

1-1-2019

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Recommended Citation

Katherine T. Vukadin, *On Opioids and ERISA: The Urgent Case for a Federal Ban on Discretionary Clauses*, 53 U. Rich. L. Rev. 687 (2022).

Available at: <https://scholarship.richmond.edu/lawreview/vol53/iss2/7>

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ON OPIOIDS AND ERISA: THE URGENT CASE FOR A FEDERAL BAN ON DISCRETIONARY CLAUSES

Katherine T. Vukadin *

ABSTRACT

The American opioid epidemic cuts across all social divisions, touching the employed and unemployed. Those with private health insurance are one of the fastest-growing affected groups, but this group struggles most to get care. Despite their insured status, the privately-insured received treatment at half the rate of those with Medicaid and at even lower rates than the uninsured. This article focuses on a significant barrier to treatment for those in employer-sponsored benefit plans: the discretionary clause. A discretionary clause grants the decision maker broad latitude and ensures that any federal court review is deferential. Claims processing in such a legal climate is stingy; recent investigations show that mental health and addiction claims are treated worst of all. Twenty-five states recently banned discretionary clauses in insurance products, but the bans do not reach most ERISA plans.

This article posits that ERISA should be amended to ban discretionary clauses. The article explains ERISA and discretionary clauses; it then shows the effect of discretionary clauses on actual cases and claims processing, focusing on mental health and substance abuse. The article then explains the recent movement away from discretionary clauses and shows why the arguments against discretionary clauses apply with even greater force to ERISA-governed plans.

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*“The very existence of ‘rights’ under such plans depends on the degree of discretion lodged in the [benefit plan] administrator.”*¹

INTRODUCTION

The American opioid epidemic cuts across all social divisions, touching the employed and unemployed. Those with private health insurance are one of the fastest-growing affected groups, but this group struggles most to get care. Of the 1.5 million people recently diagnosed with opioid use disorder, over forty percent (or 622,000 people) had private health insurance.² Only twenty-one percent of this group, however, received treatment.³ In fact, the privately insured received treatment at half the rate of those with Medicaid and at even lower rates than the uninsured.⁴ As the number of opioid-related deaths only continues to grow, steps to remove barriers to coverage for the privately insured should be taken.⁵

This article focuses on a significant barrier to treatment in employer-sponsored benefit plans: the discretionary clause. A discretionary clause lets claims reviewers interpret plan terms as they wish; if the denied claim ends up in court, this clause lends the denial a presumption of correctness. Particularly in complex mental health and substance abuse cases, a lengthy factual record, laced with the opinions of plan physicians, tends to yield at least a few facts supporting denial, even if the overall tenor of the claim supports coverage. A review under this arbitrary and capri-

1. Johnson v. Allsteel, Inc., 259 F.3d 885, 888 (7th Cir. 2001).

2. Stoddard Davenport & Katie Matthews, *Opioid Use Disorder in the United States: Diagnosed Prevalence by Payer, Age, Sex, and State*, MILLIMAN 2 (Mar. 9, 2018), http://www.milliman.com/uploadedFiles/insight/2018/Opioid_Use_Disorder_Prevalence.pdf [<https://perma.cc/37DT-PXJX>].

3. Press Release, Kaiser Family Found., Nonelderly Adults with Opioid Addiction Covered by Medicaid Were Twice as Likely as those with Private Insurance or the Uninsured to Have Received Treatment in 2016 (Apr. 12, 2018), <https://www.kff.org/medicaid/press-release/nonelderly-adults-with-opioid-addiction-covered-by-medicaid-were-twice-as-likely-as-those-with-private-insurance-or-the-uninsured-to-have-received-treatment-in-2016/> [<https://perma.cc/4PYF-7M9J>].

4. *Id.*

5. Puja Seth et al., *Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants—United States, 2015–2016*, 67 MORBIDITY & MORTALITY WKLY. REP. 349, 349 (2018), <https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6712a1-H.pdf> [<https://perma.cc/E9BT-WSXC>] (stating that opioids were involved in 33,091 deaths in 2015, increasing to 42,249 deaths in 2016).

cious standard is not concerned with the “right” decision on a claim—the question is whether the denial before the court is remotely defensible or not. The discretionary clause thus works against the plan participant, allowing the plan’s version of terms and events to prevail and expensive addiction treatment to remain out of reach.

Twenty-five states recently banned discretionary clauses in insurance products,⁶ but the bans’ effects on the Employee Retirement Income Security Act of 1974 (“ERISA”) plans are uneven. The state law bans reach insured ERISA plans (plans that use insurance to pay their claims), which remain subject to state oversight. The bans do not, however, reach self-funded ERISA plans, which pay their own claims and thus are not deemed insurance products. These widely used employer-sponsored plans therefore remain immune to this and other state law, existing in a largely regulation-free zone. About seventy-three million Americans have coverage through such self-insured plans.⁷

Discretionary clauses have been criticized since their rise in the 1990s, but the current opioid crisis only heightens the urgent need for a clear path to opioid abuse treatment through contracted benefits. Discretionary clauses should therefore be banned in insured and self-funded ERISA plans alike by means of federal law.

This article makes the case for an amendment to ERISA that would prohibit discretionary clauses. Part I provides necessary background information on ERISA and the rise of discretionary clauses. Part II shows the effect of discretionary clauses on actual cases and the claims processing climate, focusing on mental health and substance abuse. Part III explains the recent movement away from discretionary clauses, and shows why the arguments against discretionary clauses apply with even greater force with regard to ERISA-governed plans.

I. BACKGROUND ON ERISA AND DISCRETIONARY CLAUSES

In the debate in the United States over health insurance, those with employer-sponsored coverage are counted among the fortu-

6. *Owens v. Liberty Life Assurance Co.*, 184 F. Supp. 3d 580, 584 (W.D. Ky. 2016).

7. John Blum, *The Role of ERISA in Healthcare Reform, Payors, Plans & Managed Care Law Institute*, 2009 AHLA SEMINAR PAPERS (Oct. 26, 2009).

nate. About 157 million Americans are covered through an employer.⁸ These employer-sponsored benefits, however, come with an important caveat: those that are self-funded (that pay their own claims) are governed not by the state laws that traditionally govern insurance but by a federal law, ERISA.⁹ This groundbreaking law set out to ensure the security of pension benefits at a time when pensions were frequently ending up underfunded;¹⁰ by most accounts, ERISA has, for the most part, accomplished this mission.¹¹ When it comes to other welfare plans, such as health and disability benefits, however, its effects have been mixed.

ERISA begins by imposing fiduciary duties on plan decision-makers.¹² But without more, these duties—described as the highest in law¹³—are insufficient when the fiduciary's decisions are assumed to be correct, and even serious errors just result in a do-over for the plan.¹⁴

A. *ERISA Imposes Fiduciary Duties*

ERISA decision makers are bound by the duty of loyalty, the exclusive benefit rule, the duty of care, the duty to diversify investments, and the duty to follow plan terms so far as they are consistent with ERISA.¹⁵ These are duties derived from the law of

8. *Health Insurance Coverage of the Total Population, State Health Facts*, KAISER FAMILY FOUND., <https://www.kff.org/other/state-indicator/total-population/> [<https://perma.cc/7LK5-J3NQ>] (last visited Dec. 1, 2018) (follow “Data View: Number”).

9. Employee Retirement Income Security Act of 1974, Pub L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001–461 and in scattered sections of 26 U.S.C.).

10. See, e.g., JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 271 (2004).

11. *Id.* at 281.

12. George L. Flint, *The Moench Presumption: Butchering ERISA*, 59 WAYNE L. REV. 461, 461 (2013).

13. “ERISA’s duty of loyalty is the highest known to the law.’ ERISA fiduciaries must ‘discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries.’” *Singh v. RadioShack Corp.*, 882 F.3d 137, 149 (5th Cir. 2018) (alteration in original) (footnote omitted).

14. See Flint, *supra* note 12, at 462–64.

15. 29 U.S.C. § 1104(a) (2012).

ERISA imposes “higher-than-marketplace quality standards” on plan administrators and requires them to “discharge [their] duties . . . solely in the interests of the participants and beneficiaries” of the plan. And “[w]hile a fiduciary has a duty to protect the plan’s assets against spurious claims, it also has a duty to see that those entitled to benefits receive them. It must consider the interests of deserving beneficiaries as it would its own.” Moreo-

trusts, which provides much of ERISA's underpinning.¹⁶ Trust law does not provide every answer, however, and the rules of ERISA and caselaw fill in the gaps, "partly reflect[ing] a congressional determination that the common law of trusts did not offer completely satisfactory protection."¹⁷

The same person or committee that serves in a fiduciary capacity can still hold a nonfiduciary (known as "settlor") role.¹⁸ Settlor functions are generally those concerning "the establishment, termination and design of plans."¹⁹ Thus, a fiduciary can design a plan, while wearing its settlor rather than fiduciary hat, in a way that undermines the protections that ERISA provides.²⁰ That is, in deciding a plan participant's entitlement to benefits, a decision maker is bound by fiduciary duties to decide issues in the participant's interest.²¹ Yet, even if that same decision maker also acts as the plan sponsor, the decision maker can wear a settlor hat and weaken participant rights by adding a discretionary clause to the plan. In this fashion, the claims administrator can make decisions that follow the plan rules, even though the same entity tilted the plan in its own favor when wearing the settlor hat.

ver, the claims process through which a plan administrator determines a beneficiary's eligibility for benefits is not designed to be adversarial. "Indeed, one purpose of ERISA was to provide a nonadversarial method of claims settlement."

Joseph F. v. Sinclair Servs. Co., 158 F. Supp. 3d 1239, 1253 (D. Utah 2016) (alterations in original) (footnotes omitted).

16. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989).

17. Varsity Corp. v. Howe, 516 U.S. 489, 497 (1996). Trust law is just a starting point, and courts must then determine how the statute and trust law should work together. *Id.* In so doing, courts should

take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.

Id.

18. See Dana Muir & Norman Stein, *Two Hats, One Head, No Heart: The Anatomy of the ERISA Settlor/Fiduciary Distinction*, 93 N.C. L. REV. 459, 490 (2015) (citing *Varsity Corp.*, 516 U.S. at 503).

19. Information Letter from Dennis M. Kass, Assistant Sec'y, Emp. Benefits Sec. Admin., U.S. Dep't of Labor, to John N. Erlenborn (Mar. 13, 1986), <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/information-letters/03-13-1986> [<https://perma.cc/9BVV-KH9X>]. For a detailed discussion of the development of the settlor/fiduciary doctrine, see Muir & Stein, *supra* note 18, at 478–84.

20. Muir & Stein, *supra* note 18, at 464 ("[T]he settlor/fiduciary doctrine can allow employers to design plans to permit fiduciary behavior that would be flatly impermissible if not expressly provided by the plan's terms.").

21. See *supra* note 15 and accompanying text.

The addition of a discretionary clause, as explained below, gives the fiduciary's decisions a "presumption of correctness," thereby giving fiduciaries wide latitude in their decision making.²² As explained in more detail below, such a clause effectively allows fiduciaries deciding claims to "do as they please[] rather than concern themselves with any standard imposed by ERISA."²³

The fiduciary/settlor distinction also allows the plan sponsor to design a plan that undermines statutory requirements in numerous other ways.²⁴ Thus, while ERISA's fiduciary duties are significant, the donning of the settlor hat permits plan designers to set up a plan framework with features such as a discretionary clause, that undermine the very purpose of ERISA in promoting the receipt of contracted benefits.

B. *State Laws Preempted*

In addition to imposing fiduciary duties, ERISA preempts most state laws and claims, replacing them with few federal equivalents.²⁵ ERISA is thus a shield against liability for improper claims processing and against state law consumer protections, such as discretionary clause bans. Indeed, ERISA functions as a near-complete limitation on recovery available to plaintiffs: "For the vast majority of privately insured Americans who might choose to file lawsuits, ERISA is the main difference between a dismissal and a generous award or settlement."²⁶

The reason for this gap is that American health insurance has evolved into a patchwork of state and federal policies and programs, with both public and private coverage—ERISA provides only a sparse framework for governing health, disability, and other employer-sponsored benefit plans.²⁷ The Affordable Care Act

22. Flint, *supra* note 12, at 463.

23. *Id.* at 462.

24. Muir & Stein, *supra* note 18, at 522–28 (describing how plan design can undermine ERISA goals such as ready access to the federal courts and judicial review, and how plan design can also bypass crucial plan requirements such as the rule that a plan's terms be written down).

25. 29 U.S.C. § 1144(a) (2012).

26. William M. Sage, *Managed Care's Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 614 (2003).

27. 29 U.S.C. § 1132(a)(3) allows a participant or beneficiary to bring a civil action "(A) to enjoin any act or practice which violates any provision of this subchapter or the

“ACA”) has added a layer of federal requirements and protections to state-regulated plans,²⁸ while also amending ERISA to add consumer protections and the mandatory availability of independent review for denied claims.²⁹

The states, however, remain the principal regulators of insurance, through the McCarran-Ferguson Act.³⁰ Policies governed by state law are thus subject to a host of state laws and state claims, such as tort law, if the policy does not pay out when it should.³¹ But ERISA’s broad preemption provisions make these same remedies unavailable to those covered by ERISA plans. Enacted in an era when most individuals received health insurance from plans that were regulated by state laws,³² ERISA ensured that insurance contracts remained subject to state regulation.³³ The drafters could scarcely have predicted, however, how the broad preemption provision would go on to combine with other ERISA provisions to create a regulatory vacuum.

ERISA preemption begins with a broad provision that preempts all state laws touching ERISA plans: ERISA “supercede[s] any and all [s]tate laws insofar as they may now or hereafter relate to any employee benefit plan.”³⁴ ERISA preemption is interpreted broadly.³⁵ But another clause saves from preemption

terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.” 29 U.S.C. § 1132(a)(3) (2012 & Supp. V 2018).

28. See, e.g., Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 163–64 (2010) (codified as amended at 42 U.S.C. § 18022 (2012 & Supp. 2018)) (establishing the essential health benefits package for any health plan).

29. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. *Id.* The Health Care and Education Reconciliation Act of 2010 was signed into law on March 30, 2010. Pub. L. No. 111-152, 124 Stat. 1029. These two bills will be referred to as the Affordable Care Act in this article.

30. 15 U.S.C. § 1012(b) (2012).

31. VA. CODE ANN. § 38.2-510 (2014).

32. *ERISA Preemption: Remedies for Denied or Delayed Health Claims: Hearing Before the Subcomm. on Dep’t of Labor, Health & Human Servs. & Educ. & Related Agencies of the S. Comm. on Appropriations*, 105th Cong. 8 (1999) [hereinafter *ERISA Preemption Hearing*] (statement of Olena Berg, Assistant Sec’y, Pension & Welfare Benefits Admin.); see WOOTEN, *supra* note 10, at 281–82. Before ERISA, pension terms were left largely to the contracting parties, and many pensions came up short after employees had already spent decades with their employer. After several high-profile pension collapses, public opinion swayed toward a desire for reform. See, e.g., WOOTEN, *supra*, at 51 (discussing the Studebaker Corporation shutdown).

33. 29 U.S.C. § 1144(b)(2)(A) (2012); *ERISA Preemption Hearing*, *supra* note 32, at 8–9.

34. 29 U.S.C. § 1144(a) (2012).

35. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98–99 (1983) (noting that the

those state laws that regulate insurance. That is, ERISA saves from preemption “any law of any State which regulates insurance, banking, or securities.”³⁶ So although ERISA preempts a large swath of state laws, its “saving clause then reclaims a substantial amount of ground.”³⁷ Certain ERISA plans, therefore, remain subject to state laws that govern insurance.

One category of ERISA plans, however, is completely immune to state regulation; the difference turns on how claims within that plan are funded and paid. That is, if a plan pays claims directly from its own funds rather than from an insurance policy, it is considered a “self-funded” plan.³⁸ These plans usually hire a third-party administrator to review claims and decide which ones should be paid; the money paid to healthcare providers comes from the employer itself.³⁹ The employer can purchase stop-loss insurance, which protects the employer from unusually large claims, and still be considered self-funded.⁴⁰

Self-funded plans are not considered to be insurance, according to ERISA’s “deemer” clause.⁴¹ Thus, although state laws that are directed toward the insurance industry are not preempted, those laws still cannot touch self-funded ERISA plans.⁴² This regulation-free environment benefits companies sponsoring benefit plans in multiple ways. First, employers can design plans that are uniform across multiple states—although the insurance laws

preemption clause is to be broadly read); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) (stating that Congress “meant to establish pension plan regulation as exclusively a federal concern”).

36. 29 U.S.C. § 1144(b)(2)(A) (2012).

37. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 364 (2002). “Except as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance” 29 U.S.C. § 1144(b)(2)(A) (2012).

38. David Goldin, *External Review Process Options for Self-Funded Health Insurance Plans*, 2011 COLUM. BUS. L. REV. 429, 440.

39. *Id.*

40. *Id.*

41. *Id.* at 441.

We read the deemer clause to exempt self-funded ERISA plans from state laws that “regulat[e] insurance” within the meaning of the saving clause. By forbidding States to deem employee benefit plans “to be an insurance company or other insurer . . . or to be engaged in the business of insurance” the deemer clause relieves plans from state laws “purporting to regulate insurance.” As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation “relate[s] to” the plans.

FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) (alterations in original).

42. Goldin, *supra* note 38, at 441.

in various states might differ, the plans are untouched by those laws and can therefore have a uniform plan design.⁴³ In addition, ERISA imposes few substantive regulations, so that employers offering these plans can design them as they please and offer the precise options that they wish to offer and pay for.⁴⁴ Once employers realized the advantages of funding their own plans and benefitting from this regulatory safe harbor, the number of self-funded plans increased dramatically.⁴⁵

Not only are state laws preempted, but state claims are too. So, if a person covered under an ERISA plan has a claim improperly denied, that person's relief is limited to the benefit that should have been paid.⁴⁶ More often, however, the claim is simply remanded to the administrator to conduct the proper review that it should have undertaken the first time.⁴⁷ Judges have for years decried the lack of remedies for improper claims processing, frustrated that the law provides no recourse or incentive to comply.⁴⁸

43. *Id.*

44. *Id.*

45. Sixty-one percent of covered workers are in a self-funded plan, similar to the percentage reported in 2012 The percentage of covered workers who are in a plan that is completely or partially self-funded has increased over time from 49% in 2000 to 54% in 2005 and to 59% in 2010.

THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY 176 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf> [<https://perma.cc/Y7XU-F54Z>].

46. *See, e.g.,* *Graham v. Hartford Life & Accident Ins. Co.*, 501 F.3d 1153, 1162 (10th Cir. 2007) (holding that the attorney's fee issue was not ripe until after plan administrator's review on remand); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 479 (7th Cir. 1998) (affirming lower court's holding that defendant did not complete a proper vocational review and that denial of disability benefits was arbitrary and capricious but reversing fee award because defendant's decision was not "totally lacking in justification"); *St. Joseph's Hosp. of Marshfield, Inc. v. Carl Klemm, Inc.*, 459 F. Supp. 2d 824, 834 (W.D. Wis. 2006) (denying motion for attorney's fees because the defendant was not "simply out to harass" plan participant).

47. *See, e.g.,* *Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 157 (5th Cir. 2009) (explaining that remand is the usual solution when an administrator does not complete a proper claims review).

48. *See, e.g.,* *Gatlin v. Nat'l Healthcare Corp.*, 16 F. App'x 283, 290 (6th Cir. 2001) ("[A] stiffer penalty encourages plan administrators to alter their behavior with respect to employee appeals"); *Perrin v. Hartford Life Ins. Co.*, No. 06-182-JBC, 2008 U.S. Dist. LEXIS 53065, at *11 (E.D. Ky. July 7, 2008) ("[T]he defendant will take a closer look at the administrative record and its denial decisions if it is faced with more than the prospect of merely reinstating benefits."); *Elliott v. Metro. Life Ins. Co.*, No. 04-174-DLB, 2007 U.S. Dist. LEXIS 38893, at *9-10 (E.D. Ky. May 29, 2007) ("Companies would likely take a much closer look at denial decisions, and the presentation of that decision, if forced to take into account the possibility that fees will be awarded"); *Powell v. Premier Mfg. Support Servs., Inc.*, No. Civ. A. 01-05-0012, 2006 U.S. Dist. LEXIS 36105, at *28 (M.D. Tenn. June 1, 2006) ("A fee award serves as a deterrent to conclusory statements that are

Other state laws and claims affecting ERISA plans are generally preempted.⁴⁹ ERISA cases do not qualify for a jury trial, and plaintiffs are limited to those remedies set out in ERISA; no consequential, noneconomic, or punitive damages are available.⁵⁰ Nor do violations of ERISA's claims regulations result in any substantive remedy, even when plaintiffs must sue to obtain the benefits they should have received.⁵¹

As compared to their counterparts insured under non-ERISA plans, those insured under ERISA plans find their litigation options limited.⁵²

devoid of specific and fact-supported reasons for denial of benefits.”).

49. Rahda A. Pathak, *Discretionary Clause Bans & ERISA Preemption*, 56 S.D. L. REV. 500, 501 (2011) (noting that “the [Supreme] Court has been resistant to state efforts to enforce historically available remedies for behavior that is now regulated by ERISA”); *see also* Hatfield v. Blue Cross Blue Shield of Mass., Inc., 162 F. Supp. 3d 24, 38, 43 (D. Mass. 2016) (remanding the claim for full and fair review after the defendant told the insured the wrong reason for denial, gave nonspecific reasons for denial, and failed to gather necessary information to make a decision).

50. John Morrison & John McDonald, *Exorcising Discretion: The Death of Caprice in ERISA Claims Handling*, 56 S.D. L. REV. 482, 484 (2011) (citing 29 U.S.C. § 1132 (2006)).

51. *See, e.g., Lafleur*, 563 F.3d at 157 (“[F]ailure to fulfill procedural requirements generally does not give rise to a substantive damage remedy.” (quoting *Wade v. Hewlett-Packard Dev. Co.*, 493 F.3d 533, 540 (5th Cir. 2007))); *Bard v. Bos. Shipping Ass’n*, 471 F.3d 229, 244–46 (1st Cir. 2006) (striking defendant’s evidence and awarding benefits where procedural violations were “serious, had a connection to the substantive decision reached, and call[ed] into question the integrity of the benefits-denial decision itself”); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 971 (9th Cir. 2006) (stating that disregard of claims regulations leads to no substantive remedy); *Schoedinger v. United Healthcare*, No. 4:04-cv-664 SNL, 2006 U.S. Dist. LEXIS 80956, at *25 (E.D. Mo. Nov. 6, 2006) (awarding attorney’s fees and noting: “[w]hether it be purposeful or negligent, insurance companies regularly reduce and deny claims without cause, thereby increasing the cost of healthcare to providers and patients alike. If it became cost prohibitive for insurance companies to engage in this behavior, it would incentivize more accurate claims administration and processing in the future”); *Duncan v. Assisted Living Concepts, Inc.*, No. CIV.A. 3:03-CV-1931N, 2005 U.S. Dist. LEXIS 1975, at *10 (N.D. Tex. Feb. 10, 2005) (noting that there is no substantive remedy for procedural violations).

52. Section 514 preemption of state law, and, therefore, state remedies, leave ERISA’s section 502(a) civil enforcement scheme as the sole avenue of relief for negligent medical necessity and other benefits determinations. Appropriate relief would normally be found by filing a state tort claim for monetary damages, but under section 514, this is no longer possible since state tort or legislative relief would not be saved as limited to the business of insurance. Yet, section 502 only permits equitable relief for obtaining benefits that have been denied or delayed. *Ex ante*, this can require a patient to pursue the plan’s administrative appeals process and/or retain an attorney and seek preliminary injunctive relief while in the midst of a health crisis – a daunting process even for healthy claimants.

Mary Ann Chirba-Martin, *Drawing Lines in Shifting Sands: The U.S. Supreme Court’s Mixed Messages on ERISA Preemption Imperil Health Care Reform*, 36 J. LEGIS. 91, 97 (2010) (footnote omitted).

C. Discretionary Clauses Creep In

Since 1989, ERISA plans have benefitted from still another layer of insulation against claims-related liability—the discretionary clause.⁵³ A discretionary clause allows an ERISA claims administrator or other decision maker to interpret the plan and its terms as the administrator sees fit. A discretionary clause “purport[s] to reserve discretion to the insurer to interpret the terms of the contract.”⁵⁴ This clause is found nowhere in ERISA, which does not mention a judicial standard of review for denied claims. The Supreme Court addressed such clauses in the landmark case of *Firestone Tire & Rubber Co. v. Bruch*.⁵⁵ In that case, the Court searched for a default standard of review in claims cases, then found that there was no reason to depart from a *de novo* standard of review.⁵⁶ The default standard would be *de novo*, the Court explained, unless the plan contained a clause conferring discretion upon the administrator.⁵⁷ If the plan contained such a clause, the standard of review in federal court would be the arbitrary or capricious standard.⁵⁸ The standard of review, therefore, is not required by ERISA or caselaw, but is a matter of plan design.⁵⁹

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

54. *See, e.g.*, PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT § 4(B) (MODEL REGULATION SERV. 2006), <https://www.naic.org/store/free/MDL-42.pdf> [<https://perma.cc/XVB3-KF4T>].

55. 489 U.S. at 115.

56. *Id.* at 114–15.

57. *Id.* at 115; *see also* *Fendler v. CNA Grp. Life Assurance Co.*, 247 F. App'x 754, 758 (6th Cir. 2007) (quoting *Firestone*, 489 U.S. at 115) (noting that where “the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan,’ courts apply an arbitrary and capricious standard of review”); *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 380 (6th Cir. 1996). In order for a court to apply the arbitrary and capricious standard, the grant of discretion to the administrator must be clear. *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 555 (6th Cir. 1998) (*en banc*).

58. *Fendler*, 257 F. App'x at 758.

59. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385–86 (2002) (“Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards on which the statute was silent, we held that a general or default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan’s benefit determinations were matters of high or unfettered discretion Nothing in ERISA, however, requires that these kinds of decisions by so ‘discretionary’ in the first place; whether they are is simply a matter of plan design or the drafting of an HMO contract.”).

The decision seemed to be an invitation to add a clause and avoid de novo review, and employers quickly accepted.⁶⁰ Today, discretionary clauses are ubiquitous in ERISA plans.⁶¹ Discretionary clauses proliferated in non-ERISA insurance products too, but, as explained below, state insurance officials are acting to ban the clauses.

When a claim is denied under an ERISA plan, the beneficiary can seek review within the plan, then external review.⁶² The participant can then seek redress in federal court pursuant to ERISA remedies. But, as described below, a denial from a plan with a discretionary clause will—in all but the most egregious cases—be affirmed.

II. DISCRETIONARY CLAUSES CHANGE OUTCOMES IN COURT AND INFLUENCE CLAIMS PROCESSING PROCEDURES; MENTAL HEALTH CLAIMS ARE HIT HARDEST

Under the arbitrary and capricious standard, a denial is affirmed unless the decision was “whimsical, random, or unreasoned.”⁶³ Claims processing outcomes reflect this state of affairs, with scandal after scandal showing that lenient review at the

60. Professor John Langbein predicted this effect. “The Court’s emphasis . . . on the trust instrument as the basis for deferential review raises the prospect that an ERISA plan may opt out of [*Firestone*’s] de novo review and back into the pre-*[Firestone]* world of judicial deference merely by inserting some boilerplate to that effect in the plan instrument.” John Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 220 (1990). Discretionary clauses increased in popularity during the 1990s, following the *Firestone* decision. Morrison & McDonald, *supra* note 50, at 482–84; *see also* Shawn McDermott, *CRS § 10-3-1116, ERISA Preemption, and the Standard of Review*, COLO. LAW., July 2010, at 75.

61. *See, e.g.*, Morrison & McDonald, *supra* note 50, at 482.

62. 29 U.S.C. § 1133 (2012). Every benefit plan must “provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant,” and “afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.” *Id.*; 29 C.F.R. § 2560.503-1(f) (2012). For description of external review, *see* 26 C.F.R. § 54.9815-2719T(a)(2)(iv) (temporary regulations that expire on July 22, 2013, according to 26 C.F.R. § 54.9815-2719T(h)); 26 C.F.R. § 54.9815-2719 (“interim final regulations” with no stated expiration date according to 26 C.F.R. § 54.9815-2719(h)); Emp. Benefits Sec. Admin., *Affordable Care Act Implementation FAQs Part I*, U.S. DEP’T LAB. 1, 3–4 (Sept. 20, 2010), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-i.pdf> [<https://perma.cc/XN5M-HYPZ>]; Emp. Benefits Sec. Admin., *Technical Releases*, U.S. DEP’T LAB., <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/11-01> [<https://perma.cc/N5QE-VFNG>].

63. *Teskey v. M.P. Metal Products, Inc.*, 795 F.2d 30, 32 (7th Cir. 1986).

federal court level means that aggressive claims processing is the order of the day. Mental health claims, with their often-complex and fact-intensive records, are particularly vulnerable.

A. *An Undemanding Review of Denials*

Under the arbitrary and capricious standard of review, the decision need not be the same decision that the court would have made, or even the right decision.⁶⁴ Indeed, some courts using this standard hardly question the claims administrator's decision at all.⁶⁵ The Fifth Circuit Court of Appeals observed that "review of the administrator's decision need not be particularly complex or technical; it need only assure that the administrator's decision falls somewhere on a continuum of reasonableness—even if on the low end."⁶⁶ In one case involving ERISA plan benefits, the Seventh Circuit Court of Appeals described the low bar for arbitrary and capricious review:

Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review⁶⁷

A denial challenged in federal court is thus presumed to be correct unless the plaintiff can somehow overcome the presumption.⁶⁸

In addition to serving as an undemanding lens for claim denials, the arbitrary and capricious standard also cuts off discovery, so that the court does not view evidence beyond the existing claim

64. "Under this deferential standard, a plan administrator's decision 'will not be disturbed if reasonable.'" *Stephan v. Unum Life Ins. Co. of Am.*, 697 F.3d 917, 929 (9th Cir. 2012) (quoting *Conkright v. Frommert*, 559 U.S. 506, 521 (2010)). "This reasonableness standard requires deference to the administrator's benefits decision unless it is '(1) illogical, (2) implausible, or (3) without support in inferences that may be drawn from the facts in the record.'" *Id.* (quoting *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 676 (9th Cir. 2011)).

65. *Van Boxel v. Journal Co. Emps.' Pension Tr.*, 836 F.2d 1048, 1050 (7th Cir. 1987); *Graham v. L & B Realty Advisors, Inc.*, No. Civ. A. 3:02CV0293-N, 2003 U.S. Dist. LEXIS 17272, at *6 (N.D. Tex. Sept. 30, 2003) ("Although there is clear evidence to the contrary, the Court, with some reluctance, acknowledges some concrete evidence supporting Unum's decision.").

66. *Corry v. Liberty Life Assurance Co.*, 499 F.3d 389, 398 (5th Cir. 2007).

67. *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985).

68. *See, e.g., Lipker v. AK Steel Corp.*, 698 F.3d 923, 928 (6th Cir. 2012); *Viera v. Life Ins. Co.*, 642 F.3d 407, 413–14 (3rd Cir. 2011).

record.⁶⁹ This lenient standard for judicial review is understandably a feature that insurance plans have grown to “highly prize[].”⁷⁰

B. *Fertile Ground for Improper Denials*

In this legal climate, claims processing predictably grew to reflect the deferential review that denials would receive in court. In the early 2000s, an in-depth investigation of Unum/Provident Corporation (“Unum”), one of America’s largest disability insurance companies, revealed the kind of claims processing that flourishes within the protective umbrella of discretionary clauses.⁷¹ The respected National Association of Insurance Commissioners (“NAIC”) noted that Unum’s claims processing practices were well known as aggressive, but an investigation revealed much worse: “selective review of the administrative record, lack of objectivity, abuse of discretion, misuse of ambiguous test results, and claims evaluation practices that defied common sense and bordered on outright fraud.”⁷²

The NAIC views these practices not as those of a rogue actor, but as an illustration of the kind of practices that thrive under the arbitrary-and-capricious standard’s protective umbrella.⁷³ Indeed, the Unum investigation uncovered an internal memorandum linking its view of claims processing directly to ERISA and its lenient standards.⁷⁴ In that memo, an Unum employee explicitly cited the deferential review in court and noted the many advantages of ERISA that “may influence our course of action” when working within the “gray areas” of claims processing.⁷⁵ The

69. See, e.g., JO-EL MEYER & MARK DEBOFSKY, DISCRETIONARY CLAUSES IN ERISA HEALTH & DISABILITY PLANS—ARE THEY STILL VIABLE? 1, 3 (2015), <https://www.debofsky.com/What-s-New/Discretionary-Clauses-in-ERISA-Health-and-Disability-Plans-Are-They-Still-Viable.pdf> [<https://perma.cc/QKP7-5B8Z>] (stating that the arbitrary and capricious standard precludes normal trial practices, such as discovery).

70. *Rush Prudential HMO, Inc. v Moran*, 536 U.S. 355, 384 (2002).

71. Brief for National Association of Insurance Commissioners as Amici Curiae Supporting Appellee at 19, *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009) (No. 08-35246).

72. *Id.* at 19–20.

73. *Id.* at 16.

74. *Id.* at 22.

75. *Id.* at 23 (citing Mark D. DeBofsky, *Disability Insurance Under the ERISA Law: Economic Security or Litigation Nightmare*, 25 J. INS. REG. 33, 37–38 (2007)). The internal memorandum noted:

The advantages of ERISA coverage in litigious situations are enormous: state

Unum investigation ended in heavy fines and agreements to reassess a number of claim denials.⁷⁶

Courts too have observed that the claims processing incentives are quite different once a deferential standard of review applies:

When presented with a benefits claim, the administrator is aware of the risk that his decision may be subject to judicial review. The administrator has an incentive to avoid intense scrutiny by the courts (such processes can be costly and time-consuming) and is, therefore, more likely to choose an interpretation that will be favored by the reviewing court Administrators whose decisions are subject to only deferential review . . . are not as constrained by the possibility of judicial review.⁷⁷

Indeed, the improper addition of a discretionary clause to an ERISA plan was considered a harm to a plaintiff such that it would support standing in federal court.⁷⁸ The addition of such a clause, the court held, was a significant shift in risk toward the insured and away from the plan.⁷⁹

For any benefit claim, therefore, the presence of a discretionary clause is significant. Recent events show, however, that the harms are only exacerbated for mental health and particularly addiction claims.

C. Mental Health and Substance Abuse Claims Are Hard Hit

Today, the Unum scandal is old news, but a new victim of discretionary clauses has emerged: mental health and addiction claimants.

law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review.

Memorandum from Jeff McCall to Glenn Felton, IDC Mgmt. Grp. (Oct. 2, 1995), <http://www.erisa-claims.com/library/Provident%20memo.pdf> [<https://perma.cc/ZXK6-7KPF>].

76. Press Release, N.Y. Att'y Gen. Press Office, Spitzer and Serio Announce Settlement with Nation's Largest Disability Insurer (Nov. 18, 2004), <https://ag.ny.gov/press-release/spitzer-and-serio-announce-settlement-nations-largest-disability-insurer> [<https://perma.cc/XBR8-TRAU>] (announcing a settlement with Unum and requiring it and five of its subsidiaries to reassess about 200,000 previously denied claims, restructure the claim procedures to increase objectivity and fairness, and pay a \$15 million fine).

77. *Johnson v. Allsteel, Inc.*, 259 F.3d 885, 889 (7th Cir. 2001).

78. *Id.* at 887–90 (reversing dismissal for lack of standing, and explaining that the insertion of a discretionary clause was a considerable transfer of risk toward the insured and a change to the rights of the insured).

79. *Id.* at 888, 890.

Parity laws⁸⁰ (the “Parity Law”) require that mental health and addiction claims be treated just the same as medical claims, but mental health and addiction claims are still denied at much greater rates than medical claims.⁸¹ One reason is that Parity Law violations are all too common, with more stringent utilization review and requirements imposed on mental health and particularly addiction claims.⁸² Another, though, is that mental

80. The Mental Health Parity Act of 1996 (“MHPA”) and the Paul Welstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) require the financial requirements and treatment limitations for mental health and substance abuse benefits be no more restrictive than the financial requirements and treatment limitations for substantially all benefits for medical and surgical treatments. Mental Health Parity Act of 1996, Pub. L. No. 104-204, §§ 701–02, 110 Stat. 2874, 2944–45, *amended by* Paul Welstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511–12, 122 Stat. 3765, 3881 (codified as amended at 29 U.S.C. § 1185a (2012)). “[T]reatment limitations’ includes, limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.” Paul Welstone and Pete Domenici Mental Health Parity and Addiction Equity Act § 512(a)(1) (codified at 29 U.S.C. § 1185a(a)(3)(B)(iii) (2012)). The MHPAEA provides that: (1) the treatment limitations applicable to mental-health benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits (non-mental health benefits) covered by the plan (or coverage); and (2) there are no separate treatment limitations that are applicable only with respect to [mental health benefits]. *Id.* (codified at 29 U.S.C. § 1185a(a)(3)(A)(i)–(ii) (2012)); *see also* Baudoin v. Blue Cross Blue Shield of La., No. 6:12-00657, 2018 U.S. Dist. LEXIS 47613, at *12–13 (W.D. La. Mar. 21, 2018) (finding that a health care plan did not impose greater restrictions on mental health and substance abuse treatment than it did on other medical care where the plan requires all types of inpatient treatment to be medically necessary in order to obtain coverage).

81. Jessica Frenkel, *With Great Power Comes No Responsibility: The Tragedy & the Irony of ERISA Preemption*, 88 U. COLO. L. REV. 1169, 1188–89, 1191 (2017).

82. Despite the Parity Law, investigators have found payors limiting mental health and addiction claims by illegally imposing more stringent rules on mental health and addiction treatments. *See, e.g.*, Emp. Benefits Sec. Admin., *Fact Sheet: FY 2017 MPAEA Enforcement*, U.S. DEPT LAB., <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2017.pdf> [<https://perma.cc/9SGW-SZ2H>] (last visited Dec. 1, 2018). The fact sheet describes numerous enforcement actions that uncovered illegal limits on mental health and addiction treatments, some from America’s largest health insurers. For example, investigators described one plan that impermissibly imposed day limits:

The Los Angeles Regional Office uncovered a plan that imposed an impermissible annual day limit on residential treatment for substance use disorders. As a result of this investigation, the plan issued a special notice to all participants notifying them of a 30-calendar day window for submission of claims affected by the previous limitation on their substance use disorder benefits. Four claims, with billed amounts totaling \$74,165, were submitted, reprocessed and paid by the plan. The plan also revised its documents to remove the impermissible limitation for future plan years.

Id. at 3. Investigations over just one year revealed violations that disadvantaged mental health and addiction treatment in the following ways: higher co-pays, concurrent reviews that were not imposed on medical treatments, overly stringent precertification requirements, and limitations on stays for mental health and addiction treatment. *Id.* at 3–4. In particular, the ValueOptions settlement agreement with the State of New York Attorney

health and addiction claims are vulnerable to denial due to their complicated factual records and the murky application of most plans' "medical necessity" requirement.⁸³

Recent investigations show just how badly mental health claimants are treated. At ValueOptions (now known as Beacon Health Strategies), the administrator of behavioral claims for forty-five million people in all fifty states, an investigation revealed that mental health claims were denied at twice the rate of medical claims.⁸⁴ Substance abuse disorder claims were hit hardest, denied nearly four times as often as those for medical and surgical claims.⁸⁵

Utilization review for behavioral health claims is more stringent than for medical claims.⁸⁶ For any claim, whether for mental health or medical/surgical care, the approval process can be bewildering.⁸⁷ In the ValueOptions settlement, utilization review of mental health claims is described as even worse: "intensive and frequent": "providers and members must spend a great deal of time justifying each day or visit."⁸⁸ As part of the settlement

General showed that addiction-only cases were treated even worse than already-disadvantaged mental health claims. ValueOptions, Inc., Assurance No. 14-176 (Mar. 4, 2015), <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf> [<https://perma.cc/G2CK-9MTE>].

83. Frenkel, *supra* note 81, at 1190–95 ("The mentally ill are targets for [denial of benefits] in part because there is far more uncertainty regarding diagnosis criteria and treatment effectiveness for behavioral conditions than for most physical conditions.").

84. This was the conclusion of an extensive investigation by the New York State Attorney General. Press Release, N.Y. State Att'y Gen. Press Office, A.G. Schneiderman Announces Settlement with ValueOptions to End Wrongful Denial of Mental Health and Substance Abuse Treatment Services (Mar. 5, 2015) [hereinafter Press Release, ValueOptions], <https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-valueoption-s-end-wrongful-denial-mental-health> [<https://perma.cc/Q6U6-2XK5>] (describing a settlement between the attorney general's office and Beacon Health Options, formerly ValueOptions, requiring the managed care company to dramatically reform its claims review process and pay a \$900,000 penalty).

85. *Id.*

86. Frenkel, *supra* note 81, at 1189, 1193 (stating that psychiatrists were more than twice as likely than primary care doctors to experience strict utilization reviews and to compromise on treatment because of this (citing Mark Schlesinger et al., *Some Distinctive Features of the Impact of Managed Care on Psychiatry*, 8 HARV. REV. PSYCHIATRY 216, 224 (2000))).

87. Sage, *supra* note 26, at 629 ("[T]he experience of requesting coverage of a proposed treatment, receiving a response, and negotiating or formally appealing an adverse decision is complex, impersonal, time-consuming, adversarial, and mysterious.").

88. Value Options, Inc., Assurance No. 14-176 (Mar. 4, 2015), <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf> [<https://perma.cc/G2CK-9MTE>]. Note that the facts in these agreements are fact-findings by the investigators and are not admitted facts by the defendants.

agreement, ValueOptions paid \$250,000 in previously denied claims and a fine of \$900,000.⁸⁹ Another large company, the BC/BS licensee named Excellus, denied inpatient substance use disorder treatment *seven times* as often as inpatient medical services.⁹⁰

Even when plans follow the letter of the Parity Law, a paradoxical effect sometimes results. For example, the standard inpatient rehabilitation stay used to be thirty days, but the Parity Law prohibits numerical limits for mental health and addiction treatment that are not similarly imposed on medical and surgical treatment.⁹¹ Because medical treatment is not standardized at thirty days, mental health treatment cannot be meted out that way either. With numerical limits prohibited, insurers have cut down, often approving as few as five days' treatment, with patients then fighting for additional days.⁹² In some cases just *one day* of substance abuse treatment is approved at a time, according to a recent settlement agreement, even though, as the agreement states, "[I]t is not possible to complete substance abuse rehabilitation treatment in one day."⁹³

1. The Medical Necessity Rabbit Hole

Furthermore, the approval of additional days (or any days at all) depends on whether the treatment is deemed "medically necessary."⁹⁴ This subjective determination is where many claims flounder.⁹⁵ Medical necessity can be a difficult standard to apply

89. *Id.* at 44; Press Release, ValueOptions, *supra* note 84.

90. Press Release, N.Y. Att'y Gen. Press Office, A.G. Schneiderman Announces Settlement with Excellus Health Plan to End Wrongful Denial of Mental Health and Addiction (Mar. 18, 2015) [hereinafter Press Release], Excellus], <https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-excellus-health-plan-end-wrongful-denial-mental> [https://perma.cc/B99K-XYPF] (describing settlement agreement in which Excellus would reform its claims processing procedures, pay up to \$9 million in previously denied claims, and refrain from using improper requirements such as mandating that individuals fail at one treatment before obtaining another).

91. D. Brian Hufford, *Insurers Have to Pay for Addiction Treatment. Trump Just Has to Enforce the Law*, WASH. POST (Nov. 8, 2017), <https://www.washingtonpost.com/news/posteverything/wp/2017/11/08/why-wont-the-trump-administration-push-insurers-to-pay-for-treating-addiction/> [https://perma.cc/D4W7-2NQ4].

92. *Id.*

93. ValueOptions, Inc., Assurance No. 14-176) (Mar. 4, 2015), <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf> [https://perma.cc/G2CK-9MTE].

94. *Id.* at 5.

95. SARAH ROSENBAUM ET AL., DEP'T OF HEALTH AND HUMAN SERVS., MEDICAL NECESSITY IN PRIVATE HEALTH PLANS: IMPLICATIONS FOR BEHAVIORAL HEALTH CARE 12–

to any claim, because most plans have a multipart, complex definition that can lend itself to subjective applications.⁹⁶ In addition, denial on the basis of medical necessity is particularly hard to appeal when, as was the case at ValueOptions, the denial is set out in boilerplate language rather than specifics.⁹⁷ Medical necessity has, for these reasons, long been a problematic source of denials and inconsistent decision making.⁹⁸

Medical necessity is even more difficult to assess in mental health and substance abuse cases, in part because of the complicated factual records such cases often contain, with sometimes-contradictory evidence.⁹⁹ When every day of treatment must be

13 (2003).

96. Here is the definition of “medically necessary” from a 2018 BlueCross BlueShield of Texas employer-sponsored plan:

Medically Necessary or Medical Necessity means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant’s condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Claim Administrator . . . shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

BLUECROSS BLUESHIELD OF TEX., YOUR HEALTH CARE BENEFITS PROGRAM: CITY OF RICHARDSON 53 (2018), <http://www.cor.net/home/showdocument?id=20972> [<https://perma.cc/2XJY-DEK7>].

97. ValueOptions, Inc., Assurance No. 14-176) (Mar. 4, 2015), <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf> [<https://perma.cc/G2CK-9MTE>] (stating that Emblem admitted that ValueOptions’ denial letters “primarily state in general rather than specific terms why the member’s condition does not meet medical necessity criteria” and that the letters were insufficient and often “mischaracterize[d] the level of treatment requested”).

98. Sage, *supra* note 26, at 601 (“[D]ecisions involving medical necessity are frequently characterized by inconsistent administration, poor communication, distrust and, if disputes arise, relatively unprincipled, results-oriented judicial resolution.”).

99. Frenkel, *supra* note 81, at 1190–91.

justified as “medically necessary,” treatment becomes shorter, which is proven to hurt mental health and substance abuse patients.¹⁰⁰ Substance abuse treatment’s success turns in part on the treatment’s length and intensity.¹⁰¹ Furthermore, a mental health or substance abuse patient might be stable in treatment but quickly deteriorate if discharged before treatment is complete.¹⁰² This definition is thus a poor fit for mental health and addiction treatment, and the specific cases bear this out.

2. Specific Cases: The Human Cost

On appeal of a mental health medical necessity determination, contradictory evidence favors the claims administrator, because there is frequently at least some crumb of evidence to support the denial.¹⁰³ For example, the case of *Island View Residential Treatment Center v. BlueCross BlueShield* featured a typically lengthy and complex record with conflicting evidence, which provided an easy path to affirming the denial of payment.¹⁰⁴ The patient was a minor and the plan participant was her parent.¹⁰⁵ The patient, Sarah, was diagnosed with bipolar disorder, cannabis dependence, and an eating disorder.¹⁰⁶ She at times indicated she did not care if she lived or died and entered into a suicide pact with another patient at a treatment facility.¹⁰⁷ On the night before her admission to one of the facilities, she had run away, was smoking marijuana, and was found partially clothed in a field.¹⁰⁸

100. *Id.* at 1196 (citing Rani A. Desai et al., *Mental Health Service Delivery & Suicide Risk*, 162 AM. J. PSYCHIATRY 311, 313 (2005)).

101. *Id.* (citing MARGARET EDMUNDS ET AL., INST. OF MED., MANAGING MANAGED CARE: QUALITY IMPROVEMENTS IN BEHAVIORAL HEALTH 84 (1997)).

102. *Id.* at 1195 (“Medical necessity only permits psychiatrists to stabilize patients without addressing the patients’ underlying issues and treatment resistance.”).

103. *See, e.g.*, *Burton v. Unum Life Ins. Co. of America*, No. A-09-CA-532-SS, 2010 U.S. Dist. LEXIS 58267, at *34–35 (W.D. Tex. June 14, 2010) (affirming denial of disability benefits and noting that “[t]he evidence in this case from the physicians who personally examined Burton is, at best, inconsistent and highly inconclusive (and at worst, nonexistent) on the question of whether he was impaired due to bipolar disorder in March 2007”). The *Burton* court noted the arbitrary and capricious standard and also that the plaintiff almost certainly suffered from bipolar disorder at the relevant times, and that his non-compliance with the policy requirements might have been a symptom of the disorder. *Id.* at *35–36.

104. No. 07-10581-DPW, 2007 U.S. Dist. LEXIS 94901, at *62–65, *69–70, *72–73, *78 (D. Mass. Dec. 28, 2007).

105. *Id.* at *2–3.

106. *Id.* at *7–9.

107. *Id.* at *11.

108. *Id.* at *9–10.

She was treated at several different residential programs, and BlueCross BlueShield denied the vast majority of the claims for the treatment.¹⁰⁹

The court's path to affirming the denial is typical of this kind of case:

(1) The presence of a discretionary clause, triggering the lenient arbitrary and capricious review. In this case, the requisite language was in the plan.¹¹⁰

(2) The next step was the presence of an extensive, multipart "medical necessity" plan provision.¹¹¹

(3) Next, the court pointed to facts in the record supporting both the denial and provision of benefits.¹¹² But under arbitrary and capricious review, however, the facts supporting the plaintiffs' view were simply "off base."¹¹³ This is because the stated goal of the arbitrary and capricious standard is not to determine the *right* outcome, but to see whether the denial before the court can be supported by any evidence.¹¹⁴ As long as the supporting facts are there, the others are not even addressed.

109. *Id.* at *2.

110. *Id.* at *52–53.

111. *Id.* at *5–6. The opinion describes the clause as follows:

First, the "health care services must be required to diagnose or treat [the claimant's] illness, injury, symptom, complaint or condition." Second, the services had to be "[c]onsistent with the diagnosis and treatment of [the claimant's] condition." Third, the services had to be "[e]ssential to improve [the claimant's] net health outcome and as beneficial as any established alternative covered by this contract" Fourth, the services had to be "[a]s cost effective as any established alternatives and consistent with the level of skilled services that are furnished." Finally, the services had to be "[f]urnished in the least intensive type of medical care setting required by [the claimant's] medical condition."

Id. (alterations in original).

112. *Id.* at *62–63, *69–71.

113. *Id.* at *65.

114. *Id.* (stating that the standard is "not which side we believe is right, but whether [the decision maker] had substantial evidentiary grounds for a reasonable decision in its favor" (quoting *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998))). A dissenter in the *Doyle* opinion stated that the majority's analysis of the record, which the dissent described as "choos[ing] between doctors . . . selectively read[ing] medical reports from the same doctors or evaluators, selecting those parts which support its action and ignoring those which do not", effectively meant that review of "total disability" cases were rendered "substantially review-free" by this kind of review. *Doyle*, 144 F.3d at 189 (Cofin, J., dissenting).

(4) The absence of the treating physician rule, meaning that the reviewing court was not required to give special deference to physicians who actually treated the patient over those hired by the payor who has denied the claims.¹¹⁵ The court noted the financial conflict present in the case, namely that the claims administrator was also responsible for payment.¹¹⁶ The lenient abuse of discretion standard of review, however, remained unchanged.¹¹⁷

Indeed, courts regularly recognize the conflict that exists when the same entity both decides and pays claims.¹¹⁸ But plaintiffs are not entitled to an automatic reduction in deference due to such a conflict.¹¹⁹ To change the lenient standard of review, the plaintiff must in many cases bring forward evidence of how that conflict affected the claim.¹²⁰ Thus, with a complicated factual record, a lenient standard of review despite clear structural conflicts, mental health and addiction cases are even more vulnerable to unfair denials than medical cases.

Claims processing practices such as these should not be further protected by discretionary clauses that protect the decision-makers.

3. Appeal and External Review

External review is available—and often effective—but mental health claimants rarely apply. ERISA provides for an internal

115. *Island View Residential Treatment Ctr., Inc.*, 2007 U.S. Dist. LEXIS 94901, at *73–74 (stating the general rules that in ERISA cases, unlike in Social Security disability cases, treating physicians' opinions are not entitled to special deference (citing *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 825, 834 (2003))).

116. *Id.* at *54 (“[T]here is a conflict of interest because Blue Cross has the role of both the payor of claims and the Plan Fiduciary/Plan Administrator.”).

117. *See id.* at *59.

118. *See, e.g., Adamson v. Unum Life Ins. Co. of Am.*, 455 F.3d 1209, 1213 (10th Cir. 2006) (“Whatever the merits concerning the potential motivation of an insurer doubling as a plan administrator, such observations were never meant to be an *ipso facto* conclusive presumption to be applied without regard to the facts of the case—including the solvency of the insurer or the nature or size of the claim. The fact that Unum administered and insured the group term life insurance portion of this plan does not on its own warrant a further reduction in deference.”).

119. *Id.* at 1212–13.

120. “The F. Family must instead offer some proof that a conflict ‘could [have] plausibly jeopardize[d] the plan administrator’s impartiality.’ It has failed to do so.” *Joseph F. v. Sinclair Servs. Co.*, 158 F. Supp. 3d 1239, 1250 (C.D. Utah 2016) (alterations in original) (footnote omitted). The court did not state what such evidence would look like, or how the family would go about finding it. The court did not consider the defendant’s counterfactual reason for the claim denial as evidence of a conflict.

appeal process for denied claims, and since the ACA's passage an external review by a more independent person must also be available.¹²¹ While external review was rightly heralded as an important new right,¹²² external review processes are notoriously under-used. Plan participants simply do not access the process.¹²³

One reason for the low usage is that claimants are already beleaguered by illness and paperwork so they are hard pressed to work through the multiple internal reviews required before external review is available: “[I]t helps to consider the kind of consumers who might need to appeal a claims denial—including, for example, patients undergoing chemotherapy, extensive surgery, or severe mental illness, or terminally ill patients seeking experimental therapies.”¹²⁴

121. The Patient Protection and Affordable Care Act (“PPACA”) created authority for new internal and external claims and appeals procedures to be issued jointly by the Department of Treasury’s Internal Revenue Service, the Department of Labor’s Employee Benefits Security Administration (“EBSA”), and the Department of Health and Human Services (“HHS”). Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, sec. 1001, § 2719, 124 Stat. 119, 137–38 (enacted on March 23); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (enacted on March 30); *Sinclair Servs. Co.*, 158 F. Supp. 3d, at 1250; Juliette Forstenzer Espinoza, *Strengthening Appeals Rights for Privately Insured Patients: The Impact of the Patient Protection and Affordable Care Act*, PUB. HEALTH REP. 460 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3366385/pdf/phr1270004604.pdf> [<https://perma.cc/NYB3-4XU4>]; *Extension of Non-Enforcement Period Relating to Certain Interim Procedures for Internal Claims and Appeals Under the Patient Protection and Affordable Care Act*, U.S. DEP’T LAB. (Mar. 8, 2011), <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/11-01> [<https://perma.cc/R7NF-YM2C>]. The court also did not state what such evidence would look like, or how the family would go about finding it. The court did not consider the defendant’s counter-factual reason for the claim denial as evidence of a conflict.

122. Press Release, U.S. Dep’t of Labor Press Office, Administration Announces New Affordable Care Act Measures to Protect Consumers and Put Patients Back in Charge of Their Care (July 22, 2010), [<https://perma.cc/25PF-PF5Y>] (stating that the new rules would help end “some of the worst insurance company abuses”).

123. Dustin D. Berger, *The Management of Health Care Costs: Independent Medical Review After “Obamacare”*, 42 U. MEM. L. REV. 255, 288 (2010) (“The consensus seems to be that [independent medical review] is a critical consumer protection against faulty or biased MCO denials of care . . . [independent medical review] may even legitimize the process of utilization review because it ensures that consumers can resort to an independent and unbiased medical appeal.”); Karen Pollitz et al., *Assessing State External Review Programs and the Effects of Pending Federal Patient’s Right Legislation*, KAISER FAMILY FOUND., at v, vii, 2–3, 5, 7 (2000), <https://georgetown.app.box.com/s/1bk4e4owpwjy48vu88xgnvwheuc88fty>. (“Taken together, these findings suggest that the internal appeals process is too lengthy and difficult for most consumers to complete, and may result in the very low use of external review observed in every state.”).

124. Geraldine Dallek & Karen Pollitz, *External Review of Health Plan Decisions: An Update*, KAISER FAMILY FOUND. 4 (2000), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/external-review.pdf> [<https://perma.cc/PC39-3ZPV>].

Obstacles that the healthy can overcome may be overwhelming for the severely ill.¹²⁵ The drop-out rate is high at each level of appeal, leaving only a handful of claimants who persist all the way to external review.¹²⁶

The mental health claims utilization process described above is much more intensive and time-consuming even than the everyday medical claims process, so it is unsurprising that few mental health claimants access external review. Recent investigations revealed that claimants in some cases could not even request authorization for additional days or visits until the claims for all previously authorized days or visits had been exhausted—a process that could take weeks or months.¹²⁷ Faced with this byzantine process, fewer than eighty of the 2300 eligible ValueOptions members persisted through the internal appeals and filed for external review.¹²⁸ As noted above, ValueOptions often granted or denied inpatient substance abuse treatment one day at a time—each day's denial, therefore, would be a separate claim that a participant would need to pursue all the way to external review.¹²⁹ This would be a dizzyingly complex task for any person, let alone a person beset with addiction or serious mental illness of a level that would require inpatient treatment.

When participants did reach external review, however, the results were striking: forty-two percent of externally reviewed denials were reversed from 2011 to 2013.¹³⁰ Even more telling, the mere filing of an external review often resulted in a denial's reversal: when Emblem plan staff were directed to review mental health claims before they went to external review, Emblem then reversed its denial in twenty percent of the cases it reviewed, before that claim ever actually reached the external reviewer's desk.¹³¹ Apparently, Emblem knew the right result all along.

125. *Id.*

126. Pollitz, *supra* note 123, at 5 (“At each stage of the process, a substantial proportion of consumers do not challenge adverse decisions by their health plans.” The same study gives the example of consumers in Pennsylvania, where “from January 1999 through September 2000, consumers appealed almost 8,200 health plan denials,” 4469 of which were upheld. Of these 4469, only 1062 pursued the second level of appeal. Of those 1062, 618 were upheld, but only 124 of the persistently denied claims were pursued to external appeal level.)

127. ValueOptions, Inc., Assurance No. 14-176 (Mar. 4, 2015), <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf> [<https://perma.cc/G2CK-9MTETE>].

128. *Id.* at 11.

129. *See id.* at 10.

130. *Id.* at 11.

131. *Id.*

The degree to which externally reviewed claims are reversed speaks to the poor quality of decision making at the initial and internal appeal levels, and one cannot help wonder how many improperly denied claims remained denied due to the participant's inability to persist through levels of denial.

4. The Devastating Results

Denial of access to mental health and addiction treatment can be devastating. Here are a few specific instances from recent investigations: A fourteen-year-old plan member with an eating disorder was receiving partial hospitalization when ValueOptions denied additional days, her treatment had to be disrupted while her family appealed, causing great emotional distress.¹³² In another case, ValueOptions denied coverage of residential treatment for a young woman with anorexia nervosa whose weight was dangerously low: seventy-two percent of her ideal body weight; the external reviewer was strongly critical of the claims processor's actions on this claim.¹³³ Although improper mental health and addiction claim denials can be measured in dollars and cents, the immense human cost must also be considered.

In sum, it is difficult to know the exact effect of discretionary clauses on claims processing. In hearings, investigations, and studies, however, a theme emerges: When a discretionary clause is present, claims processing is less extensive, there is less medical review, and less evidence is needed to uphold a denial.¹³⁴

III. THE RISING TIDE AGAINST DISCRETIONARY CLAUSES

Discretionary clauses have long been the target of criticism from policy-makers, judges, and commentators,¹³⁵ but outright re-

132. *Id.* at 10.

133. *Id.* at 17.

134. *See, e.g., Health Insurance and Managed Care (B) Committee*, 2004 WL 3650374, at *6–7 (2004) (“When the threshold of proof is reduced, companies will limit the amount of investment they make in their claims department. The inclination then is to have less medical review and resources expended; therefore, the management of claims are reduced.” “Commissioner Gomez reiterated that when he was in private practice he noticed a pattern that when the [discretionary] clause was in effect, the files were thinner and it took very little to uphold the finding.”).

135. Judge Richard Posner observed that employee benefits (in that case, a pension) are “too important . . . for most employees to want to place them at the mercy of a biased tribunal subject to only a narrow form of ‘arbitrary and capricious’ review, relying on the

jection of these clauses is now spreading rapidly through the states. The bans' effect on ERISA plans, however, is uneven.

A. *The State-Law Bans*

State insurance officials from across the political spectrum are now banning discretionary clauses in state insurance products, calling them unfair to citizens. These bans grew out of the NAIC's analysis in the wake of the Unum scandal. The NAIC studied the clauses and concluded that they should be banned as "inequitable, deceptive, and misleading to consumers."¹³⁶ In particular, the NAIC worried about the conflict that arises when the claims adjudicator is also the plan's administrator or insurer.¹³⁷

So, in 2002, the NAIC drafted a model act entitled the Prohibition on the Use of Discretionary Clauses Model Act.¹³⁸ The model act shows state legislatures how to pass laws that prohibit discretionary clauses in health insurance contracts.¹³⁹ The model law's purpose is to ensure that consumers receive those benefits to which they are due and that "health insurance benefits and disability income protection coverage are contractually guaranteed."¹⁴⁰ The law also takes into account the inherent conflict existing when the entity paying the claims is the same one deciding them.¹⁴¹ Twenty-five states have either banned or limited discre-

company's [own] interest in its reputation to prevent it from acting on its bias." *Van Boxel v. Journal Co. Emps.' Pension Tr.*, 836 F.2d 1048, 1052 (7th Cir. 1987).

136. Brief of Amicus Curiae, *supra* note 71, at 16. Some bans prohibit discretionary clauses only in certain types of insurance policies, such as health or disability, while others ban discretionary clauses across many categories of insurance. *See e.g.*, Meyer & DeBofsky, *supra* note 69, at 5–6 (noting, for example, that Texas bans discretionary clauses in health and disability insurance policies, while Washington bans discretionary clauses in all insurance policies).

137. *Id.* at 11 (stating that there is a clear conflict of interest when the employer "both funds the plan and evaluates the claim" (citing *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 111 (2008))).

138. MODEL REGULATION SERV., PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT § 4 (Nat'l Assoc. of Ins. Comm'rs 2006), <https://www.naic.org/store/free/MDL-42.pdf> [<https://perma.cc/X3YX-CSMA>]; Joshua Foster, Note, *ERISA, Trust Law, and the Appropriate Standard of Review: A De Novo Review of Why the Elimination of Discretionary Clauses Would Be an Abuse of Discretion*, 82 ST. JOHN'S L. REV. 735, 745 (2008).

139. *See* Foster, *supra* note 138, at 745.

140. PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT, *supra* note 138, § 4.

141. The model act's purpose is "to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due." *Id.*; *see also* Brief for Amicus Curiae, *supra* note 71, at 18.

tionary clauses in health insurance policies governed by ERISA, or are in the process of doing so.¹⁴²

Such bans may be prompted by the insurance commission's staff or as a result of complaints that prompt further analysis. In the case of the State of Hawaii, the ban arose out of complaints from employers who did not want their employees to be subject to discretionary clauses in their health insurance policies.¹⁴³ The Hawaii Insurance Commissioner rejected discretionary clauses as a breach of the insurer's fiduciary duty and of the duty of good faith and fair dealing in every contract.¹⁴⁴

The California legislature enacted a ban on discretionary clauses¹⁴⁵ after some particularly egregious instances of claim denials involving discretionary clauses.¹⁴⁶ Like a similar ban in Texas,¹⁴⁷ the ban is broad, applying to any "policy, contract, certificate, or agreement."¹⁴⁸ Similarly, the Utah Insurance Commis-

142. *Owens v. Liberty Life Assurance Co.*, 184 F. Supp. 3d 580, 584 (W.D. Ky. 2016).

143. Memorandum 2004-13H from J.P. Schmidt, Insurance Commissioner, State of Hawaii Insurance Division, Department of Commerce & Consumer Affairs, to HMSA, Mutual Benefits Societies, Health Maintenance Organizations, and Insurers Offering Health Insurance (Dec. 8, 2004), http://files.hawaii.gov/dcca/ins/commissioners_memo/commissioners_memorandum_2004/ins_commissioners_memorandum_13h.pdf [<https://perma.cc/GG3W-LZXC>] ("[T]he Insurance Commissioner has received a number of complaints regarding various provisions questioned by employers as to legality. Of particular concern is clause 15 of the Agreement for Group Health Plan entitled '[Insurer's] Discretionary Authority.'").

144. *Id.* at 5.

Such contractual provisions are a violation of the insurer's obligation to act in good faith and deal fairly because a conflict of interest occurs when an insurer has discretionary authority to interpret the insurance contract in regards to what benefits it will pay . . . Such contractual provisions are a breach of an insurer's fiduciary duty to act solely in the interest of its insureds who are plan participants and beneficiaries.

Id.; see also Meyer & DeBofsky, *supra* note 69, at 5.

145. CAL. INS. CODE §10110.6 (West 2013 & Supp. 2018).

146. See, e.g., *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 873 (9th Cir. 2008) (noting that insurer sent nonsensical denial letters, denied coverage despite a lack of medical progress, and did not send letter requiring additional information to the plaintiff).

147. TEX. ADMIN. CODE § 3.1203 (West 2017).

148. CAL. INS. CODE § 10110.6 (2013 & West Supp. 2018).

(a) If a policy, contract, certificate, or agreement offered, issued, delivered, or renewed, whether or not in California, that provides or funds life insurance or disability insurance coverage for any California resident contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the policy, contract, certificate, or agreement, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

sioner banned discretionary clauses with a strongly worded statement declaring them unfair and deceptive.¹⁴⁹ In conservative and more liberal states alike, discretionary clauses are being banned as deceptive and unfair.

B. *State Bans and ERISA Plans*

Recent caselaw makes clear that state-law discretionary clause bans extend not only to state insurance products but also to insured ERISA-governed products, through ERISA's preemption carve-out for state insurance laws. Self-funded ERISA plans, though, remain untouched.

ERISA preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”¹⁵⁰ The preemption command is broad: “[a] law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.”¹⁵¹ State law bans on discretionary clauses fall within the preemption clause because they “relate to [a] employee benefit plan.”¹⁵²

Even though discretionary clauses fall within ERISA's broad preemption clause, this is not the end of the analysis. The discretionary clause bans are then saved from preemption because they satisfy the applicable two-part test: the laws are (1) specifically directed toward insurance and (2) they substantially affect the risk pooling arrangement between the insurer and the insured.¹⁵³

(b) For purposes of this section, “renewed” means continued in force on or after the policy's anniversary date.

Id.

149. Discretionary clauses purport to give an insurer full and final discretion in interpreting benefits in an insurance contract. In the department's view, under Utah Code Annotated (U.C.A.) § 31A-21-201(3), those clauses and provisions in accident and health, life, and annuity insurance contracts are inequitable, misleading, deceptive, obscure, unfair, not in the public interest, and otherwise contrary to law, and they encourage misrepresentation and violate a statute.

UTAH INS. DEPT., INS. COMM'R, BULL. NO. 2002-7, DISCRETIONARY CLAUSES PROHIBITED (2002), <https://insurance.utah.gov/wp-content/uploads/2002-7.pdf> [<https://perma.cc/9VE4-B95T>].

150. 29 U.S.C. § 1144(a) (2012).

151. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138–39 (1990) (citing *Shaw v. Delta Air Lines, Inc.*, 465 U.S. 85, 96–97 (1983)).

152. 29 U.S.C. § 1144(a) (2012); *Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan*, 856 F.3d 686, 692–93 (9th Cir. 2017).

153. *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341–42 (2003); see also *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 355 (2002); *Pilot Life Ins. Co. v.*

Laws are specifically directed toward the insurance industry if they are based in “policy concerns specific to the insurance industry.”¹⁵⁴ While ERISA defendants argued that discretionary clause bans are preempted with regard to ERISA plans, the Ninth Circuit Court of Appeals recently made clear that they are not.¹⁵⁵ The Seventh Circuit Court of Appeals recently concurred that although the employers and plans at issue are not insurance companies they need not be insurance companies in order for the bans to govern the plans themselves.¹⁵⁶ That is, the discretionary clause bans are still directed towards the insurance industry and satisfy the first prong.¹⁵⁷ Furthermore, the bans satisfy the second prong of the test, namely in that they substantially affect the risk pooling arrangement between insurer and insured.¹⁵⁸ When a discretionary clause is banned, this affects the risk pooling arrangement, because the ban limits the relationship between the insurer and the insured, also directly governing the claims that will be paid.¹⁵⁹

Thus, discretionary clause bans are saved from preemption and insurers can no longer include discretionary clauses in ERISA policies subject to state law. This is a highly significant victory for the states seeking to ban discretionary clauses—in its writ of certiorari to the Supreme Court (which was denied), Standard Insurance stated that “this issue . . . affects a massive number of cases, as there are nearly two million ERISA benefits denials annually that are potentially subject to challenge in federal court”¹⁶⁰

Dedeaux, 481 U.S. 41, 48–50 (1987).

154. *Unum Life Ins. Co. v. Ward*, 526 U.S. 358, 363, 368, 372–73 (1999).

155. *Orzechowski*, 856 F.3d at 692.

156. *Fontaine v. Metro Life Ins. Co.*, 800 F.3d 883, 889–90, 892 (7th Cir. 2015).

157. The court explained that despite its effects outside the insurance industry, the law was still specifically directed toward insurance for purposes of the preemption analysis:

While [the law firm] is not an insurer and is nevertheless affected by [the prohibition], that does not mean that [the law] is not specifically directed toward entities engaged in insurance. The Supreme Court rejected essentially the same too-clever argument in *Miller* Prohibitions on discretionary clauses, like any-willing-provider laws, have similarly inevitable effects on “entities outside the insurance industry.” Just as in *Miller*, that does not change their character as insurance regulations.

Id. at 887.

158. *Id.* at 887–88.

159. *Orzechowski*, 856 F.3d at 694.

160. See Morrison & McDonald, *supra* note 50, at 483 (citing Petition for Writ of Certiorari, *Standard Ins. Co. v. Lindeen*, 560 U.S. 904 (2010) (No. 09-885)).

Discretionary clause bans are thus saved from preemption, but the millions of people insured under self-funded plans are still subject to discretionary clauses. That is, because of their self-funded status, a large portion of ERISA plans are nonetheless exempt from these state-law discretionary clause bans as well as other state laws and regulations.¹⁶¹ This outcome is mandated by the architecture of ERISA, which contains another related clause that prevents state laws from directly affecting self-funded ERISA plans.¹⁶²

As explained above, self-funded plans are plans in which claims are paid by the employer itself, perhaps also with stop-loss insurance.¹⁶³ ERISA itself states that these self-funded plans can never be deemed to be insurance, and the state laws do not touch these plans.¹⁶⁴ Thus, the result is a bright line rule—state-law discretionary bans apply to non-ERISA insurance products as well as ERISA-governed insured plans, but not to self-funded ERISA plans.¹⁶⁵

Thus, in the movement against discretionary clauses, there remain only two categories of plans that are not subject to discretionary clause bans: insurance products in those states that have opted not to adopt such plans (although the number that has adopted them is growing), and ERISA plans that are self-funded

161. [T]he deemer clause's scope turns on the presence or absence of traditional insurance. If the state law is applied to a traditional insurance policy, then the state law falls outside the deemer clause and thus within the saving clause—even if the insurance policy backstops an ERISA plan. On the other hand, if the state law is applied to an ERISA plan itself, which is how such laws operate on self-funded plans, the law falls within the deemer clause and thus is preempted, even if it is a bona fide insurance regulation that only incidentally affects ERISA concerns. The result is a simple, 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." *Williby v. Aetna Life Ins. Co.*, 867 F.3d 1129, 1136 (9th Cir. 2017) (citation omitted) (citing *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990)).

162. *Id.*

163. Goldin, *supra* note 38, at 440.

164. *Williby*, 867 F.3d at 1136.

165. The court notes the Ninth Circuit has most recently decided *Williby v. Aetna Ins. Co.*, in which it held ERISA preempted California Insurance Code section 10110.6(a) to the extent it would otherwise be applicable to a 'self-funded' ERISA plan. *Williby* is distinguishable from the instant case, because the Plan at issue here is not self-funded, but is an insurance policy.

Dorsey v. Metro. Life Ins. Co., No. 2:15-cv-02126-KJM-CKD, 2017 U.S. Dist. LEXIS 139010, at *25 & n.11 (E.D. Cal. Aug. 28, 2017) (citations omitted) (citing *Williby*, 867 F.3d at 1137).

by the employer. Ironically, then, the plans subject to the federal law that was meant to help employees and preserve their benefits is leaving them worse off than before. ERISA, however, has of course been amended before, and the time has come to amend it and ban the unfair and unwarranted discretionary clauses.

IV. NO BASIS FOR DISCRETIONARY CLAUSES IN ERISA PLANS

Discretionary clauses have no place in ERISA plans, especially self-funded plans, and the current mental health and opioid crisis heightens the need for their removal. Discretionary clauses undermine ERISA plans, especially self-funded plans. The facts do not support economic justifications for the inclusion of discretionary clauses.

A. *Discretionary Clauses Are at Odds with ERISA's Two Main Legislative Purposes*

Discretionary clauses are directly at odds with the following aspects of ERISA:

Ensuring contracted benefits. Congress enacted ERISA to protect contracted benefits¹⁶⁶—discretionary clauses undermine this goal. As an initial matter, ERISA's overarching goal and *raison d'être* is the preservation of employees' interests in their benefit plans.¹⁶⁷ Discretionary clauses undermine this goal, because they allow claims decisions to be made within a spectrum of discretion, rather than according to the qualifications for receiving benefits.

166. "Congress enacted ERISA to 'protect . . . the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004) (alterations in original) (quoting ERISA § 2(b), 29 U.S.C. § 1001(b) (2012)); *see also* U.S. Airways, Inc. v. McCutchen, 569 U.S. 88, 100 (2013) (stating that "ERISA's principal function" is "to 'protect contractually defined benefits'" (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)); *Conkright v. Frommert*, 559 U.S. 506, 516–17 (2010) ("Congress enacted ERISA to ensure that employees would receive the benefits they had earned" and to ensure "fair and prompt enforcement of rights under a plan . . ."); *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) ("Congress' desire to offer employees enhanced protection for their benefits . . .").

167. ERISA § 2(b), 29 U.S.C. § 1001(b) (2012) ("It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans . . .").

Ready access to the federal courts. Furthermore, ERISA was meant to allow ready access to the federal courts.¹⁶⁸ When a discretionary clause applies, the plaintiff does not have access to a federal court's full review of a denial. The court's review is necessarily constrained, the analysis is less searching, and the review depends on whether the denial is based on some reason, rather than whether the denial is correct. In this fashion, plan participants are denied the courts' analysis of their claims, and their access to the courts is constrained.

The duty to follow ERISA's statutory terms over any plan term. Even if a term contravening ERISA is included in an ERISA plan, the fiduciaries should not follow it. Where, for example, a plan provision required trustees to follow plan participants' instructions, the Department of Labor observed that ERISA's prudence and exclusive purpose still applied: "[W]hen a conflict between the prudence standard and plan provisions occurs, section 404(a)(1)(D) requires that the plan provisions give way to the statutory requirements."¹⁶⁹ Likewise, when an ERISA plan clause required forfeiture of pension benefits, a court found that the clause violated ERISA section 203; the clause had to yield to ERISA's clear statutory commands.¹⁷⁰ A denial of pensions would violate the vesting rules of ERISA section 203, and the clause that called for this denial was not consistent with the provisions of Title I. Therefore, the court held the Committee's members in breach of their section 404(a) duty.¹⁷¹

B. *The Trust-Law Basis for Discretionary Clauses Is Ill-Founded*

The prevalence of discretionary clauses grew out of the Supreme Court's analogy to trust law in the *Firestone* case.¹⁷² In that case, the Court explained trust law's influence on ERISA, and how the statute "codif[ied] and ma[de] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law

168. *Id.* ("It is hereby declared to be the policy of this chapter to . . . provid[e] . . . ready access to the Federal courts.")

169. Dep't of Lab., Opinion Letter on Tender Offers (Feb. 23, 1989), BNA Pension Rep., 390. *Accord* Winer v. Edison Bros. Stores Pension Plan, 447 F. Supp. 836, 837 (E.D. Mo. 1978), *aff'd*, 593 F.2d 307 (8th Cir. 1979).

170. *Winer*, 447 F. Supp. at 837.

171. *Id.*

172. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989).

of trusts.”¹⁷³ But there is a limit: “wholesale importation of the arbitrary and capricious standard into ERISA is unwarranted.”¹⁷⁴

The Court explained a basis in trust law for a deferential standard of review when a trustee exercises discretionary powers: that is, when discretionary power is given to a trustee, then the review of that exercise should be deferential.¹⁷⁵ The Court also emphasized that the review should depend on the terms of the trust, and that in the absence of such a discretionary grant (as was the case in *Firestone*), the review should be de novo.¹⁷⁶ Indeed, the overarching message of *Firestone* is that de novo review, not deferential review, makes more sense in the context of this consumer-protective statute: “Adopting *Firestone’s* reading of ERISA would require us to impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.”¹⁷⁷

The *Firestone* Court then stated in dicta, continuing its trust-law analogy, that there is nothing to “foreclose[] parties from agreeing upon a narrower standard of review” than de novo.”¹⁷⁸

But there are two problems with this analogy. First, trust law was always meant as a starting point for ERISA law, not the guiding principle.¹⁷⁹ ERISA’s legislative purpose of employee benefit protection was always meant to override any allegiance to trust law principles.¹⁸⁰ Moreover, trust law and ERISA law are fundamentally different. ERISA was enacted to protect employees’ benefits, whereas trust law carries out a settlor’s intent.¹⁸¹

173. *Id.* at 110 (citing H.R. REP. NO. 93-533, at 4649 (1973)).

174. *Id.* at 109.

175. *Id.* at 111 (citing RESTATEMENT (SECOND) OF TRUSTS § 187 (AM. LAW INST. 1959)).

176. *Id.* at 115.

177. *Id.* at 113–14.

178. *Id.* at 115.

179. *Varity v. Howe*, 516 U.S. 489, 497 (1996) (“[W]e believe that the law of trusts often will inform, but will not necessarily determine the outcome of, an effort to interpret ERISA’s fiduciary duties. In some instances, trust law will offer only a starting point, after which courts must go on to ask whether, or to what extent, the language of the statute, its structure, or its purposes require departing from common-law trust requirements.”).

180. *Id.*

181. 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, 1336 (2007) (“The controlling consideration in determining the meaning of a donative document is the donor’s intention” (citing RESTATEMENT (THIRD) OF PROP.: WILLS AND OTHER DONATIVE TRANSFERS § 10.1 (AM. LAW INST. 2003))); *accord.* RESTATEMENT (THIRD) OF TRUSTS § 4 (AM. LAW INST. 2003).

The settlor of a trust therefore acts with an autonomy that is appropriate for that donative role.¹⁸² Employee benefits, of course, are not a gift but are a substantial part of employees' compensation package and the source of tax advantages for employers.¹⁸³

Second, the notion that employees can "agree" to accept a particular standard of review for their benefit claim denials ignores the reality of how employment negotiations function and the present ubiquity of discretionary clauses. First of all, the employee does not "agree" to any particular benefit term through individual negotiation.¹⁸⁴ A potential employee can perhaps negotiate the amount of money that he or she will contribute to the cost of benefits, but job-seekers are not advised to negotiate details such as standards of review in existing benefit plans.¹⁸⁵ A review of popular websites advising job seekers to negotiate various aspects of their contribution to benefits did not raise the issue of standard of review, or give any advice at all regarding discretionary clauses.¹⁸⁶ Thus, the idea that employees have "agreed" to such clauses does not appear to be based in reality.

Thus, although *Firestone* contemplated some sort of trust-based employee negotiation that could result in a fair adoption of the

182. *Id.*

183. See, e.g., *Employee Benefits*, INTERNAL REVENUE SERV., <https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits> [<https://perma.cc/X9UN-DKEQ>] (last visited Dec. 1, 2018), (explaining the tax advantages of offering employee benefit plans); News Release, U.S. Dep't of Labor, Employer Costs for Employee Compensation—December 2016 (Mar. 17, 2017), https://www.bls.gov/news.release/archives/ecec_03172017.pdf [<https://perma.cc/2WEE-T4AJ>] (noting that employee benefits amount to about one-third of employee compensation).

184. See, e.g., Muir & Stein, *supra* note 18, at 519 ("[B]enefit plans are typically not the bilateral product of active bargaining by the parties but rather are drafted by the employer without direct, and certainly not individual, negotiation with the employees."); Langbein, *supra* note 181, at 1323–34 ("As a practical matter, the employee has no opportunity to bargain with the employer about matters such as the standard of review of benefit denials. Accordingly, it is a mischaracterization to depict these parties as 'agreeing' to preclude impartial judicial review of self-serving plan decisionmaking." (footnotes omitted)).

185. See, e.g., Lillian Childress, *8 Must-Ask Questions About Your Company's Health Insurance Options*, GLASSDOOR (Mar. 14, 2017), <https://www.glassdoor.com/blog/health-insurance-options/> [<https://perma.cc/X46W-GJG5>] (suggesting that individuals inquire about pre-existing condition limitations and other issues but not mentioning discretionary clauses); Vicki Salemi, *Don't Overlook These Expenses When Negotiating Your Salary*, MONSTER, <https://www.monster.com/career-advice/article/compare-health-insurance-job-offer-open-enrollment> [<https://perma.cc/TNT9-8FGF>] (last visited Dec. 1, 2018) (citing various benefit questions to ask and assess but not mentioning discretionary clauses).

186. See, e.g., Alden Wicker, *5 Often Overlooked Benefits That You Should Negotiate with a New Job Offer*, FASTCOMPANY (Jan. 19, 2016), <https://www.fastcompany.com/3055541/5-often-overlooked-benefits-that-you-should-negotiate-with-a-new-job> [<https://perma.cc/TFW9-GEQP>].

discretionary standard of review, that idea is inconsistent with trust law and the realities of employees' negotiating situation vis-à-vis the benefit plans offered to them.

C. *Economic Concerns*

Critics of further regulation of employer-sponsored plans often make three economic arguments: (1) economic principles already protect the consumer sufficiently due to reputational concerns that prevent sharp claims practices, (2) claims processing without discretionary clauses would be too expensive, (3) employers don't have to give any benefits, and the system should not be so complex that they refrain from doing so. These concerns are addressed in turn below.

1. Reputation

The reputational argument states that every plan sponsor and plan administrator has a vested interest in maintaining plans that satisfy employee-customers.¹⁸⁷ A company cannot succeed, this argument goes, by denying claims and maintaining sharp claims practices.¹⁸⁸ This theory is not borne out, however, when recent fines and prosecutions for illegal claims processing are compared with the profitability of the companies. Companies found to be breaking the claims processing laws seem to be doing just fine.

In 2014, UnitedHealth was fined \$173 million in California for unfair claims processing practices.¹⁸⁹ That same year, UnitedHealth earned record profits.¹⁹⁰ In 2015, the New York Attorney General imposed large fines on claims processors ValueOptions and Excellus and also required that the two reverse their denials

187. See, e.g., Foster, *supra* note 138, at 756 ("If an insurance company develops a reputation for being ineffective or unreliable, that insurance company will likely not find success within an industry teeming with other providers.")

188. *Id.* at 756–57.

189. Don Jergler, *UnitedHealth's \$173M Fine May Be Warning to P/C Insurers*, INS. J. (July 30, 2014), <https://www.insurancejournal.com/news/west/2014/07/30/336212.htm> (explaining that state officials likely believed the violations were knowing violations, given the size of the fine and the fact that investigators had requested an even heavier fine).

190. Bob Herman, *United Health Ends 2014 with Sizable Profits*, MOD. HEALTHCARE (Jan. 21, 2015), <http://www.modernhealthcare.com/article/20150121/NEWS/150129988> [<https://perma.cc/6NHM-LGMQ>].

of many claims that should have been paid.¹⁹¹ ValueOptions (now Beacon Health) is privately held, so it is difficult to know its internal finances.¹⁹² Its website, however, reports in 2018 that it is the undisputed leader in the field, with 4,700 employees and forty million covered people.¹⁹³ Excellus reports that it provides health insurance to 1.5 million members and has a Standard and Poor's rating of BBB+, or "stable."¹⁹⁴ As explained above, Unum was cited in many cases for its sharp claims processing practices and improper denials.¹⁹⁵ Its practices led to the NAIC's creation of a discretionary-clause ban model act.¹⁹⁶ Nevertheless, the company steadily ranks in the Fortune 500.¹⁹⁷ If Unum's financial health has suffered from improper claims processing, the effects are neither obvious nor crippling.

2. Expense

Is awarding contracted benefits just too expensive? Judges, analysts, and industry representatives have speculated that if discretionary clauses are banned from insurance products, more claims are likely to be paid, and the cost of that insurance will hence increase.¹⁹⁸ A California study performed by respected human resources firm, Milliman, Inc., found that the effects on the insurance market would be modest if discretionary clauses in disability insurance products were banned.¹⁹⁹ The study's authors predicted that in the absence of a discretionary clause, litigation of disability claims could be expected to increase and claims pro-

191. Press Release, ValueOptions, *supra* note 84; Press Release, Excellus, *supra* note 90.

192. Beacon Health Options, Inc., *Private Company Financial Report*, PRIVCO, https://www.privco.com/company/beacon-health-strategies_private_stock_annual_report_financials [<https://perma.cc/6V8C-7628>] (last visited Dec. 1, 2018) (providing the extent of what is publicly known about ValueOption's internal finances).

193. *Who We Are*, BEACON HEALTH OPTIONS, <https://www.beaconhealthoptions.com/who-we-are/> [<https://perma.cc/S46W-3S69>] (last visited Dec. 1, 2018).

194. *Corporate Overview, Company Information*, EXCELLUS, <https://www.excellusbcs.com/wps/portal/xl/our/compinfo/> [<https://perma.cc/S2QF-JS2T>] (last visited Dec. 1, 2018).

195. *Supra* text accompanying notes 73–78.

196. *Supra* text accompanying notes 137–41.

197. *Unum Group*, FORTUNE, <http://fortune.com/fortune500/unum-group/> [<https://perma.cc/Z28K-W6KU>] (last visited Dec. 3, 2018) (ranking 267th in 2018).

198. See, e.g., Foster, *supra* note 138, at 757 ("Additional litigation ultimately means that the insurance company, along with the beneficiaries, will have additional costs.").

199. ROBERT W. BEAL & DANIEL D. SKWIRE, MILLIMAN, INC., *IMPACT OF DISABILITY INSURANCE POLICY MANDATES PROPOSED BY THE CALIFORNIA DEPARTMENT OF INSURANCE* 8 (2005).

cessors might permit individuals to remain on disability payments longer than they otherwise might, in order to avoid litigation.²⁰⁰ While Milliman also predicted that insurance premiums would increase, the increase would be modest, on the order of three to four percent per year.²⁰¹

Although the Milliman study predicted an increase in litigation in the absence of discretionary clauses, that effect would be somewhat mitigated in the case of self-insured ERISA plans. The non-ERISA plaintiffs analyzed in the Milliman study have the full array of state-law remedies.²⁰² Furthermore, in advance of creating their model discretionary ban law, the state insurance commissioners who comprise NAIC assessed the prospect of increased litigation without discretionary clauses and determined that ERISA's limited remedial scheme would still keep litigation in check—the result of banning discretionary clauses would be to keep the litigation process the same except for a different standard of review.²⁰³

If there are additional costs of providing benefits as contracted, a portion of that cost might well be passed on to consumers. Even if the cost increases, however, the removal of discretionary clauses would mean that plan participants could rely more on their benefits, instead of paying their portion of the cost only to find out that the benefits are not there when needed for a mental health crisis or child's struggle with an eating disorder or substance abuse. When discretionary clauses are removed from plans, fairness is restored to claims handling; claimants are entitled to their benefits when they meet the conditions for receiving them.²⁰⁴

200. *Id.* at 8–9.

201. In such an environment, disability insurers might permit some insureds to remain on disability insurance longer than they otherwise might, which would in turn cause a decrease in the recovery rate of about two to three percent. *Id.*

202. See Foster, *supra* note 138, at 755 (“[M]ost applications of state law are rendered irrelevant by ERISA.”).

203. *Health Insurance and Managed Care (B) Committee, supra* note 134, at *6 (noting that without discretionary clauses, litigation would increase but would remain constrained by ERISA's limited remedial scheme).

204. Morrison & McDonald, *supra* note 50, at 483 (“Without [the arbitrary and capricious] standard of review, insureds are entitled to their health or disability benefits when the evidence shows they are so entitled.”).

3. Benefits as Retractable Gifts

As courts have repeatedly recognized, employers generally need not offer any benefit plans at all to employees—these programs are largely voluntary. This was one of the original concerns that animated ERISA's creation.²⁰⁵ Some have argued that if discretionary clauses are banned, employers may decide not to offer benefits at all. Indeed, this argument is repeated whenever an employee-friendly revision to ERISA is proposed.²⁰⁶

But of course, employee benefit plans are hardly a gift to employees. This view of employee benefits—known as the gratuity theory—harkens back to the early days of pensions, when they were considered an optional pat on the back to a faithful employee.²⁰⁷ The gratuity theory has long been abandoned.²⁰⁸ Today, benefit plans are a substantial part of employees' compensation package and are frequently used to recruit and retain valued employees, to take advantage of tax benefits, and to substitute for additional cash wages.²⁰⁹ Furthermore, the understanding of em-

205. Congress sought to encourage employers to create employee benefit plans without mandating that they do so. *Conkright v. Frommert*, 559 U.S. 506, 516–17 (2010). To that end, “ERISA ‘induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.’” *Id.* at 517 (alterations in original) (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)); *see also* *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (“Congress’ desire . . . not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.”).

206. *See, e.g.*, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 120 (2008) (Roberts, J., concurring). “We have long recognized ‘the public interest in encouraging the formation of employee benefit plans.’ Ensuring that reviewing courts respect the discretionary authority conferred on ERISA fiduciaries encourages employers to provide medical and retirement benefits to their employees through ERISA-governed plans—something they are not required to do.” *Id.* (citation omitted).

207. Norman Stein, *An Article of Faith: The Gratuity Theory of Pensions and Faux Church Plans*, AM. B. ASSOC., http://web.archive.org/web/20180109033327/http://www.americanbar.org/content/newsletter/groups/laborLaw/ebc_newsletter/14_sum_ebc_news/faith.html (“The age of employer-sponsored pension plans began in this country during the last quarter of the nineteenth century, when American Express and other transportation, retail and industrial firms adopted pension programs for their employees. For a good part of the next century, the prevailing legal theory concerning these programs was that the pension promise was an unenforceable promise to make a future gift—a mere gratuity. No amount of work by an employee could ensure him the payment of a pension, and many pension plans were largely unfunded. A pension was no better than the aggregate of an employer’s decency and solvency. The gratuity theory, however, began to erode in the 1930s . . .”).

208. *Id.*

209. “The difference between pension as contract and pension as gratuity has been a theme of employee benefits law for more than a century, and ERISA is sometimes reck-

ployee benefits as gifts or gratuities existed in the time before ERISA and has since been abandoned in lieu of an understanding of employee benefits as promised parts of an employee's compensation.²¹⁰

As an important part of employees' compensation, benefit plans should not be essentially illusory, which they can be if decision-makers can interpret plan terms and definitions as they see fit, to the detriment of employees. After all, if discretionary clauses are banned, denials are still reviewed, but they are reviewed in order to reach the *correct* decision, on the entire record, not simply the decision that the plan decision-maker would prefer.

V. A FEDERAL BAN ON DISCRETIONARY CLAUSES COULD FIND BIPARTISAN GROUND

An amendment to ERISA may seem to be a partisan issue, with business-friendly interests opposing consumer protections. But could a discretionary clause ban be different? Perhaps so, considering recent bipartisan work on mental health legislation, legislators' demonstrated willingness to negotiate over ERISA reform, and the fact that discretionary clause bans are now on the books in both red and blue states.²¹¹

A. *Paths to Mental Health Treatment as a Bipartisan Issue*

Even in the current rancorous political climate, legislators find common ground in promoting mental health treatment.²¹² The 21st Century Cures Act was the fruit of a years-long, bipartisan and bicameral effort to aid those with mental health issues.²¹³ It

oned to be the culmination of an evolutionary move from employee benefit plan as gratuity to employee benefit plan as contract." Muir & Stein, *supra* note 18, at 518.

210. *Id.*

211. See Stephen Eide, *Congress Is Making Bipartisan Progress on Mental Health Reform*, HILL (Aug. 9, 2017, 10:40 AM), <http://thehill.com/blogs/pundits-blog/healthcare/345869-congress-is-making-bipartisan-progress-on-mental-healthcare> [https://perma.cc/YU M6-WWUJ]; *Discretionary Clauses Outlawed in Many States*, MORGAN & PAUL, PLLC, <https://www.erisadisabilitybenefits.com/longtermdisability/discretionaryclausesbannedinrisapolicies.html> [https://perma.cc/LF2H-2CAP] (last visited Dec. 1, 2018); *infra* Part V.B.

212. Eide, *supra* note 211.

213. 21st Century Cures Act, Pub L. No. 114-255, 130 Stat. 1033 (2016) (codified as amended at 42 U.S.C. § 300aa-11); Elaine Z. Loumbas, *21st Century Cures Act: A Myriad of Health Law Remedies*, 29 HEALTH LAW. 31, 31 (2017) (noting the broad bipartisan support behind this law); Maggie Fox, *Senate Passes Sweeping 21st Century Cures Act Funding Medicine*, NBC NEWS (Dec. 7, 2016, 6:35 PM),

received overwhelming bipartisan support and passed into law in 2016.²¹⁴ This effort includes the creation of a new assistant secretary for Mental Health and Substance Use, improved coordination of mental health resources, increased steps toward mental health parity, additional monies for the effort against opioid abuse, and many other provisions.²¹⁵ Congress worked together and passed a law that is recognized as both far-reaching and helpful.²¹⁶

At the state level, discretionary clause bans have also drawn bipartisan support, even in more conservative states. In the wake of the Unum scandal, state insurance commissioners from across the political spectrum worked toward banning discretionary clauses, starting with their model act to effect this goal.²¹⁷ State discretionary bans have been passed in more liberal states, such as California, but also in more conservative, pro-business states, such as Texas.²¹⁸ In Texas, which first passed a discretionary clause ban in 2009 and expanded it in 2012, the Office of Public Insurance Counsel reported that the ban was well received across party lines.²¹⁹ In South Dakota, described in the *New York Times* as “reliably Republican,”²²⁰ discretionary clauses are banned in all health plans.²²¹

news/senate-passes-sweeping-21st-century-cures-act-funding-medicine-n693351 [https://perma.cc/Y7MB-PNL6].

214. Loumbas, *supra* note 213, at 31.

215. See *id.* at 31–38; *Mental Health Reform in the 115th Congress*, AMERICAN PSYCHIATRIC ASS'N, <https://www.psychiatry.org/psychiatrists/advocacy/federal-affairs/comprehensive-mental-health-reform> [https://perma.cc/N9EF-HBMU] (last visited Dec. 3, 2019).

216. See Fox, *supra* note 213.

217. See Langbein, *supra* note 181, at 1340; PROHIBITION ON THE USE OF DISCRETIONARY CLAUSES MODEL ACT § 4 (MODEL REGULATION SERV. 2006), <https://www.naic.org/store/free/MDL-42.pdf> [https://perma.cc/XDT5-PFMF].

218. See *Discretionary Clauses Outlawed in Many States*, *supra* note 211.

219. [The Office of Public Insurance Counsel] petitioned the Texas Department of Insurance (TDI) to create rules prohibiting discretionary clauses in October 2009. The petition received strong support from members of the Texas Legislature, the American Association of Retired Persons, the Texas Medical Association, the National Multiple Sclerosis Society, the Center for Public Policy Priorities and many others. The rules went into full effect on June 1, 2011.

Legislature Prohibits Discretionary Clauses, OFF. PUB. INS. COUNS., <http://opic.texas.gov/health-insurance/legislature-prohibits-discretionary-clauses> [https://perma.cc/35WV-YG4Z].

220. *South Dakota Presidential Race Results: Donald J. Trump Wins*, N.Y. TIMES (Aug. 1, 2017, 11:26 AM), <https://www.nytimes.com/elections/2016/results/south-dakota-president-clinton-trump> [https://perma.cc/CKT9-3SAC].

221. A discretionary clause is not permitted in any individual or group health

The difference lies, however, in the healthcare lobbying effort in Washington, D.C., which is cohesive and well funded.²²² But as the opioid crisis continues to worsen, the hunt for paths to treatment increases in seriousness.²²³ In the case of ERISA plans, the participants already have contracted benefits—the legislature should take every necessary step to permit access, over any lobbying efforts.

B. *Willingness to Deal*

Industry lobbyists have willingly negotiated over amendments to ERISA when faced with reform-minded legislators and the threat of drastic changes to ERISA. In discussions long preceding the ACA for example, Senator Edward Kennedy championed the cause of ERISA reform, holding Senate hearings and exposing the effects of state claim preemption in the ERISA landscape.²²⁴

policy. No policy offered or issued in this state by a health carrier or plan to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services may contain a discretionary clause or similar provision purporting to reserve discretion to the health carrier or plan to interpret the terms of the policy or to provide standards of interpretation or review that are inconsistent with the laws of this state. The provisions of this rule apply to any health insurance policy issued or renewed after June 30, 2008.

S.D. Admin. R. 20:06:52:02 (2008).

222. See Robert Steinbrook, *Election 2008—Campaign Contributions, Lobbying, and the U.S. Health Sector*, 357 NEW ENG. J. MED. 736, 736–38 (2007) (describing election contributions and lobbying resources of the health care sector); Heather T. Williams, Comment, *Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism*, 89 N.C. L. REV. 607, 660 (2011) (noting the healthcare industry's well-funded lobbying presence in Washington, D.C.); Ctr. for Responsive Politics, *Health: Sector Profile, 2017*, OPENSECRETS, <https://www.opensecrets.org/lobby/indus.php?id=H&year=2017> [<https://perma.cc/PBP8-TF27>] (last updated Apr. 24, 2018) (stating that \$562,953,377 were spent on healthcare lobbying in 2017, up slightly from 2016); Dan Eggen, *Health Sector Has Donated Millions to Lawmakers*, WASH. POST (Mar. 8, 2009), www.washingtonpost.com/wp-dyn/content/article/2009/03/07/AR2009030701748.html [<https://perma.cc/LY9G-T4UB>] (“The health-care sector has long ranked with financial services and energy interests as one of the most powerful political forces in Washington, and it spent nearly \$1 billion on lobbying in the past two years alone.”); see also David D. Kirkpatrick, *Health Lobby Takes Fight to the States*, N.Y. TIMES (Dec. 28, 2009), <https://www.nytimes.com/2009/12/29/health/policy/29lobby.html> [<https://perma.cc/U54H-8FWX>] (describing extensive health care lobbying efforts).

223. *Opioid Overdose: Understanding the Epidemic*, CTRS. DISEASE CONTROL & PREVENTION (Aug. 30, 2017), <https://www.cdc.gov/drugoverdose/epidemic/index.html> [<https://perma.cc/GADM-NN9B>] (“In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999.”).

224. *ERISA Preemption Hearing*, *supra* note 32, at 8–9.

Senator Kennedy urged that reform of ERISA preemption was crucial to any ERISA reform and that the industry must be held responsible for these life-and-death decisions.²²⁵ Faced with this serious threat to their state-law immunity, industry and employer representatives started to deal: instead of jettisoning ERISA preemption, they proposed, claims procedures could be reformed and external review could be made mandatory.²²⁶ Industry representatives stopped short of agreeing to these reforms on the spot, but they seemed relieved at this possible substitute for more far-reaching reform.²²⁷ In the end, these more modest changes were included in the ACA, instead of the more penetrating reform that some had sought.²²⁸

A ban on discretionary clauses could result from an initiative all its own, or it could, like external review, serve as a fall-back position from a broader reform movement taking aim at preemption. In any event, history shows that ERISA reform is difficult but not impossible.

C. *Succeeding at the State Level*

An ERISA ban on discretionary clauses would draw opposition from industry, just as it did at the state level.²²⁹ State insurance

225. *Id.* at 3 (statement of Sen. Edward M. Kennedy) (“Every other industry in American can be held responsible for its actions. Health plan decisions can truly mean life or death, and they do not deserve immunity.”).

226. According to the testimony of Mr. Gallagher of Groom & Nordberg, a Washington, D.C., employee benefits law firm, repeal of ERISA preemption would be “disastrous” for ERISA healthcare plans. He argued that employers would scale back benefits if preemption were repealed and employers would scale back benefits. *Id.* Another witness, industry representative Mark A. Smith, said external review would be a better reform than the removal of preemption:

Mr. Smith: [A]s an alternative to changing some of these ERISA remedies, we would certainly favor some type of an appeal process to help resolve some of these issues.

Senator Specter: How about external appeal?

Mr. Smith: Under the right circumstances. That is fraught with certain difficulties, as well. But it is something we would certainly prefer to some of the ERISA remedy changes.

Id. at 46 (emphasis added).

227. *Id.*

228. See 42 U.S.C. § 300gg-19(b) (2012) (describing the external review process that was contemplated as an alternative to repealing state preemption during the Senate Committee Hearing concerning ERISA reform); *ERISA Preemption Hearing*, *supra* note 32, at 49.

229. See, e.g., Morrison & McDonald, *supra* note 50, at 486–87 (“After hearings and comments, the Health Insurance and Managed Care (B) Committee of the NAIC voted to adopt the ‘Prohibition on Use of Discretionary Clauses Model Act.’ At the June 2002 NAIC

commissioners were able to prevail despite this opposition because of the NAIC's research indicating that the consumer was so clearly disadvantaged by these clauses.²³⁰ The case is even stronger when it comes to ERISA plans because of the structural disadvantages to consumers and the case law that has evolved around ERISA plans.

At every turn, the ERISA claimant is disadvantaged in ways that the state-law plan participant is not, with regard to conflicts, absence of remedies, and even within the most recent rule-making as part of the ACA. First, there is the lack of a meaningful remedy if harmed by utilization review, which in turn removes some of the incentive for plan administrators to pay claims in the gray area for those covered by self-funded plans.²³¹ In addition, ERISA plaintiffs can recover no attorneys' fees during the prelitigation phase, and there is no discovery allowed due to the arbitrary and capricious standard.²³² As a secondary effect, the lack of a real remedy or attorney's fees for ERISA violations also makes ERISA cases very unappealing for attorneys to take.²³³

As another disadvantage, the ACA's new external review requirement is less stringent for ERISA plans. The ACA adds binding external review to ERISA and non-ERISA plans—the review must be done by an independent review organization (“IRO”).²³⁴ Plans must “implement an effective external review process that meets minimum standards established by the Secretary.”²³⁵ The rules require that plans assign external reviews to an IRO accredited by the Utilization Review Accreditation Commission (“URAC”) or by another national accrediting organization.²³⁶

meeting, despite a ‘flurry of notes to commissioners’ and an industry attempt to derail the model act procedurally, the NAIC passed the model with ‘five ‘no’ votes and three states’ abstaining.” (footnote omitted).

230. *Id.* at 488.

231. Goldin, *supra* note 38, at 442.

232. *See, e.g.*, Meyer & DeBofsky, *supra* note 69; David A. Pratt, *Focus On . . . Attorney's Fees in ERISA Litigation*, 24 J. PENSION BENEFITS 9, 11 (2017).

233. *Health Insurance and Managed Care (B) Committee, supra* note 134 (noting that it is difficult to get attorneys to take ERISA benefits cases due to the limited remedial scheme, lack of damages beyond the benefit itself, and lack of any punitive damages).

234. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1001 § 2719, 124 Stat. 119, 887–88 (2010) (codified at 42 U.S.C. § 300gg-19 (2012)); 29 C.F.R. § 2590.715-2719(d)(2)(iii)(A) (2018); *see also* 29 U.S.C. § 1185d (2012) (incorporating by reference the ACA's binding external review requirement into ERISA).

235. Patient Protection and Affordable Care Act § 2719(b)(2), 124 Stat. at 888.

236. 29 C.F.R. § 2590.715–2719(d)(2)(iii)(A) (2018).

ERISA-governed plans are treated more leniently and are required to contract with just three IROs and rotating assignments among them.²³⁷ State-law plans, however, must assign cases randomly, choosing from a list of external reviewers.²³⁸ With only three contracted IRO, then, the ERISA plan reviewers are repeat players who may seek to maintain a good business relationship.²³⁹ Lawyers representing plan participants found problems with ERISA-contracted IROs: IROs “violate[d] URAC standards, the NAIC Model Act, and the intent of the federal regulations.”²⁴⁰ One such lawyer stated explicitly that ERISA-contracted IROs act differently—and worse—than those hired for non-ERISA plans.²⁴¹

Thus, the reasons for banning discretionary clauses in state-law-governed plans apply with even greater force to ERISA plans.

CONCLUSION

Discretionary clauses in ERISA plans are without any justifiable legal basis and should be banned. Many insurance products are naturally at risk of moral hazard—the risk that once the participant is insured, he or she (or, in the case of health insurance, perhaps the physician) will take on excessive risk, which will fall on the payor. In the case of ERISA-governed health plans, this is not the case.

ERISA plans already contain significant gate-keeping features, such as the murky “medical necessity” requirement,²⁴² sweeping state law preemption,²⁴³ and the absence of attorney’s fees for all

237. *Id.* § 2590.715–2719(d)(2)(iii)(2)(2).

238. *Id.* § 2590.715–2719(c)(2)(viii).

239. Courts agree that such facts could indeed raise a fair inference that the financial conflict can influence the denial of a plaintiff’s claim. *See Jenkins v. Price Waterhouse Long Term Disability Plan*, 564 F.3d 856, 859 n.5 (7th Cir. 2009); *Maiden v. Aetna Life Ins. Co.*, No. 3:14-CV-901, 2016 U.S. Dist. LEXIS 1428, at *5–6 (N.D. Ind. Jan. 6, 2016); *see also Demer v. IBM Corp. LTD Plan*, 835 F.3d 893, 902-03 (9th Cir. 2016).

240. Letter from Jennifer C. Jaff, Esq., Sec’y of Labor, to Phyllis Borzi, Assistant Sec’y of Labor (Nov. 21, 2011), <https://www.scribd.com/document/73353491/Self-funded-Plan-IRO-Problems> [<https://perma.cc/U76B-X59U>].

241. *Id.* (“In every case, [the IRO] has done things that I have never seen them do when they are contracted by a state to conduct independent reviews.”).

242. Sage, *supra* note 26, at 629 (noting that medical necessity decisions are “variable”).

243. *Id.* at 597 n.3.

but the most egregious cases.²⁴⁴ Mental health and substance use claims are particularly vulnerable in this environment, and investigations reveal that those facing mental health and substance abuse diagnoses simply are not getting the care that is contracted for and for which they qualify under their benefits.

Without discretionary clauses, court review would serve the important function of making sure that the outcome was the *right* one, not simply the one that can be defended without a “guffaw” under a lenient standard of review.

To defend the presence of discretionary clauses in employee benefit plans is to accept that the expedient, litigation-free outcome is more important than the correct outcome. Americans in employer-sponsored plans deserve better, especially those struggling with mental health and substance abuse problems. The United States is in an opioid crisis that robs individuals of their futures and the country of their contributions. Private health plans are not pulling their weight in paying for treatment, and they need to do so by removing discretionary clauses and paying for contracted benefits. A discretionary clause ban would be one step toward recovery.

244. See *supra* note 46 and accompanying text.