[12]

Further, according to UnumProvident's most recent SEC Form 10-K filing, from 2004 through 2007, revenues have remained flat, benefit payments have declined, and 2007's "net income" was just short of $1 billion greater than it was is 2004.[13] UnumProvident's

[12] *See* Unum "Stock Dividend & Split History," *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-dividends.

[13] *See* "10-K Annual Report" (Feb. 25, 2008), *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=112190&p=irol-

website trumpets that it remains the number one seller of both group and individual disability insurance, further undermining the assertion that news affecting reputation has an effect.[14] Despite the charges taken against earnings, the scandal surrounding Unum's conduct has not affected its reputation – or at least its bottom line. Profits have soared. If anything, the Unum situation offers the wrong lesson for the insurance industry.

According to United Healthcare's 10K filing for the year ending December 31, 2007, while performing slightly less well than their "peer group," for the last five years it has substantially outperformed both the S&P 500 and the Fortune 50.[15] Like UnumProvident, United Health Group's stock is clearly not suffering from the reports of the New York and California investigations.

In a survey published this month asking hospital executives to rate various health insurers, United Healthcare came in last, with 91% of the executives giving United Healthcare an unfavorable rating. United

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sec&secCat01.1_rs=11&secCat01.1_rc=10.

[14] *See* Unum "Our Corporation," *available at* http://www.unum.com/aboutus/whoweare.aspx (viewed on March 28, 2008).

[15] *See* UnitedHealth Group "Annual Report on Form 10-K for period ended December 31, 2007," at 17-18, *available at* http://www.unitedhealthgroup.com/invest/2007/10-K_2007.pdf (viewed on March 28, 2008).

Healthcare's atrocious reputation has done nothing to affect its domination of the industry or its bottom line profits.[16]

Thus, in law-and-economics terms, there is no well-functioning market that distributes information to prospective employees about the "reputation for fair dealing" of particular insurers. This market distortion results in a severe information asymmetry. As such, prospective employees will—absent unique circumstances—simply look at the type, level, amount, and cost (if any) of benefits offered by a potential employer, and not insurers' claim rejection rates. For instance, an employee might consider whether a plan is an HMO versus PPO or what the level of co-payments and deductibles are. But whether one employer's insurer versus another employer's insurer has a better track record for granting claims is simply not a piece of information that is readily available—other than perhaps from scattered hearsay—for a prospective employee to take into account.

Nor is the marketplace as robust as Petitioners and their *amici* claim. A recent article pointed out that the top ten disability insurers control 83% of the market share.[17] And even the strongest proponents of the "re-

[16] *See* 2008 National Payor Survey, "Payor Image and Reputation," at 9, *available at* http://www.daviespublicaffairs.com/downloads/Payor_Survey_Results_Web.pdf (viewed on March 28, 2008).

[17] *See* "2008 Group Disability Insurers," *available at*

putational interest" argument have come to question its underpinnings. The First Circuit, in *Denmark v. Liberty Life Assur. Co.,* 481 F.3d 16, 30 (1st Cir. 2007), has questioned its prior jurisprudence; and even the Seventh Circuit acknowledged in *Rud v. Liberty Life Assur. Co.,* 438 F.3d 772, 776 (7th Cir. 2006), that its earlier rulings may "reflect[ ] too sunny a view of the operation of labor markets." Without any empirical or actuarial evidence from Petitioners, this Court cannot accept theory and conjecture when it has been shown that an interest in a good reputation has hardly proven to be a deterrent against misbehavior.

C. Employee Incentives Promote Conflicted Behavior

Petitioners and their *amici* argue that it is difficult to incentivize employees to participate in wrongful denials of claims (Petitioners' Brief at 31-32). However, the cases and situations cited above suggest that when employees are offered rewards or threatened with punishment, they become highly motivated to deny even meritorious claims.

In addition to these cases, the Eighth Circuit found that "[a]pparently to limit claim payments, Aetna provides incentives and bonuses to its claims reviewers

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http://www.workforce.com/section/02/feature/25/37/29/index.html (viewed on March 15, 2008).

based on criteria that include a category called 'claims savings,'" in other words, the total value of claims denied. *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). Taken together—the bonuses in *Armstrong*, the testimony and documentation in *Bennett* on how Unum motivated its employees, Health Net's measuring employee performance by how many policies the employee rescinds (including characterizing an employee who exceeded her goal as having a "banner year"), and the raffle disclosed in *Wilkerson*—it is plainly evident that insurers structure their work environments so that claim decisions are not made by unbiased individuals.

Rather, the only tangible evidence the public has glimpsed involve employees who are highly motivated either by potential rewards for saving their employers' money or who are threatened with punishment if they fail to deny enough claims. Thus, there is ample evidence that insurers have actively worked to give their employees incentives to close or deny claims. In each of the situations recounted above, the insurance companies had absolutely no problem in motivating its employees to quickly fall into step. All it took was for the supervisor to provide direction and to give praise when goals were met.

Theoretical and unsubstantiated beliefs about how corporations behave, and how corporate employees act, should not be sufficient to outweigh the real life evi-

dence to the contrary. Accordingly, as Professor Langbein concludes:

> [T]he view advanced in the Seventh Circuit – that "applying a law-and-economics rationale . . . establishes that no conflict exists" in benefit denial cases involving conflicted decisionmakers – is bad law and bad economics.

Langbein, *supra*, at 1331.

D. The Threat of Increased Costs Is Not a Basis for Maintaining Undiminished Deference

Amici for Petitioner argue that recognition of a conflict when insurers both administer claims and pay benefits would increase the cost of litigation. *See* Brief of Petitioners at 28; Brief of America's Health Insurance Plans as Amicus Curiae at 19. That argument was already rejected by this Court in *Firestone* when it made it clear that "the threat of increased litigation is not sufficient to outweigh the reasons for a *de novo* standard that we have already explained." 489 U.S. at 115.

That holding rested on this Court's sound recognition that ERISA's primary goal is "to promote the interests of employees and their beneficiaries in employee

benefit plans, and to protect contractually defined benefits," 489 U.S. at 113 (citations and internal quotation marks omitted), and that to do otherwise "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted," *id.* at 114 (emphasis added).

In any event, there is no dispute that recognition of a conflict of interest would *not* significantly increase insurance costs. In a study commissioned by America's Health Insurance Plan ("AHIP"), two consulting actuaries predicted that entirely eliminating discretionary clauses in ERISA-governed plans and *instituting full "de novo" review with a jury trial* would increase disability insurance premiums *by only 3-4%*.[18] Of course, there are no jury trials in ERISA claims for benefits. *See* James F. Jorden at al., HANDBOOK ON ERISA LITIGATION (3d ed. 2006), at 4-164. Moreover, the actuaries estimated increased costs based on the "average cost to litigate individual" disability claims,[19] which not only include jury trials, but typically punitive damages, which are also not available in ERISA actions. *See* Eugene Anderson et al., INSURANCE COVERAGE LITIGATION (2000), at 8-4; Jorden at al., *supra*, at 4-150. Thus, the 3-4% figure is a gross over-estimate of increased costs. As such, is not surprising that AHIP ignored its own

[18] See "Impact of Disability Insurance Policy Mandates Proposed by the California Department of Insurance," at 8, *available at* http://www.ahip.org/content/default.aspx?docid=13557 (viewed on March 29, 2008) (emphasis added).
[19] *See id.* at 9.

study in its amicus brief filed in this case, instead arguing that a "*de novo* standard" would "drive up costs," but notably failing to specify by how much. Brief of AHIP, at 19.

When Congress decided "to protect" employees' "contractually defined benefits" with the strict duty of loyalty from trust law and a prohibition of exculpatory clauses in benefit plans, it made a considered choice that raising insurance costs was well worth the added protection for employees. *See* 1 ERISA Leg. History 604 ("it is intended that coverage . . . be construed liberally *to provide the maximum degree of protection* to working men and women covered by private retirement programs") (emphasis added), *quoted in* Jorden at al., *supra*, at 1-8 n.11. And for good reason. It is unimaginable that employees would trade-in a truly "full and fair" neutral court proceeding to save a few percentage points on costs, just as no one would choose to fly on a substantially more accident-prone airline or undergo a major medical procedure at a hospital with a significantly higher mortality rate simply to save a few cents on the dollar. This is especially so because disputes over welfare benefits often occur in times of serious illness or disability—the very moment when the ability to challenge a benefit denial in a court proceeding that affords no deference to the insurer, even if somewhat more expensive, would be a small price to pay.

In sum, employee benefits are too important to en-

trust payment decisions to insurers that can decide in their unfettered discretion when payments are due. Our court system would not trust insurers in any other context to make decisions reviewable only for arbitrariness; even more so, no legitimate rationale supports giving undiminished authority to insurers in the protective ERISA context. As this Court rightly recognized in *Firestone*, the cost savings argument cannot override ERISA's language, legislative history, and judicial precedent.

E. Undiminished Deference is Not Justified by Principles of Freedom of Contract

Finally, there is no reason to find that principles of freedom of contract compel an undiminished abuse of discretion review of insurers' findings. Such an argument would contravene the regulatory purpose behind ERISA. As noted earlier, Congress' motivation in enacting ERISA was to intervene in order to prevent unfettered contractual freedom from harming employee benefit plan participants. Thus, the law incorporates a strict and protective duty of loyalty for plan administrators as well as a provision that makes it unlawful to include exculpatory clauses in employee benefit plans. 29 U.S.C. § 1110(a). Indeed, when *Firestone* was before the Court, the Solicitor General argued that the prohibition of exculpatory clauses in ERISA means the "language in a plan document purporting to give biased administrators unbounded discretion to decide what

the terms of the plan mean . . . would not be enforceable under ERISA." Brief for the United States as Amicus Curiae Supporting Respondents, 1987 U.S. Briefs 1054 (LEXIS) at 27 n.11.

Further criticism of Petitioners' freedom of contract argument comes from academic quarters. In his recent essay, Professor John Langbein points out:

> In resorting to the language of contract to justify the self-serving behavior of an ERISA plan administrator who decides benefit claims, Judge Posner overlooks a profoundly important difference: ERISA requires the administrator (or an insurer exercising delegated powers of plan administration) to act in a fiduciary capacity. Under ERISA's duty of loyalty, the decisionmaker must interpret and apply plan terms "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ." [29 U.S.C. § 1104(a)(1).] Judge Posner is, therefore, confusing a contract counterparty, who is allowed to act selfishly, with an ERISA fiduciary, who is forbidden to.

Langbein, *supra*, at 1329-30.

ERISA imposes other substantial restraints on free-

dom of contract. Its inclusion of rules prohibiting self-dealing and kickbacks (29 U.S.C. §§ 1106-1108) make Congress' intent to place limits on freedom of contract clear. Moreover, the principle of ERISA as regulatory law has been well-accepted, as illustrated by *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1987), where Judge Posner (before adopting his "freedom of contract" stance rejected by Professor Langbein above) noted:

> Nor is it clear that the contractual perspective is the correct one in which to view claims under ERISA. A Congress committed to the principles of freedom of contract would not have enacted a statute that interferes with pension arrangements voluntarily agreed on by employers and employees. ERISA is paternalistic; and it seems incongruous therefore to deny disappointed pension claimants a meaningful degree of judicial review on the theory that they might be said to have implicitly waived it.

Id. at 1052.

Again, Petitioners' argument fails to take into consideration that a primary goal of ERISA is "to protect contractually defined benefits," *Massachusetts Mutual v. Russell*, 473 U.S. 134, 148 (1985). Once plan terms governing the provision of benefits are contractually established, ERISA relies on stricter trust law prin-

ciples to protect these "contractually defined benefits." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 163 (3rd Cir. 2007). *Cf. Original Great American Chocolate Chip Cookie Co. v. River Valley Cookies, Ltd.*, 970 F.2d 273, 280 (7th Cir. 1992) (Posner, J.) ("Contract law . . . does not proceed on the philosophy that I am my brother's keeper. That philosophy may animate the law of fiduciary obligations but parties to a contract are not each other's fiduciaries."). Accordingly, freedom of contract is not a justification for ignoring the conflict of interest under which administrators of unfunded benefit plans operate.

CONCLUSION

The current regime of ERISA benefit adjudication under the arbitrary and capricious standard of review consists of no more than a lenient "administrative" review without any opportunity for trial proceedings or even the taking of discovery absent a preliminary showing that an actual conflict infected the claim determination. *See, e.g., Semien v. Life Insurance Co. of North America*, 436 F.3d 805 (7th Cir.); *cert. denied* 127 S. Ct. 53 (2006). That manner of adjudication, coupled with the limited remedies available under ERISA, enhances the danger of conflicted plan administrators' misbehavior.

There is nothing in the record to support Petitioners' argument that insurance companies are sufficiently enlightened that they would not sacrifice long-term re-

putational interests for short-term profits. All the empirical evidence proves the contrary is true. While a particular case might be considered to have but "trivial" value, hundreds or thousands of such cases denied with impunity under the abuse of discretion standard undoubtedly can be highly profitable – in UnumProvident's case, at least $200 million in extra profits.

Nor have the scandals cited above resulted in any deficit to the insurers' reputations or modification of aberrant behavior. The evidence also shows that employees are more than willing to follow the instructions of their supervisors. The Sun Life example demonstrates this in bold relief. When their supervisor called for "25 more terms" in a day and a half, the claims examiners complied, tripling their daily average of denials and terminations. These facts belie a statistical fluke as the cause of the spike in denials; the cases cited by amici show a pattern of employees receiving either punishment for not going along with unjustified claim denial (*Bennett*) or reward for those who do (*Wilkerson, Bates, Armstrong*). Thus, the dual-role conflict is palpable. In *Brown v. Blue Cross & Blue Shield*, the Eleventh Circuit appropriately noted, "A conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries." 898 F.2d at 1565. That observation is the one reflecting reality; to ignore such motivations is to deprive plan participants of deserved benefits.

Accordingly, when the insurer of employee benefits both determines the eligibility to receive benefits and is responsible for paying the benefits out of its own funds, a conflict exists that must be factored into the deference, if any, to be accorded the benefit claim determination.

For these reasons, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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